AGENDA

Florida Board of Pharmacy
Legislative Committee Meeting

April 2, 2018 – 1:00 p.m.

Residence Inn Tallahassee Universities at the Capitol,
600 West Gaines Street, Tallahassee, Florida 32304, 850-329-9080

Committee Members:
Jeenu Philip, BPharm – Chair
Jonathan Hickman, PharmD
Mark Mikhael, Pharm D
David Wright, BPharm

Board Staff
C. Erica White, MBA, JD - Executive Director
Savada Knight, Regulatory Supervisor

Board Counsel:
David Flynn, Assistant Attorney General
Lawrence Harris, Assistant Attorney General

Note: Participants in this public meeting should be aware that these proceedings are being recorded.

1. **Review of Bills from the 2018 Legislative Session (spreadsheet)** – (pg.2)
   - HB 21 (pg. 10)
   - HB 675 (pg. 215)

2. **Advanced Practice Technician Discussion**

3. **Old Business / New Business**

4. **Public Comment**

5. **Adjourn**

TAB #1

BILLS FILED FOR THE 2018 SESSION FOR CHAPTER 465 (last updated March 16, 2018)

Bill Number	Companion Bills	Bill Title	Chapters	Summary from Online Sunshine	Notes
CS/SB 8	**CS/HB 21** **HB 1159** **SB 458**	Controlled Substances		Controlled Substances; Prohibiting managed care plans and their fiscal agents or intermediaries from imposing certain requirements or conditions on recipients as a prerequisite to receiving medication-assisted treatment (MAT) services to treat substance abuse disorders; authorizing certain boards to require practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial license renewal; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; prohibiting the dispensing of certain controlled substances in an amount that exceeds a 3-day supply or a medically necessary 7-day supply if certain criteria are met, etc. APPROPRIATION: $53,555,360.00 http://www.flsenate.gov/Session/Bill/2018/00008	03/07/18 - Senate Laid on Table, refer to CS/CS/HB 21
CS/HB 21	**CS/SB 8** **HB 1159** **SB 458**	Controlled Substances	456.0301 456.072 456.44 458.3265 459.0137 465.0155 465.0276 893.03 893.04 893.055 893.0551 893.13 893.147 458.331 459.015	Controlled Substances; Requires practitioners to complete specified board-approved continuing education course to prescribe controlled substances; defines "acute pain"; provides for adoption of standards of practice for treatment of acute pain; limits prescribing of opioids for acute pain in certain circumstances; requires pain management clinic owners to register approved exemptions with DOH; provides requirements for pharmacists & practitioners for dispensing of controlled substances to persons not known to them; conforms state controlled substances schedule to federal controlled substances schedule; revises & provides definitions; revises requirements for prescription drug monitoring program. http://www.flsenate.gov/Session/Bill/2018/00021	Signed by Officers and presented to Governor on Wednesday, March 14, 2018

Bill Number	Companion Bills	Bill Title	Chapters	Summary from Online Sunshine	Notes
			463.0055 782.04 893.135 921.0022		
CS/HB 351	**SB 1494**	Prescription Drug Pricing Transparency	465.0244, F.S. 465.1862, F.S. 624.49, F.S. (new) 627.64741, F.S. (new) 627.6572, F.S. (new) 641.314, F.S. (new)	Prescription Drug Pricing Transparency; Requires pharmacists inform customers of certain generically equivalent drug products & whether her or his cost-sharing obligation exceeds retail price of prescription; requires registration of pharmacy benefit managers with OIR; requires rulemaking; requires certain terms in health insurer or health maintenance organization contracts with pharmacy benefit managers; provides applicability. http://www.flsenate.gov/Session/Bill/2018/00351	Ordered enrolled on Thursday, March 08, 2018.
CS/HB 431	**SB 524**	Testing for and Treatment of Influenza and Streptococcus		Testing for and Treatment of Influenza and Streptococcus; Requires specified licensed pharmacists to report certain information to DOH; authorizes pharmacists to test for & treat influenza & streptococcus; provides requirements with respect thereto; requires that written protocol between pharmacist & supervising physician contain certain information, terms, & conditions; requires that pharmacists provide evidence of current certification by Board of Pharmacy to supervising physician; requires that pharmacists submit their written protocols to board. http://www.flsenate.gov/Session/Bill/2018/00431	Died in Health & Human Services Committee on Saturday, March 10, 2018.
HB 513	**SB 1252**	Distributing Pharmaceutical Drugs and Devices	465.027, F.S.	Distributing Pharmaceutical Drugs and Devices; Revises an exception to pharmacy regulations for certain manufacturers & distributers of dialysis drugs or supplies.	Signed by Officers and presented to Governor on Wednesday, March 14, 2018.

Bill Number	Companion Bills	Bill Title	Chapters	Summary from Online Sunshine	Notes
				http://www.flsenate.gov/Session/Bill/2018/00513	
SB 524	**CS/HB 431**	Influenza Virus and Streptococcal Infections		Influenza Virus and Streptococcal Infections; Requiring a pharmacist testing for and treating the influenza virus and streptococcal infections to maintain patient records using certain standards and for a specified time; requiring a pharmacist seeking to test for and treat the influenza virus and streptococcal infections to obtain certification through a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine, etc. http://www.flsenate.gov/Session/Bill/2018/00524	Died in Health Policy on Saturday, March 10, 2018
SB 534		Regulation of Pharmacy Benefits Managers		Regulation of Pharmacy Benefits Managers; Redefining the term "administrator" to include pharmacy benefits managers, etc. http://www.flsenate.gov/Session/Bill/2018/00534	Died in Health Policy on Saturday, March 10, 2018
HB 675	**SB 1128**	Pharmacies	465.003, F.S. 465.004, F.S. 469.019, F.S. 465.0252, F.S. 499.003, F.S.	Pharmacies; **Revises membership of Board of Pharmacy;** establishes Class III institutional pharmacies; provides requirements for such pharmacies; revises notice requirements; authorizes distribution of medicinal drugs & prepackaged drug products without specified permit under certain conditions;	Ordered enrolled on Friday, March 09, 2018

Bill Number	Companion Bills	Bill Title	Chapters	Summary from Online Sunshine	Notes
			499.01, F.S.	removes provision exempting certain drug re-packagers from specified permit requirements. http://www.flsenate.gov/Session/Bill/2018/00675	
CS/CS/HB 679	**SB 848**	Telepharmacy		Telepharmacy; Authorizes registered pharmacy technicians to dispense drugs under certain circumstances; provides permit requirements for remote dispensing site pharmacies; provides requirements & prohibitions for remote dispensing site pharmacies; requires the prescription department manager to visit the remote dispensing site pharmacy; requires work experience for registered pharmacy techs; prohibits registered pharmacy techs to perform certain compounding; authorizes Florida licensed pharmacists to be the prescription drug manager at more than one remote dispensing site pharmacy. http://www.flsenate.gov/Session/Bill/2018/00679	Died on Second Reading Calendar on Saturday, March 10, 2018
CS/HB 689	**SB 914**	Pharmacy		Pharmacy; Provides licensure requirements for & revising responsibilities of consultant pharmacists. http://www.flsenate.gov/Session/Bill/2018/00689	Died in Health Policy on Saturday, March 10, 2018.
CS/SB 848	**CS/HB 679**	Remote Dispensing Site Pharmacies		Remote Dispensing Site Pharmacies; Redefining the term “pharmacy” to include remote dispensing site pharmacies; providing that an offsite pharmacist who supervises a registered pharmacy technician at a remote dispensing site is not considered to be not present or off duty; providing permit requirements for remote dispensing site pharmacies, etc.	Died in Messages on Saturday, March 10, 2018.

