1 SENATE BILL NO. 672

2 AMENDMENT IN THE NATURE OF A SUBSTITUTE

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

4 on ________________)

5 (Patron Prior to Substitute--Senator Dunnavant)

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

8 **Be it enacted by the General Assembly of Virginia:**

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

11 **§ 32.1-325. Board to submit plan for medical assistance services to U.S. Secretary of Health**
12 **and Human Services pursuant to federal law; administration of plan; contracts with health care**
13 **providers.**

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

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

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

27 such policies has been excluded from countable resources and (ii) the amount of any other revocable or
28 irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the
29 individual's or his spouse's burial expenses;
30 3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically
31 needy persons whose eligibility for medical assistance is required by federal law to be dependent on the
32 budget methodology for Aid to Families with Dependent Children, a home means the house and lot used
33 as the principal residence and all contiguous property. For all other persons, a home shall mean the house
34 and lot used as the principal residence, as well as all contiguous property, as long as the value of the land,
35 exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of
36 home as provided here is more restrictive than that provided in the state plan for medical assistance
37 services in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as
38 the principal residence and all contiguous property essential to the operation of the home regardless of
39 value;
40 4. A provision for payment of medical assistance on behalf of individuals up to the age of 21, who
41 are Medicaid eligible, for medically necessary stays in acute care facilities in excess of 21 days per
42 admission;
43 5. A provision for deducting from an institutionalized recipient's income an amount for the
44 maintenance of the individual's spouse at home;
45 6. A provision for payment of medical assistance on behalf of pregnant women which provides for
46 payment for inpatient postpartum treatment in accordance with the medical criteria outlined in the most
47 current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American
48 Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards
49 for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and
50 Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the
51 children which are within the time periods recommended by the attending physicians in accordance with
52 and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines

53 or Standards shall include any changes thereto within six months of the publication of such Guidelines or
54 Standards or any official amendment thereto;
55 7. A provision for the payment for family planning services on behalf of women who were
56 Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such
57 family planning services shall begin with delivery and continue for a period of 24 months, if the woman
58 continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the
59 purposes of this section, family planning services shall not cover payment for abortion services and no
60 funds shall be used to perform, assist, encourage or make direct referrals for abortions;
61 8. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow
62 transplants on behalf of individuals over the age of 21 who have been diagnosed with lymphoma, breast
63 cancer, myeloma, or leukemia and have been determined by the treating health care provider to have a
64 performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant.
65 Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;
66 9. A provision identifying entities approved by the Board to receive applications and to determine
67 eligibility for medical assistance, which shall include a requirement that such entities (i) obtain accurate
68 contact information, including the best available address and telephone number, from each applicant for
69 medical assistance, to the extent required by federal law and regulations, and (ii) provide each applicant
70 for medical assistance with information about advance directives pursuant to Article 8 (§ 54.1-2981 et
71 seq.) of Chapter 29 of Title 54.1, including information about the purpose and benefits of advance
72 directives and how the applicant may make an advance directive;
73 10. A provision for breast reconstructive surgery following the medically necessary removal of a
74 breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained,
75 for all medically necessary indications. Such procedures shall be considered noncosmetic;
76 11. A provision for payment of medical assistance for annual pap smears;
77 12. A provision for payment of medical assistance services for prostheses following the medically
78 necessary complete or partial removal of a breast for any medical reason;

