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HOUSE BILL NO. 1323

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Health, Welfare and Institutions on February 10, 2022)

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

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

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

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

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

7. A provision for the payment for family planning services on behalf of women who were Medicaid-eligible for prenatal care and delivery as provided in this section at the time of delivery. Such family planning services shall begin with delivery and continue for a period of 24 months, if the woman continues to meet the financial eligibility requirements for a pregnant woman under Medicaid. For the

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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
73 obtained, 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
86 days from the time the ordered durable medical equipment and supplies are first furnished by the
87 durable 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
90 guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal
91 examinations, all in accordance with American Cancer Society guidelines. For the purpose of this
92 subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate
93 specific antigen;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

179 C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for
180 medical assistance or related services, the Board, subject to the approval of the Governor, may adopt,
181 regardless of any other provision of this chapter, such amendments to the state plan for medical
182 assistance services as may be necessary to conform such plan with amendments to the United States

183 Social Security Act or other relevant federal law and their implementing regulations or constructions of
184 these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health
185 and Human Services.

186 In the event conforming amendments to the state plan for medical assistance services are adopted, the
187 Board shall not be required to comply with the requirements of Article 2 (§ 2.2-4006 et seq.) of Chapter
188 40 of Title 2.2. However, the Board shall, pursuant to the requirements of § 2.2-4002, (i) notify the
189 Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or
190 regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the
191 regulations are necessitated by an emergency situation. Any such amendments that are in conflict with
192 the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular
193 session of the General Assembly unless enacted into law.

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

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

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

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

208 4. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement
209 or contract, with a provider who is or has been a principal in a professional or other corporation when
210 such corporation has been convicted of or otherwise pled guilty to any violation of § 32.1-314, 32.1-315,
211 32.1-316, or 32.1-317, or any other felony or has been excluded from participation in any federal
212 program pursuant to 42 C.F.R. Part 1002.

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

215 6. (Expires January 1, 2020) Provide payments or transfers pursuant to § 457 of the Internal Revenue
216 Code to the deferred compensation plan described in § 51.1-602 on behalf of an individual who is a
217 dentist or an oral and maxillofacial surgeon providing services as an independent contractor pursuant to
218 a Medicaid agreement or contract under this section. Notwithstanding the provisions of § 51.1-600, an
219 "employee" for purposes of Chapter 6 (§ 51.1-600 et seq.) of Title 51.1 shall include an independent
220 contractor as described in this subdivision.

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

222 E. In any case in which a Medicaid agreement or contract is terminated or denied to a provider
223 pursuant to subsection D, the provider shall be entitled to appeal the decision pursuant to 42 C.F.R.
224 § 1002.213 and to a post-determination or post-denial hearing in accordance with the Administrative
225 Process Act (§ 2.2-4000 et seq.). All such requests shall be in writing and be received within 15 days of
226 the date of receipt of the notice.

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

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

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

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

247 H. The Department of Medical Assistance Services shall:

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

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

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

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

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

269 *K. When the services provided for by such plan are services related to initiation of treatment with or*
270 *dispensing or administration of a vaccination by a pharmacist, pharmacy technician, or pharmacy intern*
271 *in accordance with § 54.1-3303.1, the Department shall provide reimbursement for such service in an*
272 *amount that is no less than the reimbursement amount for such service by a health care provider*
273 *licensed by the Board of Medicine.*

274 **§ 38.2-3408. Policy providing for reimbursement for services that may be performed by certain**
275 **practitioners other than physicians.**

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

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

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

292 **§ 54.1-3303.1. Initiating of treatment with and dispensing and administering of controlled**
293 **substances by pharmacists.**

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

299 1. Naloxone or other opioid antagonist, including such controlled paraphernalia, as defined in
300 § 54.1-3466, as may be necessary to administer such naloxone or other opioid antagonist;

301 2. Epinephrine;

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

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

305 5. Dietary fluoride supplements, in accordance with recommendations of the American Dental

306 Association for prescribing of such supplements for persons whose drinking water has a fluoride content
 307 below the concentration recommended by the U.S. Department of Health and Human Services;

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

313 7. ~~Vaccines included on the Immunization Schedule published by the Centers for Disease Control~~
 314 ~~and Prevention or that have a current emergency use authorization from the U.S. Food and Drug~~
 315 ~~Administration;~~

316 8. Tuberculin purified protein derivative for tuberculosis testing; and

317 9. 8. Controlled substances for the prevention of human immunodeficiency virus, including controlled
 318 substances prescribed for pre-exposure and post-exposure prophylaxis pursuant to guidelines and
 319 recommendations of the Centers for Disease Control and Prevention.

320 B. A pharmacist who initiates treatment with or dispenses or administers a drug or device pursuant to
 321 this section shall notify the patient's primary health care provider that the pharmacist has initiated
 322 treatment with such drug or device or that such drug or device has been dispensed or administered to
 323 the patient, provided that the patient consents to such notification. If the patient does not have a primary
 324 health care provider, the pharmacist shall counsel the patient regarding the benefits of establishing a
 325 relationship with a primary health care provider and, upon request, provide information regarding
 326 primary health care providers, including federally qualified health centers, free clinics, or local health
 327 departments serving the area in which the patient is located. If the pharmacist is initiating treatment
 328 with, dispensing, or administering injectable or self-administered hormonal contraceptives, the pharmacist
 329 shall counsel the patient regarding seeking preventative care, including (i) routine well-woman visits, (ii)
 330 testing for sexually transmitted infections, and (iii) pap 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*
 334 *set forth in regulations of the Board vaccines authorized by the U.S. Food and Drug Administration,*
 335 *including vaccines authorized for emergency use in response to a public health emergency, or may*
 336 *cause such vaccines to be administered by a pharmacy technician or pharmacy intern under the direct*
 337 *supervision of the pharmacist. A pharmacist who administers a vaccination pursuant to subdivision A 7*
 338 *this subsection shall report such administration to the Virginia Immunization Information System in*
 339 *accordance with the 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*
 342 *allergies, adverse reactions, contraindications, or diagnoses or conditions of the patient that would be*
 343 *adverse to the initiation of treatment, dispensing, or administration of a drug or device pursuant to this*
 344 *section.*

345 E. *A pharmacist who initiates treatment with or dispenses or administers a drug or device pursuant*
 346 *to this section shall have a referral relationship with a physician or other appropriate health care*
 347 *provider to address patient adverse reactions or complications from such initiation of treatment,*
 348 *dispensing, or administration, including a toll-free telephone number that is available 24 hours a day*
 349 *through which the patient may contact a registered nurse who can connect the patient with a physician,*
 350 *physician assistant, or nurse practitioner licensed by the Board of Medicine regarding any adverse*
 351 *reaction or complication.*

352 **§ 54.1-3321. Registration of pharmacy technicians.**

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

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

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

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

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

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

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

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

366 8. *The administration of vaccines included on the Immunization Schedule published by the Centers*
 367 *for Disease Control and Prevention or that have approval or a current emergency use authorization*

368 from the U.S. Food and Drug Administration to persons five years of age or older, as set forth in
369 regulations of the Board, under the supervision of a pharmacist who is present at the same physical
370 location as the pharmacy technician at the time such vaccine is administered, and consistent with the
371 requirements of § 54.1-3303.1; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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