Bill Number	Companion Bills	Bill Title	Chapters	Summary from Online Sunshine	Notes
				http://www.flsenate.gov/Session/Bill/2018/00848	
SB 914	**CS/HB 689**	Practice of Pharmacy		Practice of Pharmacy; Requiring a pharmacist seeking licensure as a consultant pharmacist to complete additional training as required by the Board of Pharmacy; authorizing a pharmacist who is certified to administer vaccines to adults to perform specified services under certain conditions, etc. http://www.flsenate.gov/Session/Bill/2018/00914	Died in Health Policy on Saturday, March 10, 2018.
HB 1047	**SB 1486**	Department of Health		Department of Health; Revises and provides provisions relating to DOH, including licensure, registration, inspection, discipline, permits, adverse incidents, education requirements; Repeals provisions related to registration, registration certificates; change of ownership or address, advertising, information, periodic inspections, & equipment & supplies; suspension & revocation & administrative fines, rules, violations, qualifications for licensure as massage therapist. http://www.flsenate.gov/Session/Bill/2018/01047/?Tab=Citations	Died on Second Reading Calendar on Saturday, March 10, 2018
CS/HB 1099	**SB 1564**	Advanced Birth Centers		Advanced Birth Centers; Provides for issuance, renewal, denial, and revocation of licenses to establish advanced birth center by AHCA; provides penalty for operating without a license. http://www.flsenate.gov/Session/Bill/2018/01099	Died in Health & Human Services Committee on Saturday, March 10, 2018

BILLS FILED FOR THE 2018 SESSION FOR CHAPTER 465 (last updated March 16, 2018)

Bill Number	Companion Bills	Bill Title	Chapters	Summary from Online Sunshine	Notes
SB 1128	**HB 675**	Pharmacy		Pharmacy; **Revising the membership of the Board of Pharmacy**; establishing Class III institutional pharmacies; authorizing such pharmacies to dispense, compound, and fill prescriptions, prepare prepackaged drug products, and conduct other pharmaceutical services between certain entities under common control; providing that a prescription drug re-packager permit and a restricted prescription drug distributor permit are not required for the distribution of medicinal drugs or prepackaged drug products between entities under common control under certain circumstances, etc. http://www.flsenate.gov/Session/Bill/2018/01128	Senate Laid on Table, refer to CS/HB 675.
CS/SB 1252	**HB 513**	Distributing Pharmaceutical Drugs and Devices		Home Renal Dialysis; Revising conditions under which manufacturers, or agents thereof, who distribute home dialysis supplies are exempt from the requirements of the Florida Pharmacy Act, etc. http://www.flsenate.gov/Session/Bill/2018/01252	03/06/18 -Senate Laid on Table, refer to HB 513.
SB 1486	**CS/HB 1047**	Department of Health		Department of Health; Requiring the Department of Health to adopt rules to implement a federal program to further encourage qualified physicians to relocate to and practice in underserved areas; revising health care practitioner licensure eligibility requirements for certain members of the armed forces and their spouses; requiring certain pharmacies and outsourcing facilities	Senate Died in Rules on Saturday, March 10, 2018.

Bill Number	Companion Bills	Bill Title	Chapters	Summary from Online Sunshine	Notes
				located in this state to obtain a permit in order to create, ship, mail, deliver, or dispense compounded sterile products; revising qualifications for licensure as a massage therapist, etc. http://www.flsenate.gov/Session/Bill/2018/01486	
SB 1564	**CS/HB 1099**	Advanced Birth Centers		Advanced Birth Centers; Provides for issuance, renewal, denial, and revocation of licenses to establish advanced birth center by AHCA; provides penalty for operating without a license. http://www.flsenate.gov/Session/Bill/2018/01099	Senate - Withdrawn from further consideration

1
2 An act relating to controlled substances; creating s.
3 456.0301, F.S.; requiring certain boards to require
4 certain registered practitioners to complete a
5 specified board-approved continuing education course
6 to obtain authorization to prescribe controlled
7 substances as part of biennial license renewal and
8 before a specified date; providing course
9 requirements; providing that the course may be offered
10 in a distance learning format and requiring that it be
11 included within required continuing education hours;
12 prohibiting the Department of Health from renewing the
13 license of a prescriber under specified circumstances;
14 specifying a deadline for course completion; providing
15 an exception from the course requirements for certain
16 licensees; requiring such licensees to submit
17 confirmation of course completion; authorizing certain
18 boards to adopt rules; amending s. 456.072, F.S.;
19 authorizing disciplinary action against practitioners
20 for violating specified provisions relating to
21 controlled substances; amending s. 456.44, F.S.;
22 defining the term "acute pain"; requiring the
23 applicable boards to adopt rules establishing certain
24 guidelines for prescribing controlled substances for
25 acute pain; providing that the failure of a prescriber

26 to follow specified guidelines is grounds for
27 disciplinary action; limiting opioid drug
28 prescriptions for the treatment of acute pain to a
29 specified period under certain circumstances;
30 authorizing such prescriptions for an extended period
31 if specified requirements are met; requiring a
32 prescriber who prescribes an opioid drug for the
33 treatment of pain other than acute pain to include a
34 specific indication on the prescription; requiring a
35 prescriber who prescribes an opioid drug for the
36 treatment of pain related to a traumatic injury with a
37 specified Injury Severity Score to concurrently
38 prescribe an emergency opioid antagonist; amending ss.
39 458.3265 and 459.0137, F.S.; requiring pain management
40 clinics to register with the department or hold a
41 valid certificate of exemption; requiring certain
42 clinics to apply to the department for a certificate
43 of exemption; providing requirements for such
44 certificates; requiring the department to adopt rules
45 necessary to administer such exemptions; amending s.
46 465.0155, F.S.; providing requirements for pharmacists
47 for the dispensing of controlled substances to persons
48 not known to them; defining the term "proper
49 identification"; amending s. 465.0276, F.S.;
50 prohibiting the dispensing of certain controlled

51 substances in an amount that exceeds a 3-day supply
52 unless certain criteria are met; providing an
53 exception for the dispensing of certain controlled
54 substances by a practitioner to the practitioner's own
55 patients for the medication-assisted treatment of
56 opiate addiction; providing requirements for
57 practitioners for the dispensing of controlled
58 substances to persons not known to them; defining the
59 term "proper identification"; amending s. 893.03,
60 F.S.; correcting a cross-reference; conforming the
61 state controlled substances schedule to the federal
62 controlled substances schedule; amending s. 893.04,
63 F.S.; authorizing a pharmacist to dispense controlled
64 substances upon receipt of an electronic prescription
65 if certain conditions are met; amending s. 893.055,
66 F.S.; revising and providing definitions; revising
67 requirements for the prescription drug monitoring
68 program; authorizing rulemaking; requiring dispensers
69 to report information to the department for each
70 controlled substance dispensed; providing
71 applicability; requiring the department to maintain an
72 electronic system for certain purposes which meets
73 specified requirements; requiring certain information
74 to be reported to the system by a specified time;
75 specifying direct access to system information;

76 authorizing the department to enter into reciprocal
77 agreements or contracts to share prescription drug
78 monitoring information with certain entities;
79 providing requirements for such agreements;
80 authorizing the department to enter into agreements or
81 contracts for secure connections with practitioner
82 electronic systems; requiring specified persons to
83 consult the system for certain purposes within a
84 specified time; providing exceptions to the duty of
85 specified persons to consult the system under certain
86 circumstances; requiring the department to issue
87 citations to prescribers or dispensers who fail to
88 meet specified requirements relating to consulting the
89 system; providing a system for discipline of specified
90 persons for failing to meet such requirements;
91 prohibiting a person from failing to report the
92 dispensing of a controlled substance when required to
93 do so; specifying penalties; authorizing the
94 department to enter into agreements or contracts for
95 specified purposes; providing for the release of
96 information obtained by the system; allowing specified
97 persons to have direct access to information for the
98 purpose of reviewing the controlled drug prescription
99 history of a patient; providing prescriber or
100 dispenser immunity from liability for review of

101 patient history when acting in good faith; providing
102 construction; prohibiting the department from
103 specified uses of funds; requiring the department to
104 conduct or participate in studies for specified
105 purposes; requiring an annual report to be submitted
106 to the Governor and Legislature by a specified date;
107 providing report requirements; authorizing the
108 department to establish a certain direct-support
109 organization for specified purposes; defining the term
110 "direct-support organization"; requiring a direct-
111 support organization to operate under written contract
112 with the department; providing contract requirements;
113 requiring the direct-support organization to obtain
114 written approval from the department for specified
115 purposes; providing for an independent annual
116 financial audit by the direct-support organization;
117 providing that copies of such audit be provided to
118 specified entities; authorizing the department to
119 adopt certain rules relating to resources used by the
120 direct-support organization; providing for future
121 repeal of provisions relating to the direct-support
122 organization; requiring the department to adopt rules
123 to implement the system; amending s. 893.0551, F.S.;
124 revising provisions concerning the release of
125 information held by the prescription drug monitoring