79 13. A provision for payment of medical assistance which provides for payment for 48 hours of
80 inpatient treatment for a patient following a radical or modified radical mastectomy and 24 hours of
81 inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for
82 treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring
83 the provision of inpatient coverage where the attending physician in consultation with the patient
84 determines that a shorter period of hospital stay is appropriate;
85 14. A requirement that certificates of medical necessity for durable medical equipment and any
86 supporting verifiable documentation shall be signed, dated, and returned by the physician, physician
87 assistant, or nurse practitioner and in the durable medical equipment provider's possession within 60 days
88 from the time the ordered durable medical equipment and supplies are first furnished by the durable
89 medical equipment provider;
90 15. A provision for payment of medical assistance to (i) persons age 50 and over and (ii) persons
91 age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines
92 of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations,
93 all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA
94 testing" means the analysis of a blood sample to determine the level of prostate specific antigen;
95 16. A provision for payment of medical assistance for low-dose screening mammograms for
96 determining the presence of occult breast cancer. Such coverage shall make available one screening
97 mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through
98 49, and one such mammogram annually to persons age 50 and over. The term "mammogram" means an
99 X-ray examination of the breast using equipment dedicated specifically for mammography, including but
100 not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average
101 radiation exposure of less than one rad mid-breast, two views of each breast;
102 17. A provision, when in compliance with federal law and regulation and approved by the Centers
103 for Medicare & Medicaid Services (CMS), for payment of medical assistance services delivered to
104 Medicaid-eligible students when such services qualify for reimbursement by the Virginia Medicaid
105 program and may be provided by school divisions, regardless of whether the student receiving care has an

106 individualized education program or whether the health care service is included in a student's
107 individualized education program. Such services shall include those covered under the state plan for
108 medical assistance services or by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
109 benefit as specified in § 1905(r) of the federal Social Security Act, and shall include a provision for
110 payment of medical assistance for health care services provided through telemedicine services, as defined
111 in § 38.2-3418.16. No health care provider who provides health care services through telemedicine shall
112 be required to use proprietary technology or applications in order to be reimbursed for providing
113 telemedicine services;

114 18. A provision for payment of medical assistance services for liver, heart and lung transplantation
115 procedures for individuals over the age of 21 years when (i) there is no effective alternative medical or
116 surgical therapy available with outcomes that are at least comparable; (ii) the transplant procedure and
117 application of the procedure in treatment of the specific condition have been clearly demonstrated to be
118 medically effective and not experimental or investigational; (iii) prior authorization by the Department of
119 Medical Assistance Services has been obtained; (iv) the patient selection criteria of the specific transplant
120 center where the surgery is proposed to be performed have been used by the transplant team or program
121 to determine the appropriateness of the patient for the procedure; (v) current medical therapy has failed
122 and the patient has failed to respond to appropriate therapeutic management; (vi) the patient is not in an
123 irreversible terminal state; and (vii) the transplant is likely to prolong the patient's life and restore a range
124 of physical and social functioning in the activities of daily living;

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

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

131 21. A provision for payment for medical assistance for infant hearing screenings and all necessary
132 audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United

133 States Food and Drug Administration, and as recommended by the national Joint Committee on Infant
134 Hearing in its most current position statement addressing early hearing detection and intervention
135 programs. Such provision shall include payment for medical assistance for follow-up audiological
136 examinations as recommended by a physician, physician assistant, nurse practitioner, or audiologist and
137 performed by a licensed audiologist to confirm the existence or absence of hearing loss;

138 22. A provision for payment of medical assistance, pursuant to the Breast and Cervical Cancer
139 Prevention and Treatment Act of 2000 (P.L. 106-354), for certain women with breast or cervical cancer
140 when such women (i) have been screened for breast or cervical cancer under the Centers for Disease
141 Control and Prevention (CDC) Breast and Cervical Cancer Early Detection Program established under
142 Title XV of the Public Health Service Act; (ii) need treatment for breast or cervical cancer, including
143 treatment for a precancerous condition of the breast or cervix; (iii) are not otherwise covered under
144 creditable coverage, as defined in § 2701 (c) of the Public Health Service Act; (iv) are not otherwise
145 eligible for medical assistance services under any mandatory categorically needy eligibility group; and (v)
146 have not attained age 65. This provision shall include an expedited eligibility determination for such
147 women;

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

153 24. A provision, when authorized by and in compliance with federal law, to establish a public-
154 private long-term care partnership program between the Commonwealth of Virginia and private insurance
155 companies that shall be established through the filing of an amendment to the state plan for medical
156 assistance services by the Department of Medical Assistance Services. The purpose of the program shall
157 be to reduce Medicaid costs for long-term care by delaying or eliminating dependence on Medicaid for
158 such services through encouraging the purchase of private long-term care insurance policies that have
159 been designated as qualified state long-term care insurance partnerships and may be used as the first source

