BEYOND THE BELTWAY

POWER TO DECIDE

Pharmacist Prescribing of Hormonal Contraceptives

Over the last few years, there has been a growing interest in expanding the authority of pharmacists to directly prescribe and dispense some hormonal birth control methods. This eliminates the need for patients to first get a prescription from a doctor before going to have it filled at a pharmacy. Currently, 17 states (including the District of Columbia) have enacted policies to allow pharmacists to prescribe and dispense self-administered hormonal methods (e.g., the pill, patch, ring, and shot). See the status of implementation in Table 1.

46% of pharmacies in Oregon prescribe contraception.

Allowing pharmacists to prescribe is not a new concept or limited to birth control. Many states provide pharmacists with varying levels of prescribing authority for certain products.[1] Some states allow collaborative practice agreements (CPAs), which require pharmacists to have a supervising physician. A plurality of states have statewide protocols specifically for prescribing hormonal contraception (among other drugs). Statewide protocols do not require agreements with physicians, as the authority comes directly from the state. A few other states are using standing orders. A standing order could act like a CPA or a statewide protocol, depending on whether the authority is derived from a supervising physician the pharmacist has identified and entered into an agreement with (CPA), or the state department of health director who can grant authority to all pharmacists in the state (statewide protocol).

"Research from **Oregon** and **New Mexico** shows that pharmacists in rural areas are similarly likely to prescribe birth control as pharmacists in urban areas."

While there are some differences between these states policies, there are several similarities. Pharmacists are required to undergo a training and to refer patients at some point in the process to their primary care provider, or local providers for patients that do not already have one. Patients are required to complete a self-screening tool to identify risks.

10% of new prescriptions for pills or patches were written by a pharmacist.

(Among Medicaid enrollees in Oregon)

1 Adams, A.J. and Weaver, K.K. (2016). The Continuum of Pharmacist Prescriptive Authority. Annals of Pharmacotherapy, 50(9): 778-784 https://doi.org/10.1177/1060028016653608

States that have done well implementing pharmacist prescribing show the potential it has to increase access to some forms of contraception for some women. For instance, 46% of pharmacies in Oregon prescribe contraception. Among Medicaid enrollees in that state, 10% of new prescriptions for pills or patches were written by a pharmacist.[2] Additional research from Oregon and New Mexico shows that pharmacists in rural areas are similarly likely to prescribe birth control as pharmacists in urban areas.[3] Dr. Rebecca Stone, University of Georgia Pharmacist, has keenly noted, "Effective hormonal contraceptives have been safely used by women for more than 50 years, and pharmacists are well-trained to help women select and use these medications effectively."[4]

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Allowing pharmacists in more states to prescribe hormonal contraception could be especially useful for women without ready access to a doctor from whom they can get a prescription. Some 67% of women in a nationwide survey said they would benefit from accessing contraception directly from a pharmacist without having to pay a fee to visit a physician or clinic.[5] As one consumer summarized the benefit of this service, "My prescription had run out and I don't have a doctor to fill it. The pharmacist was just able to take care of it—super easy and convenient."[6] New research from Oregon, California, Colorado, and Hawaii suggests that this model is filling a gap for some women, as those receiving contraception from a pharmacist were more likely to be younger, uninsured, and have less education than women receiving contraception from a clinician. The same study found that women are more likely to receive an extended supply of contraception when prescribed by a pharmacist compared to clinician-based prescriptions.[7] However, as with any law, implementation is key. California, the first state to pass a law giving pharmacists this authority, has had a different experience with the roll-out of its law, where only 5% of pharmacies were prescribing contraception in the first year after implementation.[8] Other states looking into this policy option can learn from the lessons of these early adopter states.[9]

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As other states assess whether to pursue this policy option, there are a variety of factors to take into account. For example, there are concerns about age restrictions, whether pharmacies will be able to provide a private space for patient counseling, and how to handle public and private health insurance reimbursement for pharmacists who provide counseling. States should consider the financial burden counseling services may pose for uninsured customers, as well as the barrier that an age restriction can impose for young people and those without identification. Other factors that could influence a patient's decision to use this service might include the availability of multilingual pharmacy staff, pharmacy hours, and distance to participating pharmacies.[10]

2 Anderson L., Hartung, D.M., Middleton, L., Rodriguez, M.I. (2019). Pharmacist Provision of Hormonal Contraception in the Oregon Medicaid Population. Obstetrics and Gynecology, 133(6):1231-1237. https://doi.org/10.1097/AOG.0000000000003286

3 Rodriguez, M.I., Garg B., Williams, S.M., Souphanavong J., Schrote K., Darney, B.G. (2019). Availability of Pharmacist Prescription of Contraception in Rural Areas of Oregon and New Mexico. Contraception, 101(3):210-212. https://doi.org/10.1016/j.contraception.2019.11.005