126 program; amending s. 893.13, F.S.; correcting cross-
127 references; increasing the severity of a felony for a
128 health care practitioner who provides or a person who
129 obtains certain controlled substances that are not
130 medically necessary under certain circumstances;
131 amending s. 893.147, F.S.; prohibiting any person from
132 possessing, purchasing, delivering, selling, or
133 possessing with intent to sell or deliver a tableting
134 machine, an encapsulating machine, or controlled
135 substance counterfeiting materials with knowledge,
136 intent, or reasonable cause to believe that it will be
137 used to manufacture a controlled substance or
138 counterfeit controlled substance; providing an
139 exception for persons who meet certain criteria;
140 defining terms; providing criminal penalties for
141 persons who violate specified provisions relating to
142 tableting machines, encapsulating machines, and
143 controlled substance counterfeiting materials;
144 amending ss. 458.331, 459.015, 463.0055, 782.04,
145 893.135, and 921.0022, F.S.; correcting cross-
146 references; conforming provisions to changes made by
147 the act; providing appropriations; providing effective
148 dates.
149
150 Be It Enacted by the Legislature of the State of Florida:

151

152 Section 1. Section 456.0301, Florida Statutes, is created
153 to read:
154 456.0301 Requirement for instruction on controlled
155 substance prescribing.-
156 (1)(a) The appropriate board shall require each person
157 registered with the United States Drug Enforcement
158 Administration and authorized to prescribe controlled substances
159 pursuant to 21 U.S.C. s. 822 to complete a board-approved 2-hour
160 continuing education course on prescribing controlled substances
161 offered by a statewide professional association of physicians in
162 this state that is accredited to provide educational activities
163 designated for the American Medical Association Physician's
164 Recognition Award Category 1 Credit or the American Osteopathic
165 Category 1-A continuing medical education credit as part of
166 biennial license renewal. The course must include information on
167 the current standards for prescribing controlled substances,
168 particularly opiates; alternatives to these standards;
169 nonpharmacological therapies; prescribing emergency opioid
170 antagonists; and the risks of opioid addiction following all
171 stages of treatment in the management of acute pain. The course
172 may be offered in a distance learning format and must be
173 included within the number of continuing education hours
174 required by law. The department may not renew the license of any
175 prescriber registered with the United States Drug Enforcement

176 Administration to prescribe controlled substances who has failed
177 to complete the course. The course must be completed by January
178 31, 2019, and at each subsequent renewal. This paragraph does
179 not apply to a licensee who is required by his or her applicable
180 practice act to complete a minimum of 2 hours of continuing
181 education on the safe and effective prescribing of controlled
182 substances.
183 (b) Each practitioner required to complete the course
184 required in paragraph (a) shall submit confirmation of having
185 completed such course when applying for biennial license
186 renewal.
187 (c) Each licensing board that requires a licensee to
188 complete an educational course pursuant to this subsection must
189 include the hours required for completion of the course in the
190 total hours of continuing education required by law for such
191 profession unless the continuing education requirements for such
192 profession consist of fewer than 30 hours biennially.
193 (2) Each board may adopt rules to administer this section.
194 Section 2. Paragraph (gg) of subsection (1) of section
195 456.072, Florida Statutes, is amended to read:
196 456.072 Grounds for discipline; penalties; enforcement.—
197 (1) The following acts shall constitute grounds for which
198 the disciplinary actions specified in subsection (2) may be
199 taken:
200 (gg) Engaging in a pattern of practice when prescribing

201 medicinal drugs or controlled substances which demonstrates a
202 lack of reasonable skill or safety to patients, a violation of
203 ~~any provision of~~ this chapter or ss. 893.055 and 893.0551, a
204 violation of the applicable practice act, or a violation of any
205 rules adopted under this chapter or the applicable practice act
206 of the prescribing practitioner. Notwithstanding s. 456.073(13),
207 the department may initiate an investigation and establish such
208 a pattern from billing records, data, or any other information
209 obtained by the department.
210 Section 3. Paragraphs (a) through (g) of subsection (1) of
211 section 456.44, Florida Statutes, are redesignated as paragraphs
212 (b) through (h), respectively, a new paragraph (a) is added to
213 that subsection, subsection (3) of that section is amended, and
214 subsections (4), (5), and (6) are added to that section, to
215 read:
216 456.44 Controlled substance prescribing.—
217 (1) DEFINITIONS.—As used in this section, the term:
218 (a) "Acute pain" means the normal, predicted,
219 physiological, and time-limited response to an adverse chemical,
220 thermal, or mechanical stimulus associated with surgery, trauma,
221 or acute illness. The term does not include pain related to:
222 1. Cancer.
223 2. A terminal condition. For purposes of this
224 subparagraph, the term "terminal condition" means a progressive
225 disease or medical or surgical condition that causes significant

226 functional impairment, is not considered by a treating physician
227 to be reversible without the administration of life-sustaining
228 procedures, and will result in death within 1 year after
229 diagnosis if the condition runs its normal course.
230 3. Palliative care to provide relief of symptoms related
231 to an incurable, progressive illness or injury.
232 4. A traumatic injury with an Injury Severity Score of 9
233 or greater.
234 (3) STANDARDS OF PRACTICE FOR TREATMENT OF CHRONIC
235 NONMALIGNANT PAIN.—The standards of practice in this section do
236 not supersede the level of care, skill, and treatment recognized
237 in general law related to health care licensure.
238 (a) A complete medical history and a physical examination
239 must be conducted before beginning any treatment and must be
240 documented in the medical record. The exact components of the
241 physical examination shall be left to the judgment of the
242 registrant who is expected to perform a physical examination
243 proportionate to the diagnosis that justifies a treatment. The
244 medical record must, at a minimum, document the nature and
245 intensity of the pain, current and past treatments for pain,
246 underlying or coexisting diseases or conditions, the effect of
247 the pain on physical and psychological function, a review of
248 previous medical records, previous diagnostic studies, and
249 history of alcohol and substance abuse. The medical record shall
250 also document the presence of one or more recognized medical

251 indications for the use of a controlled substance. Each
252 registrant must develop a written plan for assessing each
253 patient's risk of aberrant drug-related behavior, which may
254 include patient drug testing. Registrants must assess each
255 patient's risk for aberrant drug-related behavior and monitor
256 that risk on an ongoing basis in accordance with the plan.
257 (b) Each registrant must develop a written individualized
258 treatment plan for each patient. The treatment plan shall state
259 objectives that will be used to determine treatment success,
260 such as pain relief and improved physical and psychosocial
261 function, and shall indicate if any further diagnostic
262 evaluations or other treatments are planned. After treatment
263 begins, the registrant shall adjust drug therapy to the
264 individual medical needs of each patient. Other treatment
265 modalities, including a rehabilitation program, shall be
266 considered depending on the etiology of the pain and the extent
267 to which the pain is associated with physical and psychosocial
268 impairment. The interdisciplinary nature of the treatment plan
269 shall be documented.
270 (c) The registrant shall discuss the risks and benefits of
271 the use of controlled substances, including the risks of abuse
272 and addiction, as well as physical dependence and its
273 consequences, with the patient, persons designated by the
274 patient, or the patient's surrogate or guardian if the patient
275 is incompetent. The registrant shall use a written controlled

276 substance agreement between the registrant and the patient
277 outlining the patient's responsibilities, including, but not
278 limited to:
279 1. Number and frequency of controlled substance
280 prescriptions and refills.
281 2. Patient compliance and reasons for which drug therapy
282 may be discontinued, such as a violation of the agreement.
283 3. An agreement that controlled substances for the
284 treatment of chronic nonmalignant pain shall be prescribed by a
285 single treating registrant unless otherwise authorized by the
286 treating registrant and documented in the medical record.
287 (d) The patient shall be seen by the registrant at regular
288 intervals, not to exceed 3 months, to assess the efficacy of
289 treatment, ensure that controlled substance therapy remains
290 indicated, evaluate the patient's progress toward treatment
291 objectives, consider adverse drug effects, and review the
292 etiology of the pain. Continuation or modification of therapy
293 shall depend on the registrant's evaluation of the patient's
294 progress. If treatment goals are not being achieved, despite
295 medication adjustments, the registrant shall reevaluate the
296 appropriateness of continued treatment. The registrant shall
297 monitor patient compliance in medication usage, related
298 treatment plans, controlled substance agreements, and
299 indications of substance abuse or diversion at a minimum of 3-
300 month intervals.