160 of benefits for the participant's long-term care. Components of the program, including the treatment of
161 assets for Medicaid eligibility and estate recovery, shall be structured in accordance with federal law and
162 applicable federal guidelines;
163 25. A provision for the payment of medical assistance for otherwise eligible pregnant women
164 during the first five years of lawful residence in the United States, pursuant to § 214 of the Children's
165 Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3);
166 26. A provision for the payment of medical assistance for medically necessary health care services
167 provided through telemedicine services, as defined in § 38.2-3418.16, regardless of the originating site or
168 whether the patient is accompanied by a health care provider at the time such services are provided. No
169 health care provider who provides health care services through telemedicine services shall be required to
170 use proprietary technology or applications in order to be reimbursed for providing telemedicine services.
171 For the purposes of this subdivision, "originating site" means any location where the patient is
172 located, including any medical care facility or office of a health care provider, the home of the patient, the
173 patient's place of employment, or any public or private primary or secondary school or postsecondary
174 institution of higher education at which the person to whom telemedicine services are provided is located;
175 27. A provision for the payment of medical assistance for the dispensing or furnishing of up to a
176 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the
177 Department shall not impose any utilization controls or other forms of medical management limiting the
178 supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month
179 supply. Nothing in this subdivision shall be construed to (i) require a provider to prescribe, dispense, or
180 furnish a 12-month supply of self-administered hormonal contraceptives at one time or (ii) exclude
181 coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice,
182 for reasons other than contraceptive purposes. As used in this subdivision, "hormonal contraceptive"
183 means a medication taken to prevent pregnancy by means of ingestion of hormones, including medications
184 containing estrogen or progesterone, that is self-administered, requires a prescription, and is approved by
185 the U.S. Food and Drug Administration for such purpose; and

186 28. A provision for payment of medical assistance for remote patient monitoring services provided
187 via telemedicine, as defined in § 38.2-3418.16, for (i) high-risk pregnant persons; (ii) medically complex
188 infants and children; (iii) transplant patients; (iv) patients who have undergone surgery, for up to three
189 months following the date of such surgery; and (v) patients with a chronic health condition who have had
190 two or more hospitalizations or emergency department visits related to such chronic health condition in
191 the previous 12 months. For the purposes of this subdivision, "remote patient monitoring services" means
192 the use of digital technologies to collect medical and other forms of health data from patients in one
193 location and electronically transmit that information securely to health care providers in a different
194 location for analysis, interpretation, and recommendations, and management of the patient. "Remote
195 patient monitoring services" includes monitoring of clinical patient data such as weight, blood pressure,
196 pulse, pulse oximetry, blood glucose, and other patient physiological data, treatment adherence
197 monitoring, and interactive videoconferencing with or without digital image upload.

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

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

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

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

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

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

213 6. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card,
214 or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each
215 recipient of medical assistance services, and shall upon any changes in the required data elements set forth
216 in subsection A of § 38.2-3407.4:2, either reissue the card or provide recipients such corrective
217 information as may be required to electronically process a prescription claim.
218 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement
219 for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,
220 regardless of any other provision of this chapter, such amendments to the state plan for medical assistance
221 services as may be necessary to conform such plan with amendments to the United States Social Security
222 Act or other relevant federal law and their implementing regulations or constructions of these laws and
223 regulations by courts of competent jurisdiction or the United States Secretary of Health and Human
224 Services.
225 In the event conforming amendments to the state plan for medical assistance services are adopted,
226 the Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
227 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
228 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
229 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
230 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with the
231 Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session
232 of the General Assembly unless enacted into law.
233 D. The Director of Medical Assistance Services is authorized to:
234 1. Administer such state plan and receive and expend federal funds therefor in accordance with
235 applicable federal and state laws and regulations; and enter into all contracts necessary or incidental to the
236 performance of the Department's duties and the execution of its powers as provided by law.
237 2. Enter into agreements and contracts with medical care facilities, physicians, dentists and other
238 health care providers where necessary to carry out the provisions of such state plan. Any such agreement
239 or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is

240 reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new
241 agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement
242 or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

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

247 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing
248 agreement or contract, with a provider who is or has been a principal in a professional or other corporation
249 when such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-
250 315, 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
251 program pursuant to 42 C.F.R. Part 1002.