4 R Street Institute. (April 14, 2020). Webinar: Bipartisan Solutions for Birth Control Access. https://www.youtube.com/watch?v=s3zoVbGCamg

5 Rafie, S., Richards, E., Rafie, S., Landau, S.C., and Wilkinson, T.A. (2019) Pharmacist Outlooks on Prescribing Hormonal Contraception Following Statewide Scope of Practice Expansion. Journal of Pharmacy Education and Practice, 7(3): 96 https://doi.org/10.3390/pharmacy7030096

6 Rodriguez, M.I. (2019) Unpublished research from the PEARL study https://www.ohsu.edu/womens-health/pearl-study

7 Rodriguez, M.I., Edelman, A.B., Skye, M., Anderson, L., Darney, B.G. (2020). Association of Pharmacist Prescription With Dispensed Duration of Hormonal Contraception. Obstetrics and Gynecology, 3(5):1-12. https://doi:10.1001/jamanetworkopen.2020.5252

8 Batra P., Rafie S., Zhang Z., Singh A.V., Bird C.E., Sridhar A, Sullivan J.G. (2018). An Evaluation of the Implementation of Pharmacist-Prescribed Hormonal Contraceptives in California. Obstetrics and Gynecology, 131(5):850-855. https://doi.org/10.1097/AOG.0000000000002572

9 APhA. (2018, April 19). Pharmacist-prescribed contraception still hard to find. https://www.pharmacist.com/article/pharmacist-prescribed-contraception-still-hard-find.

10 Barber J.S., Ela E., Gatny H, Kusunoki Y, Fakih S., Batra, P., Farris K. (2019). Contraceptive Desert? Black-White Differences in Characteristics of Nearby Pharmacies. (2019). Journal of Racial and Ethnic Health Disparities 6:719-732. https://doi.org/10.1007/s40615-019-00570-3

Contraceptive access remains challenging in the US, with more than 19 million women with low incomes living in contraceptive deserts, counties in which there is not reasonable access to a health center offering the full range of contraceptive methods.[11] Given this landscape, and ongoing federal policy challenges, interest in allowing pharmacists to prescribe hormonal contraception is likely to continue gaining traction in states.

Many pharmacists are prescribing hormonal contraceptives, seeing it as an opportunity to practice at the top of their license.[12] Though pharmacist participation varies across states, advocacy within the pharmacy community for better implementation and reimbursement may increase pharmacist participation—and research has suggested pharmacist interest in states where they do not yet have the authority to prescribe contraception.[13] Like any policy option, pharmacist prescribing should not be considered a cure-all for barriers to contraceptive access. However, allowing and supporting more pharmacists to prescribe birth control provides another important access point for women, ensuring more have the power to decide if, when, and under what circumstances to get pregnant.

Below is a table that highlights key information from each state that allows pharmacists to prescribe contraception.

Table 1.

State	Bill / Guidance	Year Passed & Date in Effect for Consumers*	Pharmacist Reimbursed	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
California	SB 493 Regulations	2013 January 2014	Yes, Medicaid Fee-for-Service	Statewide Protocol	pill, patch, ring, injection	(+) Self-screening tool available in multiple languages[1] (+) Requires referral to a health care provider if these services are not available, if self-administered hormonal contraception is not recommended for patient, and after furnishing contraceptives to a patient
Colorado	SB 16-135 FAQs Protocol	2016 March 2017	Limited[2]	Statewide Protocol	pill, patch	(-) Age restriction (18 and older) (-) Cannot continue to prescribe to patient beyond three years from initial Rx, if no evidence of a clinical visit
District of Columbia	B 22-106	2018 TBD	Yes	Collaborative Practice Agreements	pill, patch, ring	(+) Requires referral to a health care provider after contraceptives are furnished or if self-administered hormonal contraception is not recommended

11 Birth Control Access. Power to Decide. https://powertodecide.org/what-we-do/access/birth-control-access

12 The Birth Control Pharmacist project provides education and training, implementation assistance, resources, and clinical updates to pharmacists prescribing contraception, and engages in advocacy, research and policy efforts to expand the role of pharmacists in family planning. Their Birth Control Pharmacies site helps people to find a pharmacy where they can obtain contraception directly from a pharmacist.