301 (e) The registrant shall refer the patient as necessary
302 for additional evaluation and treatment in order to achieve
303 treatment objectives. Special attention shall be given to those
304 patients who are at risk for misusing their medications and
305 those whose living arrangements pose a risk for medication
306 misuse or diversion. The management of pain in patients with a
307 history of substance abuse or with a comorbid psychiatric
308 disorder requires extra care, monitoring, and documentation and
309 requires consultation with or referral to an addiction medicine
310 specialist or a psychiatrist.
311 (f) A registrant must maintain accurate, current, and
312 complete records that are accessible and readily available for
313 review and comply with the requirements of this section, the
314 applicable practice act, and applicable board rules. The medical
315 records must include, but are not limited to:
316 1. The complete medical history and a physical
317 examination, including history of drug abuse or dependence.
318 2. Diagnostic, therapeutic, and laboratory results.
319 3. Evaluations and consultations.
320 4. Treatment objectives.
321 5. Discussion of risks and benefits.
322 6. Treatments.
323 7. Medications, including date, type, dosage, and quantity
324 prescribed.
325 8. Instructions and agreements.

326 9. Periodic reviews.
327 10. Results of any drug testing.
328 11. A photocopy of the patient's government-issued photo
329 identification.
330 12. If a written prescription for a controlled substance
331 is given to the patient, a duplicate of the prescription.
332 13. The registrant's full name presented in a legible
333 manner.
334 (g) A registrant shall immediately refer patients with
335 signs or symptoms of substance abuse to a board-certified pain
336 management physician, an addiction medicine specialist, or a
337 mental health addiction facility as it pertains to drug abuse or
338 addiction unless the registrant is a physician who is board-
339 certified or board-eligible in pain management. Throughout the
340 period of time before receiving the consultant's report, a
341 prescribing registrant shall clearly and completely document
342 medical justification for continued treatment with controlled
343 substances and those steps taken to ensure medically appropriate
344 use of controlled substances by the patient. Upon receipt of the
345 consultant's written report, the prescribing registrant shall
346 incorporate the consultant's recommendations for continuing,
347 modifying, or discontinuing controlled substance therapy. The
348 resulting changes in treatment shall be specifically documented
349 in the patient's medical record. Evidence or behavioral
350 indications of diversion shall be followed by discontinuation of

351 controlled substance therapy, and the patient shall be
352 discharged, and all results of testing and actions taken by the
353 registrant shall be documented in the patient's medical record.
354
355 This subsection does not apply to a board-eligible or board-
356 certified anesthesiologist, physiatrist, rheumatologist, or
357 neurologist, or to a board-certified physician who has surgical
358 privileges at a hospital or ambulatory surgery center and
359 primarily provides surgical services. This subsection does not
360 apply to a board-eligible or board-certified medical specialist
361 who has also completed a fellowship in pain medicine approved by
362 the Accreditation Council for Graduate Medical Education or the
363 American Osteopathic Association, or who is board eligible or
364 board certified in pain medicine by the American Board of Pain
365 Medicine, the American Board of Interventional Pain Physicians,
366 the American Association of Physician Specialists, or a board
367 approved by the American Board of Medical Specialties or the
368 American Osteopathic Association and performs interventional
369 pain procedures of the type routinely billed using surgical
370 codes. This subsection does not apply to a registrant who
371 prescribes medically necessary controlled substances for a
372 patient during an inpatient stay in a hospital licensed under
373 chapter 395.
374 (4) STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The
375 applicable boards shall adopt rules establishing guidelines for

376 prescribing controlled substances for acute pain, including
377 evaluation of the patient, creation and maintenance of a
378 treatment plan, obtaining informed consent and agreement for
379 treatment, periodic review of the treatment plan, consultation,
380 medical record review, and compliance with controlled substance
381 laws and regulations. Failure of a prescriber to follow such
382 guidelines constitutes grounds for disciplinary action pursuant
383 to s. 456.072(1)(gg), punishable as provided in s. 456.072(2).
384 (5) PRESCRIPTION SUPPLY.—
385 (a) For the treatment of acute pain, a prescription for an
386 opioid drug listed as a Schedule II controlled substance in s.
387 893.03 or 21 U.S.C. s. 812 may not exceed a 3-day supply, except
388 that up to a 7-day supply may be prescribed if:
389 1. The prescriber, in his or her professional judgment,
390 believes that more than a 3-day supply of such an opioid is
391 medically necessary to treat the patient's pain as an acute
392 medical condition;
393 2. The prescriber indicates "ACUTE PAIN EXCEPTION" on the
394 prescription; and
395 3. The prescriber adequately documents in the patient's
396 medical records the acute medical condition and lack of
397 alternative treatment options that justify deviation from the 3-
398 day supply limit established in this subsection.
399 (b) For the treatment of pain other than acute pain, a
400 prescriber must indicate "NONACUTE PAIN" on a prescription for

401 an opioid drug listed as a Schedule II controlled substance in
402 s. 893.03 or 21 U.S.C. s. 812.
403 (6) EMERGENCY OPIOID ANTAGONIST.—For the treatment of pain
404 related to a traumatic injury with an Injury Severity Score of 9
405 or greater, a prescriber who prescribes a Schedule II controlled
406 substance listed in s. 893.03 or 21 U.S.C. s. 812 must
407 concurrently prescribe an emergency opioid antagonist, as
408 defined in s. 381.887(1).
409 Section 4. Effective January 1, 2019, present subsections
410 (2) through (5) of section 458.3265, Florida Statutes, are
411 renumbered as subsections (3) through (6), respectively,
412 paragraphs (a) and (g) of subsection (1), paragraph (a) of
413 present subsection (2), paragraph (a) of present subsection (3),
414 and paragraph (a) of present subsection (4) of that section are
415 amended, and a new subsection (2) is added to that section, to
416 read:
417 458.3265 Pain-management clinics.—
418 (1) REGISTRATION.—
419 (a)1. As used in this section, the term:
420 a. "Board eligible" means successful completion of an
421 anesthesia, physical medicine and rehabilitation, rheumatology,
422 or neurology residency program approved by the Accreditation
423 Council for Graduate Medical Education or the American
424 Osteopathic Association for a period of 6 years from successful
425 completion of such residency program.

426 b. "Chronic nonmalignant pain" means pain unrelated to
427 cancer which persists beyond the usual course of disease or the
428 injury that is the cause of the pain or more than 90 days after
429 surgery.
430 c. "Pain-management clinic" or "clinic" means any publicly
431 or privately owned facility:
432 (I) That advertises in any medium for any type of pain-
433 management services; or
434 (II) Where in any month a majority of patients are
435 prescribed opioids, benzodiazepines, barbiturates, or
436 carisoprodol for the treatment of chronic nonmalignant pain.
437 2. Each pain-management clinic must register with the
438 department or hold a valid certificate of exemption pursuant to
439 subsection (2).
440 3. The following clinics are exempt from the registration
441 requirement of paragraphs (c)-(m) and must apply to the
442 department for a certificate of exemption ~~unless~~:
443 a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to
444 chapter 395;
445 b. A clinic in which the majority of the physicians who
446 provide services in the clinic primarily provide surgical
447 services;
448 c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation
449 whose shares are traded on a national exchange or on the over-
450 the-counter market and whose total assets at the end of the

451 corporation's most recent fiscal quarter exceeded $50 million;
452 d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical
453 school at which training is provided for medical students,
454 residents, or fellows;
455 e. A ~~The~~ clinic that does not prescribe controlled
456 substances for the treatment of pain;
457 f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from
458 federal taxation under 26 U.S.C. s. 501(c)(3);
459 g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or
460 more board-eligible or board-certified anesthesiologists,
461 physiatrists, rheumatologists, or neurologists; or
462 h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a
463 physician multispecialty practice where one or more board-
464 eligible or board-certified medical specialists, who have also
465 completed fellowships in pain medicine approved by the
466 Accreditation Council for Graduate Medical Education or who are
467 also board-certified in pain medicine by the American Board of
468 Pain Medicine or a board approved by the American Board of
469 Medical Specialties, the American Association of Physician
470 Specialists, or the American Osteopathic Association, perform
471 interventional pain procedures of the type routinely billed
472 using surgical codes.
473 (g) The department may revoke the clinic's certificate of
474 registration and prohibit all physicians associated with that
475 pain-management clinic from practicing at that clinic location

476 based upon an annual inspection and evaluation of the factors
477 described in subsection (4) ~~(3)~~.
478 (2) CERTIFICATE OF EXEMPTION.—
479 (a) A pain management clinic claiming an exemption from
480 the registration requirements of subsection (1) must apply for a
481 certificate of exemption on a form adopted in rule by the
482 department. The form must require the applicant to provide:
483 1. The name or names under which the applicant does
484 business.
485 2. The address at which the pain management clinic is
486 located.
487 3. The specific exemption the applicant is claiming with
488 supporting documentation.
489 4. Any other information deemed necessary by the
490 department.
491 (b) The department must approve or deny the certificate
492 within 30 days after the receipt of a complete application.
493 (c) The certificate of exemption must be renewed
494 biennially, except that the department may issue the initial
495 certificates of exemption for up to 3 years in order to stagger
496 renewal dates.
497 (d) A certificateholder must prominently display the
498 certificate of exemption and make it available to the department
499 or the board upon request.
500 (e) A new certificate of exemption is required for a