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

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

255 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
256 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R. §
257 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
258 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
259 the date of receipt of the notice.

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

266 F. When the services provided for by such plan are services which a marriage and family therapist,
267 clinical psychologist, clinical social worker, professional counselor, or clinical nurse specialist is licensed
268 to render in Virginia, the Director shall contract with any duly licensed marriage and family therapist,
269 duly licensed clinical psychologist, licensed clinical social worker, licensed professional counselor or
270 licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter
271 shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which
272 reimburse licensed marriage and family therapists, licensed clinical psychologists, licensed clinical social
273 workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon
274 reasonable criteria, including the professional credentials required for licensure.
275 G. The Board shall prepare and submit to the Secretary of the United States Department of Health
276 and Human Services such amendments to the state plan for medical assistance services as may be
277 permitted by federal law to establish a program of family assistance whereby children over the age of 18
278 years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of
279 providing medical assistance under the plan to their parents.
280 H. The Department of Medical Assistance Services shall:
281 1. Include in its provider networks and all of its health maintenance organization contracts a
282 provision for the payment of medical assistance on behalf of individuals up to the age of 21 who have
283 special needs and who are Medicaid eligible, including individuals who have been victims of child abuse
284 and neglect, for medically necessary assessment and treatment services, when such services are delivered
285 by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a
286 provider with comparable expertise, as determined by the Director.
287 2. Amend the Medallion II waiver and its implementing regulations to develop and implement an
288 exception, with procedural requirements, to mandatory enrollment for certain children between birth and
289 age three certified by the Department of Behavioral Health and Developmental Services as eligible for
290 services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

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

294 4. Require any managed care organization with which the Department enters into an agreement
295 for the provision of medical assistance services to include in any contract between the managed care
296 organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or
297 a representative of the pharmacy benefits manager from conducting spread pricing with regards to the
298 managed care organization's managed care plans. For the purposes of this subdivision:

299 "Pharmacy benefits management" means the administration or management of prescription drug
300 benefits provided by a managed care organization for the benefit of covered individuals.

301 "Pharmacy benefits manager" means a person that performs pharmacy benefits management.

302 "Spread pricing" means the model of prescription drug pricing in which the pharmacy benefits
303 manager charges a managed care plan a contracted price for prescription drugs, and the contracted price
304 for the prescription drugs differs from the amount the pharmacy benefits manager directly or indirectly
305 pays the pharmacist or pharmacy for pharmacist services.

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

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

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

317 **§ 54.1-3303.1. Initiating of treatment with and dispensing and administering of controlled**
318 **substances by pharmacists.**

319 A. Notwithstanding the provisions of § 54.1-3303, a pharmacist may initiate treatment with,
320 dispense, or administer the following drugs, devices, controlled paraphernalia, and other supplies and
321 equipment to persons 18 years of age or older with whom the pharmacist has a bona fide pharmacist-
322 patient relationship and in accordance with a statewide protocol developed by the Board in collaboration
323 with the Board of Medicine and the Department of Health and set forth in regulations of the Board:

324 1. Naloxone or other opioid antagonist, including such controlled paraphernalia, as defined in §
325 54.1-3466, as may be necessary to administer such naloxone or other opioid antagonist;

326 2. Epinephrine;

327 3. Injectable or self-administered hormonal contraceptives, provided the patient completes an
328 assessment consistent with the United States Medical Eligibility Criteria for Contraceptive Use;

329 4. Prenatal vitamins for which a prescription is required;