13 Stone R.H., Rafie S., Shealy K., Griffin B., Stein A.B. (2020). Pharmacist self-perception of readiness to prescribe hormonal contraception and additional training needs. Currents in Pharmacy Teaching and Learning 12(1):27-34. https://doi.org/10.1016/j.cptl.2019.10.005

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Hawaii	SB 513	2017 July 2017	Yes	Statewide Protocol	pill, patch, ring, injection	(+) Requires referral to a health care provider after contraceptives are furnished
Idaho[3]	HB 182	2019	Currently working on with private insurers	N/A	pill, patch, ring, injection	N/A
Maryland	HB 613 Regulations	2018 January 2019	Yes Medicaid FFS	Statewide Protocol	pill, patch, ring	(+) Requires referral to a health care provider after contraceptives are furnished
Michigan	...	...	...	Collaborative Practice Agreements	...	(-) Only one chain has harnessed the use of CPAs and there is no clear billing model at present so cash is charged for the consultation
Minnesota	SF 13	May 2020 (Protocol to be developed by January 1, 2021)	TBD	TBD	TBD	(-) Age restriction (18 and older, unless minor has existing Rx from a licensed physician, physician assistant, or APRN) (-) Pharmacist who prescribes and dispenses an initial Rx cannot provide a refill if patient has no evidence of a clinical visit within preceding three years.
Montana	...	...	...	Collaborative Practice Agreements	...	...
New Hampshire	HB 1822 Ph 2400 (as proposed)	2018 TBD	No	Standing order (must be renewed every year)	pill, patch, ring	(+) Insurers that cover outpatient contraceptive services must cover initial screening at pharmacy
New Mexico	16.19.26.14 NMAC Protocol	2017 June 2017	No	Statewide Protocol	pill, patch, ring, injection	(+) Requires referral to a health care provider if hormonal contraception is not recommended, desired method is not available, or if patient experiences side effects

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State	Bill / Guidance	Year Passed & Date in Effect for Consumers*	Pharmacist Reimbursed	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
Oregon	HB 2527 (expanded authority) HB 2879 (only applied to pills and the patch) Regulations	2017 2015 January 2016	Yes	Statewide Protocol	pill, patch, ring, injection	(+) Self-screening tool also available in Spanish[1] (+) Referral to a health care provider required if hormonal contraception is not recommended (-) Cannot continue to prescribe to patient beyond three years from initial Rx, without evidence of a clinical visit
Tennessee	SB 1677 Rule 1140-15	2016 Late 2019	No	Collaborative Practice Agreements	pill, patch, ring, injection	(-) Age restriction (18 and older unless an emancipated minor) (-) Pharmacists may charge an annual administrative fee, except insured patients are not required to pay it
Utah	SB 184 Rule R433-200	2018 April 2019	No	Standing order that acts as a statewide protocol (to be reevaluated in 2 years)	pill, patch, ring	(+) Self-screening tool also available in Spanish[1] (-) Age restriction (18 and older), regardless of whether patient has an existing Rx (+) Referral to a health care provider is required if hormonal contraception is not recommended (-) Cannot continue to prescribe to a patient more than 2 years after initial Rx, without evidence of consultation with a primary care provider (-) Not covered by insurance

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State	Bill / Guidance	Year Passed & Date in Effect for Consumers*	Pharmacist Reimbursed	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
Virginia	B 1506	April 2020 January 11, 2021	Yes, in private plans	Statewide (to be developed)	The law states "Injectable or self-administered hormonal contraceptives", may be clarified in protocol / regulations	(-) age restriction (18 and older)
Washington[4]	Chapter 90, 1979 Laws	1979 1998	Yes, if enrolled as a provider (except Medicaid Fee-for-Service)	Collaborative Practice Agreements		(-) age restriction (18 and older)
West Virginia	HB 2583	2019 TBD (aimed to begin training in March 2020)	No[5]	Standing order	pill, patch, ring	(+) Referral to a health care provider required if hormonal contraception is not recommended (-) Cannot continue to prescribe to a patient more than 12 months after initial Rx, w/out evidence of consultation w/ a health care practitioner (-) Age restriction (18 and older)

***Several studies have shown that while these services may theoretically be available, consumers in some states can find it hard to access these services.**

... Information forthcoming

1 All states require self-screening tools, but they may not be available in languages other than English.

2 HB 18-1112, passed in 2018, requires health benefit plans to cover services provided by a pharmacist if the services are provided within a health professional shortage area, and the plan would cover the services if provided by a licensed physician or APN. They are still pursuing coverage through Medicaid.

3 HB 182 expands the scope of practice for pharmacists to prescribe drugs in accordance with the US FDA-approved labeling and that are generally limited to minor conditions that do require a diagnosis.

4 While Washington has allowed pharmacists to prescribe contraception for several decades,up-take among pharmacies has been slow.

5 While HB 2583 does not provide for reimbursement, SB 787, passed in the 2020 legislative session, gives pharmacists provider status under WV law, requiring private plans to reimburse in-network pharmacists for services that would be reimbursed if performed by another health care provider.