501 change of address and is not transferable. A certificate of
502 exemption is valid only for the applicant, qualifying owners,
503 licenses, registrations, certifications, and services provided
504 under a specific statutory exemption and is valid only to the
505 specific exemption claimed and granted.
506 (f) A certificateholder must notify the department at
507 least 60 days before any anticipated relocation or name change
508 of the pain management clinic or a change of ownership.
509 (g) If a pain management clinic no longer qualifies for a
510 certificate of exemption, the certificateholder must notify the
511 department within 3 days after becoming aware that the clinic no
512 longer qualifies for a certificate of exemption and register as
513 a pain management clinic under subsection (1) or cease
514 operations.
515 (3) ~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities
516 apply to any physician who provides professional services in a
517 pain-management clinic that is required to be registered in
518 subsection (1).
519 (a) A physician may not practice medicine in a pain-
520 management clinic, as described in subsection (5) ~~(4)~~, if the
521 pain-management clinic is not registered with the department as
522 required by this section. Any physician who qualifies to
523 practice medicine in a pain-management clinic pursuant to rules
524 adopted by the Board of Medicine as of July 1, 2012, may
525 continue to practice medicine in a pain-management clinic as

526 long as the physician continues to meet the qualifications set
527 forth in the board rules. A physician who violates this
528 paragraph is subject to disciplinary action by his or her
529 appropriate medical regulatory board.
530 (4) ~~(3)~~ INSPECTION.—
531 (a) The department shall inspect the pain-management
532 clinic annually, including a review of the patient records, to
533 ensure that it complies with this section and the rules of the
534 Board of Medicine adopted pursuant to subsection (5) ~~(4)~~ unless
535 the clinic is accredited by a nationally recognized accrediting
536 agency approved by the Board of Medicine.
537 (5) ~~(4)~~ RULEMAKING.—
538 (a) The department shall adopt rules necessary to
539 administer the registration, exemption, and inspection of pain-
540 management clinics which establish the specific requirements,
541 procedures, forms, and fees.
542 Section 5. Effective January 1, 2019, present subsections
543 (2) through (5) of section 459.0137, Florida Statutes, are
544 renumbered as subsections (3) through (6), respectively,
545 paragraphs (a) and (g) of subsection (1), paragraph (a) of
546 present subsection (2), paragraph (a) of present subsection (3),
547 and paragraph (a) of present subsection (4) of that section are
548 amended, and a new subsection (2) is added to that section, to
549 read:
550 459.0137 Pain-management clinics.—

551 (1) REGISTRATION.—
552 (a)1. As used in this section, the term:
553 a. "Board eligible" means successful completion of an
554 anesthesia, physical medicine and rehabilitation, rheumatology,
555 or neurology residency program approved by the Accreditation
556 Council for Graduate Medical Education or the American
557 Osteopathic Association for a period of 6 years from successful
558 completion of such residency program.
559 b. "Chronic nonmalignant pain" means pain unrelated to
560 cancer which persists beyond the usual course of disease or the
561 injury that is the cause of the pain or more than 90 days after
562 surgery.
563 c. "Pain-management clinic" or "clinic" means any publicly
564 or privately owned facility:
565 (I) That advertises in any medium for any type of pain-
566 management services; or
567 (II) Where in any month a majority of patients are
568 prescribed opioids, benzodiazepines, barbiturates, or
569 carisoprodol for the treatment of chronic nonmalignant pain.
570 2. Each pain-management clinic must register with the
571 department or hold a valid certificate of exemption pursuant to
572 subsection (2).
573 3. The following clinics are exempt from the registration
574 requirement of paragraphs (c)-(m) and must apply to the
575 department for a certificate of exemption ~~unless~~:

576 a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to
577 chapter 395;
578 b. A clinic in which the majority of the physicians who
579 provide services in the clinic primarily provide surgical
580 services;
581 c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation
582 whose shares are traded on a national exchange or on the over-
583 the-counter market and whose total assets at the end of the
584 corporation's most recent fiscal quarter exceeded $50 million;
585 d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical
586 school at which training is provided for medical students,
587 residents, or fellows;
588 e. A ~~The~~ clinic that does not prescribe controlled
589 substances for the treatment of pain;
590 f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from
591 federal taxation under 26 U.S.C. s. 501(c)(3);
592 g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or
593 more board-eligible or board-certified anesthesiologists,
594 physiatrists, rheumatologists, or neurologists; or
595 h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a
596 physician multispecialty practice where one or more board-
597 eligible or board-certified medical specialists, who have also
598 completed fellowships in pain medicine approved by the
599 Accreditation Council for Graduate Medical Education or the
600 American Osteopathic Association or who are also board-certified

601 in pain medicine by the American Board of Pain Medicine or a
602 board approved by the American Board of Medical Specialties, the
603 American Association of Physician Specialists, or the American
604 Osteopathic Association, perform interventional pain procedures
605 of the type routinely billed using surgical codes.
606 (g) The department may revoke the clinic's certificate of
607 registration and prohibit all physicians associated with that
608 pain-management clinic from practicing at that clinic location
609 based upon an annual inspection and evaluation of the factors
610 described in subsection (4) ~~(3)~~.
611 (2) CERTIFICATE OF EXEMPTION.—
612 (a) A pain management clinic claiming an exemption from
613 the registration requirements of subsection (1) must apply for a
614 certificate of exemption on a form adopted in rule by the
615 department. The form must require the applicant to provide:
616 1. The name or names under which the applicant does
617 business.
618 2. The address at which the pain management clinic is
619 located.
620 3. The specific exemption the applicant is claiming with
621 supporting documentation.
622 4. Any other information deemed necessary by the
623 department.
624 (b) The department must approve or deny the certificate
625 within 30 days after the receipt of a complete application.

626 (c) The certificate of exemption must be renewed
627 biennially, except that the department may issue the initial
628 certificates of exemption for up to 3 years in order to stagger
629 renewal dates.
630 (d) A certificateholder must prominently display the
631 certificate of exemption and make it available to the department
632 or the board upon request.
633 (e) A new certificate of exemption is required for a
634 change of address and is not transferable. A certificate of
635 exemption is valid only for the applicant, qualifying owners,
636 licenses, registrations, certifications, and services provided
637 under a specific statutory exemption and is valid only to the
638 specific exemption claimed and granted.
639 (f) A certificateholder must notify the department at
640 least 60 days before any anticipated relocation or name change
641 of the pain management clinic or a change of ownership.
642 (g) If a pain management clinic no longer qualifies for a
643 certificate of exemption, the certificateholder must notify the
644 department within 3 days after becoming aware that the clinic no
645 longer qualifies for a certificate of exemption and register as
646 a pain management clinic under subsection (1) or cease
647 operations.
648 (3) ~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities
649 apply to any osteopathic physician who provides professional
650 services in a pain-management clinic that is required to be

651 registered in subsection (1).
652 (a) An osteopathic physician may not practice medicine in
653 a pain-management clinic, as described in subsection (5) ~~(4)~~, if
654 the pain-management clinic is not registered with the department
655 as required by this section. Any physician who qualifies to
656 practice medicine in a pain-management clinic pursuant to rules
657 adopted by the Board of Osteopathic Medicine as of July 1, 2012,
658 may continue to practice medicine in a pain-management clinic as
659 long as the physician continues to meet the qualifications set
660 forth in the board rules. An osteopathic physician who violates
661 this paragraph is subject to disciplinary action by his or her
662 appropriate medical regulatory board.
663 (4) ~~(3)~~ INSPECTION.—
664 (a) The department shall inspect the pain-management
665 clinic annually, including a review of the patient records, to
666 ensure that it complies with this section and the rules of the
667 Board of Osteopathic Medicine adopted pursuant to subsection (5)
668 ~~(4)~~ unless the clinic is accredited by a nationally recognized
669 accrediting agency approved by the Board of Osteopathic
670 Medicine.
671 (5) ~~(4)~~ RULEMAKING.—
672 (a) The department shall adopt rules necessary to
673 administer the registration, exemption, and inspection of pain-
674 management clinics which establish the specific requirements,
675 procedures, forms, and fees.