330 5. Dietary fluoride supplements, in accordance with recommendations of the American Dental
331 Association for prescribing of such supplements for persons whose drinking water has a fluoride content
332 below the concentration recommended by the U.S. Department of Health and Human Services;

333 6. Drugs as defined in § 54.1-3401, devices as defined in § 54.1-3401, controlled paraphernalia as
334 defined in § 54.1-3466, and other supplies and equipment available over-the-counter, covered by the
335 patient's health carrier when the patient's out-of-pocket cost is lower than the out-of-pocket cost to
336 purchase an over-the-counter equivalent of the same drug, device, controlled paraphernalia, or other
337 supplies or equipment;

338 7. Vaccines included on the Immunization Schedule published by the Centers for Disease Control
339 and Prevention ~~or that have a current emergency use authorization from the U.S. Food and Drug~~
340 ~~Administration~~ and vaccines for COVID-19;

341 8. Tuberculin purified protein derivative for tuberculosis testing; ~~and~~

342 9. Controlled substances for the prevention of human immunodeficiency virus, including
343 controlled substances prescribed for pre-exposure and post-exposure prophylaxis pursuant to guidelines
344 and recommendations of the Centers for Disease Control and Prevention;
345 10. Nicotine replacement and other tobacco cessation therapies, including controlled substances
346 as defined in the Drug Control Act (§ 54.1-3400 et seq.), together with providing appropriate patient
347 counseling;
348 11. Controlled substances or devices for the initiation of treatment of the following diseases or
349 conditions for which clinical decision making can be guided by a clinical test that is classified as waived
350 under the federal Clinical Laboratory Improvement Amendments of 1988: group A streptococcus bacteria,
351 influenza virus, and urinary tract infection; and
352 12. Tests for COVID-19 and other coronaviruses.
353 B. Notwithstanding the provisions of § 54.1-3303, a pharmacist may initiate treatment with,
354 dispense, or administer the following drugs and devices to persons three years of age or older in
355 accordance with a statewide protocol as set forth in regulations of the Board:
356 1. Vaccines included on the Immunization Schedule published by the Centers for Disease Control
357 and Prevention and vaccines for COVID-19; and
358 2. Tests for COVID-19 and other coronaviruses.
359 C. A pharmacist who initiates treatment with or dispenses or administers a drug or device pursuant
360 to this section shall notify the patient's primary health care provider that the pharmacist has initiated
361 treatment with such drug or device or that such drug or device has been dispensed or administered to the
362 patient, provided that the patient consents to such notification. No pharmacist shall limit the ability of
363 notification to be sent to the patient's primary care provider by requiring use of electronic mail that is
364 secure or compliant with the federal Health Insurance Portability and Accountability Act (42 U.S.C. §
365 1320d et seq.). If the patient does not have a primary health care provider, the pharmacist shall counsel
366 the patient regarding the benefits of establishing a relationship with a primary health care provider and,
367 ~~upon request,~~ provide information regarding primary health care providers, including federally qualified
368 health centers, free clinics, or local health departments serving the area in which the patient is located. If

369 the pharmacist is initiating treatment with, dispensing, or administering injectable or self-administered
370 hormonal contraceptives, the pharmacist shall counsel the patient regarding seeking preventative care,
371 including (i) routine well-woman visits, (ii) testing for sexually transmitted infections, and (iii) pap
372 smears.

373 ~~C.~~ D. A pharmacist who administers a vaccination pursuant to ~~subdivision~~ subdivisions A 7 and B
374 1 shall report such administration to the Virginia Immunization Information System in accordance with
375 the requirements of § 32.1-46.01.

376 E. A pharmacist who initiates treatment with, dispenses, or administers drugs, devices, controlled
377 paraphernalia, and other supplies and equipment pursuant to this section shall obtain a history from the
378 patient, including questioning the patient for any known allergies, adverse reactions, contraindications, or
379 health diagnoses or conditions that would be adverse to the initiation of treatment, dispensing, or
380 administration.