676 Section 6. Section 465.0155, Florida Statutes, is amended
677 to read:
678 465.0155 Standards of practice.—
679 (1) Consistent with the provisions of this act, the board
680 shall adopt by rule standards of practice relating to the
681 practice of pharmacy which shall be binding on every state
682 agency and shall be applied by such agencies when enforcing or
683 implementing any authority granted by any applicable statute,
684 rule, or regulation, whether federal or state.
685 (2)(a) Before dispensing a controlled substance to a
686 person not known to the pharmacist, the pharmacist must require
687 the person purchasing, receiving, or otherwise acquiring the
688 controlled substance to present valid photographic
689 identification or other verification of his or her identity. If
690 the person does not have proper identification, the pharmacist
691 may verify the validity of the prescription and the identity of
692 the patient with the prescriber or his or her authorized agent.
693 Verification of health plan eligibility through a real-time
694 inquiry or adjudication system is considered to be proper
695 identification.
696 (b) This subsection does not apply in an institutional
697 setting or to a long-term care facility, including, but not
698 limited to, an assisted living facility or a hospital to which
699 patients are admitted.
700 (c) As used in this subsection, the term "proper

701 identification" means an identification that is issued by a
702 state or the Federal Government containing the person's
703 photograph, printed name, and signature or a document considered
704 acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).
705 Section 7. Paragraph (b) of subsection (1) of section
706 465.0276, Florida Statutes, is amended, and paragraph (d) is
707 added to subsection (2) of that section, to read:
708 465.0276 Dispensing practitioner.—
709 (1)
710 (b) A practitioner registered under this section may not
711 dispense a controlled substance listed in Schedule II or
712 Schedule III as provided in s. 893.03. This paragraph does not
713 apply to:
714 1. The dispensing of complimentary packages of medicinal
715 drugs which are labeled as a drug sample or complimentary drug
716 as defined in s. 499.028 to the practitioner's own patients in
717 the regular course of her or his practice without the payment of
718 a fee or remuneration of any kind, whether direct or indirect,
719 as provided in subsection (4).
720 2. The dispensing of controlled substances in the health
721 care system of the Department of Corrections.
722 3. The dispensing of a controlled substance listed in
723 Schedule II or Schedule III in connection with the performance
724 of a surgical procedure.
725 a. For an opioid drug listed as a Schedule II controlled

726 substance in s. 893.03 or 21 U.S.C. s. 812:
727 (I) For the treatment of acute pain, the amount dispensed
728 pursuant to this subparagraph may not exceed a 3-day supply, or
729 a 7-day supply if the criteria in s. 456.44(5)(a) are met.
730 (II) For the treatment of pain other than acute pain, a
731 practitioner must indicate "NONACUTE PAIN" on a prescription.
732 (III) For the treatment of pain related to a traumatic
733 injury with an Injury Severity Score of 9 or greater, a
734 practitioner must concurrently prescribe an emergency opioid
735 antagonist, as defined in s. 381.887(1).
736 b. For a controlled substance listed in Schedule III, the
737 amount dispensed pursuant to this ~~the~~ subparagraph may not
738 exceed a 14-day supply.
739 c. The exception in this subparagraph ~~exception~~ does not
740 allow for the dispensing of a controlled substance listed in
741 Schedule II or Schedule III more than 14 days after the
742 performance of the surgical procedure.
743 d. For purposes of this subparagraph, the term "surgical
744 procedure" means any procedure in any setting which involves, or
745 reasonably should involve:
746 (I)~~a.~~ Perioperative medication and sedation that allows
747 the patient to tolerate unpleasant procedures while maintaining
748 adequate cardiorespiratory function and the ability to respond
749 purposefully to verbal or tactile stimulation and makes intra-
750 and postoperative monitoring necessary; or

751 (II)~~b.~~ The use of general anesthesia or major conduction
752 anesthesia and preoperative sedation.
753 4. The dispensing of a controlled substance listed in
754 Schedule II or Schedule III pursuant to an approved clinical
755 trial. For purposes of this subparagraph, the term "approved
756 clinical trial" means a clinical research study or clinical
757 investigation that, in whole or in part, is state or federally
758 funded or is conducted under an investigational new drug
759 application that is reviewed by the United States Food and Drug
760 Administration.
761 5. The dispensing of methadone in a facility licensed
762 under s. 397.427 where medication-assisted treatment for opiate
763 addiction is provided.
764 6. The dispensing of a controlled substance listed in
765 Schedule II or Schedule III to a patient of a facility licensed
766 under part IV of chapter 400.
767 7. The dispensing of controlled substances listed in
768 Schedule II or Schedule III which have been approved by the
769 United States Food and Drug Administration for the purpose of
770 treating opiate addictions, including, but not limited to,
771 buprenorphine and buprenorphine combination products, by a
772 practitioner authorized under 21 U.S.C. s. 823, as amended, to
773 the practitioner's own patients for the medication-assisted
774 treatment of opiate addiction.
775 (2) A practitioner who dispenses medicinal drugs for human

776 consumption for fee or remuneration of any kind, whether direct
777 or indirect, must:
778 (d)1. Before dispensing a controlled substance to a person
779 not known to the dispenser, require the person purchasing,
780 receiving, or otherwise acquiring the controlled substance to
781 present valid photographic identification or other verification
782 of his or her identity. If the person does not have proper
783 identification, the dispenser may verify the validity of the
784 prescription and the identity of the patient with the prescriber
785 or his or her authorized agent. Verification of health plan
786 eligibility through a real-time inquiry or adjudication system
787 is considered to be proper identification.
788 2. This paragraph does not apply in an institutional
789 setting or to a long-term care facility, including, but not
790 limited to, an assisted living facility or a hospital to which
791 patients are admitted.
792 3. As used in this paragraph, the term "proper
793 identification" means an identification that is issued by a
794 state or the Federal Government containing the person's
795 photograph, printed name, and signature or a document considered
796 acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).
797 Section 8. Paragraph (c) of subsection (1) and subsections
798 (2) through (5) of section 893.03, Florida Statutes, are amended
799 to read:
800 893.03 Standards and schedules.—The substances enumerated

801 in this section are controlled by this chapter. The controlled
802 substances listed or to be listed in Schedules I, II, III, IV,
803 and V are included by whatever official, common, usual,
804 chemical, trade name, or class designated. The provisions of
805 this section shall not be construed to include within any of the
806 schedules contained in this section any excluded drugs listed
807 within the purview of 21 C.F.R. s. 1308.22, styled "Excluded
808 Substances"; 21 C.F.R. s. 1308.24, styled "Exempt Chemical
809 Preparations"; 21 C.F.R. s. 1308.32, styled "Exempted
810 Prescription Products"; or 21 C.F.R. s. 1308.34, styled "Exempt
811 Anabolic Steroid Products."
812 (1) SCHEDULE I.—A substance in Schedule I has a high
813 potential for abuse and has no currently accepted medical use in
814 treatment in the United States and in its use under medical
815 supervision does not meet accepted safety standards. The
816 following substances are controlled in Schedule I:
817 (c) Unless specifically excepted or unless listed in
818 another schedule, any material, compound, mixture, or
819 preparation that contains any quantity of the following
820 hallucinogenic substances or that contains any of their salts,
821 isomers, including optical, positional, or geometric isomers,
822 homologues, nitrogen-heterocyclic analogs, esters, ethers, and
823 salts of isomers, homologues, nitrogen-heterocyclic analogs,
824 esters, or ethers, if the existence of such salts, isomers, and
825 salts of isomers is possible within the specific chemical

826 designation or class description:
827 1. Alpha-Ethyltryptamine.
828 2. 4-Methylaminorex (2-Amino-4-methyl-5-phenyl-2-
829 oxazoline).
830 3. Aminorex (2-Amino-5-phenyl-2-oxazoline).
831 4. DOB (4-Bromo-2,5-dimethoxyamphetamine).
832 5. 2C-B (4-Bromo-2,5-dimethoxyphenethylamine).
833 6. Bufotenine.
834 7. Cannabis.
835 8. Cathinone.
836 9. DET (Diethyltryptamine).
837 10. 2,5-Dimethoxyamphetamine.
838 11. DOET (4-Ethyl-2,5-Dimethoxyamphetamine).
839 12. DMT (Dimethyltryptamine).
840 13. PCE (N-Ethyl-1-phenylcyclohexylamine)(Ethylamine
841 analog of phencyclidine).
842 14. JB-318 (N-Ethyl-3-piperidyl benzilate).
843 15. N-Ethylamphetamine.
844 16. Fenethylline.
845 17. 3,4-Methylenedioxy-N-hydroxyamphetamine.
846 18. Ibogaine.
847 19. LSD (Lysergic acid diethylamide).
848 20. Mescaline.
849 21. Methcathinone.
850 22. 5-Methoxy-3,4-methylenedioxyamphetamine.

851 23. PMA (4-Methoxyamphetamine).
852 24. PMMA (4-Methoxymethamphetamine).
853 25. DOM (4-Methyl-2,5-dimethoxyamphetamine).
854 26. MDEA (3,4-Methylenedioxy-N-ethylamphetamine).
855 27. MDA (3,4-Methylenedioxyamphetamine).
856 28. JB-336 (N-Methyl-3-piperidyl benzilate).
857 29. N,N-Dimethylamphetamine.
858 30. Parahexyl.
859 31. Peyote.
860 32. PCPY (N-(1-Phenylcyclohexyl)-pyrrolidine) (Pyrrolidine
861 analog of phencyclidine).
862 33. Psilocybin.
863 34. Psilocyn.
864 35. *Salvia divinorum*, except for any drug product approved
865 by the United States Food and Drug Administration which contains
866 *Salvia divinorum* or its isomers, esters, ethers, salts, and
867 salts of isomers, esters, and ethers, if the existence of such
868 isomers, esters, ethers, and salts is possible within the
869 specific chemical designation.
870 36. Salvinorin A, except for any drug product approved by
871 the United States Food and Drug Administration which contains
872 Salvinorin A or its isomers, esters, ethers, salts, and salts of
873 isomers, esters, and ethers, if the existence of such isomers,
874 esters, ethers, and salts is possible within the specific
875 chemical designation.

876 37. Xylazine.
877 38. TCP (1-[1-(2-Thienyl)-cyclohexyl]-piperidine)
878 (Thiophene analog of phencyclidine).
879 39. 3,4,5-Trimethoxyamphetamine.
880 40. Methylone (3,4-Methylenedioxymethcathinone).
881 41. MDPV (3,4-Methylenedioxypyrovalerone).
882 42. Methylmethcathinone.
883 43. Methoxymethcathinone.
884 44. Fluoromethcathinone.
885 45. Methylethcathinone.
886 46. CP 47,497 (2-(3-Hydroxycyclohexyl)-5-(2-methyloctan-2-
887 yl)phenol) and its dimethyloctyl (C8) homologue.
888 47. HU-210 [(6aR,10aR)-9-(Hydroxymethyl)-6,6-dimethyl-3-
889 (2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-
890 ol].
891 48. JWH-018 (1-Pentyl-3-(1-naphthoyl)indole).
892 49. JWH-073 (1-Butyl-3-(1-naphthoyl)indole).
893 50. JWH-200 (1-[2-(4-Morpholinyl)ethyl]-3-(1-
894 naphthoyl)indole).
895 51. BZP (Benzylpiperazine).
896 52. Fluorophenylpiperazine.
897 53. Methylphenylpiperazine.
898 54. Chlorophenylpiperazine.
899 55. Methoxyphenylpiperazine.
900 56. DBZP (1,4-Dibenzylpiperazine).

901 57. TFMPP (Trifluoromethylphenylpiperazine).
902 58. MBDB (Methylbenzodioxolylbutanamine) or (3,4-
903 Methylenedioxy-N-methylbutanamine).
904 59. 5-Hydroxy-AMT (5-Hydroxy-alpha-methyltryptamine).
905 60. 5-Hydroxy-N-methyltryptamine.
906 61. 5-MeO-MiPT (5-Methoxy-N-methyl-N-isopropyltryptamine).
907 62. 5-MeO-AMT (5-Methoxy-alpha-methyltryptamine).
908 63. Methyltryptamine.
909 64. 5-MeO-DMT (5-Methoxy-N,N-dimethyltryptamine).
910 65. 5-Me-DMT (5-Methyl-N,N-dimethyltryptamine).
911 66. Tyramine (4-Hydroxyphenethylamine).
912 67. 5-MeO-DiPT (5-Methoxy-N,N-Diisopropyltryptamine).
913 68. DiPT (N,N-Diisopropyltryptamine).
914 69. DPT (N,N-Dipropyltryptamine).
915 70. 4-Hydroxy-DiPT (4-Hydroxy-N,N-diisopropyltryptamine).
916 71. 5-MeO-DALT (5-Methoxy-N,N-Diallyltryptamine).
917 72. DOI (4-Iodo-2,5-dimethoxyamphetamine).
918 73. DOC (4-Chloro-2,5-dimethoxyamphetamine).
919 74. 2C-E (4-Ethyl-2,5-dimethoxyphenethylamine).
920 75. 2C-T-4 (4-Isopropylthio-2,5-dimethoxyphenethylamine).
921 76. 2C-C (4-Chloro-2,5-dimethoxyphenethylamine).
922 77. 2C-T (4-Methylthio-2,5-dimethoxyphenethylamine).
923 78. 2C-T-2 (4-Ethylthio-2,5-dimethoxyphenethylamine).
924 79. 2C-T-7 (4-(n)-Propylthio-2,5-dimethoxyphenethylamine).
925 80. 2C-I (4-Iodo-2,5-dimethoxyphenethylamine).

926 81. Butylone (3,4-Methylenedioxy-alpha-
927 methylaminobutyrophenone).
928 82. Ethcathinone.
929 83. Ethylone (3,4-Methylenedioxy-N-ethylcathinone).
930 84. Naphyrone (Naphthylpyrovalerone).
931 85. Dimethylone (3,4-Methylenedioxy-N,N-
932 dimethylcathinone).
933 86. 3,4-Methylenedioxy-N,N-diethylcathinone.
934 87. 3,4-Methylenedioxy-propiophenone.
935 88. 3,4-Methylenedioxy-alpha-bromopropiophenone.
936 89. 3,4-Methylenedioxy-propiophenone-2-oxime.
937 90. 3,4-Methylenedioxy-N-acetylcathinone.
938 91. 3,4-Methylenedioxy-N-acetylmethcathinone.
939 92. 3,4-Methylenedioxy-N-acetylethcathinone.
940 93. Bromomethcathinone.
941 94. Buphedrone (alpha-Methylamino-butyrophenone).
942 95. Eutylone (3,4-Methylenedioxy-alpha-
943 ethylaminobutyrophenone).
944 96. Dimethylcathinone.
945 97. Dimethylmethcathinone.
946 98. Pentylone (3,4-Methylenedioxy-alpha-
947 methylaminovalerophenone).
948 99. MDPPP (3,4-Methylenedioxy-alpha-
949 pyrrolidinopropiophenone).
950 100. MDPBP (3,4-Methylenedioxy-alpha-

951 pyrrolidinobutyrophenone).
952 101. MOPPP (Methoxy-alpha-pyrrolidinopropiophenone).
953 102. MPHP (Methyl-alpha-pyrrolidinohexanophenone).
954 103. BTCP (Benzothiophenylcyclohexylpiperidine) or BCP
955 (Benocyclidine).
956 104. F-MABP (Fluoromethylaminobutyrophenone).
957 105. MeO-PBP (Methoxypyrrolidinobutyrophenone).
958 106. Et-PBP (Ethylpyrrolidinobutyrophenone).
959 107. 3-Me-4-MeO-MCAT (3-Methyl-4-Methoxymethcathinone).
960 108. Me-EABP (Methylethylaminobutyrophenone).
961 109. Etizolam.
962 110. PPP (Pyrrolidinopropiophenone).
963 111. PBP (Pyrrolidinobutyrophenone).
964 112. PVP (Pyrrolidinovalerophenone) or
965 (Pyrrolidinopentiophenone).
966 113. MPPP (Methyl-alpha-pyrrolidinopropiophenone).
967 114. JWH-007 (1-Pentyl-2-methyl-3-(1-naphthoyl)indole).
968 115. JWH-015 (1-Propyl-2-methyl-3-(1-naphthoyl)indole).
969 116. JWH-019 (1-Hexyl-3-(1-naphthoyl)indole).
970 117. JWH-020 (1-Heptyl-3-(1-naphthoyl)indole).
971 118. JWH-072 (1-Propyl-3-(1-naphthoyl)indole).
972 119. JWH-081 (1-Pentyl-3-(4-methoxy-1-naphthoyl)indole).
973 120. JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl)indole).
974 121. JWH-133 ((6aR,10aR)-6,6,9-Trimethyl-3-(2-
975 methylpentan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).