381 F. A pharmacist may initiate treatment with, dispense, or administer drugs, devices, controlled
382 paraphernalia, and other supplies and equipment pursuant to this section through telemedicine services,
383 as defined in § 38.2-3418.16, in compliance with all requirements of § 54.1-3303 and consistent with the
384 applicable standard of care.

385 G. A pharmacist who administers a vaccination to a minor pursuant to subdivision B 1 shall
386 provide written notice to the minor's parent or guardian that the minor should visit a pediatrician annually.

387 **§ 54.1-3321. Registration of pharmacy technicians.**

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

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

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

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

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

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

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

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

8. Under the supervision of a pharmacist, meaning the supervising pharmacist is at the same physical location of the technician or pharmacy intern, and consistent with the requirements of § 54.1-3303.1, administration of the following drugs and devices to persons three years of age or older as set forth in regulations of the Board: vaccines included on the Immunization Schedule published by the Centers for Disease Control and Prevention and vaccines for COVID-19; and

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

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

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

2. (Effective July 1, 2022) Evidence that he has successfully completed a training program that is (i) an accredited training program, including an accredited training program operated through the Department of Education's Career and Technical Education program or approved by the Board, or (ii) operated through a federal agency or branch of the military; and

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

C. The Board shall promulgate regulations establishing requirements for:

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

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

423 3. Evidence of continued competency as a condition of renewal of a registration as a pharmacy
424 technician.
425 D. The Board shall waive the initial registration fee for a pharmacy technician applicant who works
426 as a pharmacy technician exclusively in a free clinic pharmacy. A person registered pursuant to this
427 subsection shall be issued a limited-use registration. A pharmacy technician with a limited-use registration
428 shall not perform pharmacy technician tasks in any setting other than a free clinic pharmacy. The Board
429 shall also waive renewal fees for such limited-use registrations. A pharmacy technician with a limited-use
430 registration may convert to an unlimited registration by paying the current renewal fee.
431 E. Any person registered as a pharmacy technician prior to the effective date of regulations
432 implementing the provisions of this section shall not be required to comply with the requirements of
433 subsection B in order to maintain or renew registration as a pharmacy technician.
434 F. A pharmacy technician trainee enrolled in a training program for pharmacy technicians
435 described in subdivision B 2 may engage in the acts set forth in subsection A for the purpose of obtaining
436 practical experience required for completion of the training program, so long as such activities are directly
437 monitored by a supervising pharmacist.
438 G. To be registered as a pharmacy technician trainee, a person shall submit an application and a
439 fee specified in regulations of the Board. Such registration shall only be valid while the person is enrolled
440 in a pharmacy technician training program described in subsection B and actively progressing toward
441 completion of such program. A registration card issued pursuant to this section shall be invalid and shall
442 be returned to the Board if such person fails to enroll in a pharmacy technician training program described
443 in subsection B.
444 H. A pharmacy intern may perform the duties set forth for pharmacy technicians in subsection A
445 when registered with the Board for the purpose of gaining the practical experience required to apply for
446 licensure as a pharmacist.
447 **2. That the Board of Medicine, in collaboration with the Board of Pharmacy and the Department**
448 **of Health, shall establish a statewide protocol for the initiation of treatment with and dispensing**
449 **and administering of drugs and devices by pharmacists in accordance with § 54.1-3303.1 of the Code**

450 **of Virginia, as amended by this act, by November 1, 2022, and the Board of Pharmacy shall**
451 **promulgate regulations to implement the provisions of the first enactment of this act to be effective**
452 **within 280 days of its enactment. Such regulations shall include provisions for ensuring that physical**
453 **settings in which treatment is provided pursuant to this act shall be in compliance with the federal**
454 **Health Insurance Portability and Accountability Act, 42 U.S.C. § 1320d et seq., as amended.**
455 **3. That the provisions of subdivisions B 1 and 3 of § 54.1-3303.1 of the Code of Virginia, as amended**
456 **by this act, shall become effective upon the expiration of the provisions of the federal Declaration**
457 **Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures**
458 **Against COVID-19 related to the vaccination and COVID-19 testing of minors.**
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