976 122. JWH-175 (1-Pentyl-3-(1-naphthylmethyl)indole).
977 123. JWH-201 (1-Pentyl-3-(4-methoxyphenylacetyl)indole).
978 124. JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl)indole).
979 125. JWH-210 (1-Pentyl-3-(4-ethyl-1-naphthoyl)indole).
980 126. JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl)indole).
981 127. JWH-251 (1-Pentyl-3-(2-methylphenylacetyl)indole).
982 128. JWH-302 (1-Pentyl-3-(3-methoxyphenylacetyl)indole).
983 129. JWH-398 (1-Pentyl-3-(4-chloro-1-naphthoyl)indole).
984 130. HU-211 ((6aS,10aS)-9-(Hydroxymethyl)-6,6-dimethyl-3-
985 (2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-
986 ol).
987 131. HU-308 ([(1R,2R,5R)-2-[2,6-Dimethoxy-4-(2-
988 methyloctan-2-yl)phenyl]-7,7-dimethyl-4-bicyclo[3.1.1]hept-3-
989 enyl] methanol).
990 132. HU-331 (3-Hydroxy-2-[(1R,6R)-3-methyl-6-(1-
991 methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-2,5-cyclohexadiene-
992 1,4-dione).
993 133. CB-13 (4-Pentyloxy-1-(1-naphthoyl)naphthalene).
994 134. CB-25 (N-Cyclopropyl-11-(3-hydroxy-5-pentylphenoxy)-
995 undecanamide).
996 135. CB-52 (N-Cyclopropyl-11-(2-hexyl-5-hydroxyphenoxy)-
997 undecanamide).
998 136. CP 55,940 (2-[3-Hydroxy-6-propanol-cyclohexyl]-5-(2-
999 methyloctan-2-yl)phenol).
1000 137. AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl)indole).

1001 138. AM-2201 (1-(5-Fluoropentyl)-3-(1-naphthoyl)indole).
1002 139. RCS-4 (1-Pentyl-3-(4-methoxybenzoyl)indole).
1003 140. RCS-8 (1-(2-Cyclohexylethyl)-3-(2-
1004 methoxyphenylacetyl)indole).
1005 141. WIN55,212-2 ((R)-(+)-[2,3-Dihydro-5-methyl-3-(4-
1006 morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl]-1-
1007 naphthalenylmethanone).
1008 142. WIN55,212-3 ([(3S)-2,3-Dihydro-5-methyl-3-(4-
1009 morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl]-1-
1010 naphthalenylmethanone).
1011 143. Pentedrone (alpha-Methylaminovalerophenone).
1012 144. Fluoroamphetamine.
1013 145. Fluoromethamphetamine.
1014 146. Methoxetamine.
1015 147. Methiopropamine.
1016 148. Methylbuphedrone (Methyl-alpha-
1017 methylaminobutyrophenone).
1018 149. APB ((2-Aminopropyl)benzofuran).
1019 150. APDB ((2-Aminopropyl)-2,3-dihydrobenzofuran).
1020 151. UR-144 (1-Pentyl-3-(2,2,3,3-
1021 tetramethylcyclopropanoyl)indole).
1022 152. XLR11 (1-(5-Fluoropentyl)-3-(2,2,3,3-
1023 tetramethylcyclopropanoyl)indole).
1024 153. Chloro UR-144 (1-(Chloropentyl)-3-(2,2,3,3-
1025 tetramethylcyclopropanoyl)indole).

1026 154. AKB48 (N-Adamant-1-yl 1-pentylindazole-3-
1027 carboxamide).
1028 155. AM-2233(1-[(N-Methyl-2-piperidinyl)methyl]-3-(2-
1029 iodobenzoyl)indole).
1030 156. STS-135 (N-Adamant-1-yl 1-(5-fluoropentyl)indole-3-
1031 carboxamide).
1032 157. URB-597 ((3'-(Aminocarbonyl)[1,1'-biphenyl]-3-yl)-
1033 cyclohexylcarbamate).
1034 158. URB-602 ([1,1'-Biphenyl]-3-yl-carbamic acid,
1035 cyclohexyl ester).
1036 159. URB-754 (6-Methyl-2-[(4-methylphenyl)amino]-1-
1037 benzoxazin-4-one).
1038 160. 2C-D (4-Methyl-2,5-dimethoxyphenethylamine).
1039 161. 2C-H (2,5-Dimethoxyphenethylamine).
1040 162. 2C-N (4-Nitro-2,5-dimethoxyphenethylamine).
1041 163. 2C-P (4-(n)-Propyl-2,5-dimethoxyphenethylamine).
1042 164. 25I-NBOMe (4-Iodo-2,5-dimethoxy-[N-(2-
1043 methoxybenzyl)]phenethylamine).
1044 165. MDMA (3,4-Methylenedioxymethamphetamine).
1045 166. PB-22 (8-Quinolinyl 1-pentylindole-3-carboxylate).
1046 167. Fluoro PB-22 (8-Quinolinyl 1-(fluoropentyl)indole-3-
1047 carboxylate).
1048 168. BB-22 (8-Quinolinyl 1-(cyclohexylmethyl)indole-3-
1049 carboxylate).
1050 169. Fluoro AKB48 (N-Adamant-1-yl 1-

1051 (fluoropentyl)indazole-3-carboxamide).
1052 170. AB-PINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-
1053 pentylindazole-3-carboxamide).
1054 171. AB-FUBINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-
1055 (4-fluorobenzyl)indazole-3-carboxamide).
1056 172. ADB-PINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-
1057 1-pentylindazole-3-carboxamide).
1058 173. Fluoro ADBICA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-
1059 yl)-1-(fluoropentyl)indole-3-carboxamide).
1060 174. 25B-NBOMe (4-Bromo-2,5-dimethoxy-[N-(2-
1061 methoxybenzyl)]phenethylamine).
1062 175. 25C-NBOMe (4-Chloro-2,5-dimethoxy-[N-(2-
1063 methoxybenzyl)]phenethylamine).
1064 176. AB-CHMINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-
1065 (cyclohexylmethyl)indazole-3-carboxamide).
1066 177. FUB-PB-22 (8-Quinolinyl 1-(4-fluorobenzyl)indole-3-
1067 carboxylate).
1068 178. Fluoro-NNEI (N-Naphthalen-1-yl 1-
1069 (fluoropentyl)indole-3-carboxamide).
1070 179. Fluoro-AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-
1071 (fluoropentyl)indazole-3-carboxamide).
1072 180. THJ-2201 (1-(5-Fluoropentyl)-3-(1-
1073 naphthoyl)indazole).
1074 181. AM-855 ((4aR,12bR)-8-Hexyl-2,5,5-trimethyl-
1075 1,4,4a,8,9,10,11,12b-octahydronaphtho[3,2-c]isochromen-12-ol).

1076 182. AM-905 ((6aR,9R,10aR)-3-[(E)-Hept-1-enyl]-9-
1077 (hydroxymethyl)-6,6-dimethyl-6a,7,8,9,10,10a-
1078 hexahydrobenzo[c]chromen-1-ol).
1079 183. AM-906 ((6aR,9R,10aR)-3-[(Z)-Hept-1-enyl]-9-
1080 (hydroxymethyl)-6,6-dimethyl-6a,7,8,9,10,10a-
1081 hexahydrobenzo[c]chromen-1-ol).
1082 184. AM-2389 ((6aR,9R,10aR)-3-(1-Hexyl-cyclobut-1-yl)-
1083 6a,7,8,9,10,10a-hexahydro-6,6-dimethyl-6H-dibenzo[b,d]pyran-1,9
1084 diol).
1085 185. HU-243 ((6aR,8S,9S,10aR)-9-(Hydroxymethyl)-6,6-
1086 dimethyl-3-(2-methyloctan-2-yl)-8,9-ditritio-7,8,10,10a-
1087 tetrahydro-6aH-benzo[c]chromen-1-ol).
1088 186. HU-336 ((6aR,10aR)-6,6,9-Trimethyl-3-pentyl-
1089 6a,7,10,10a-tetrahydro-1H-benzo[c]chromene-1,4(6H)-dione).
1090 187. MAPB ((2-Methylaminopropyl)benzofuran).
1091 188. 5-IT (2-(1H-Indol-5-yl)-1-methyl-ethylamine).
1092 189. 6-IT (2-(1H-Indol-6-yl)-1-methyl-ethylamine).
1093 190. Synthetic Cannabinoids.—Unless specifically excepted
1094 or unless listed in another schedule or contained within a
1095 pharmaceutical product approved by the United States Food and
1096 Drug Administration, any material, compound, mixture, or
1097 preparation that contains any quantity of a synthetic
1098 cannabinoid found to be in any of the following chemical class
1099 descriptions, or homologues, nitrogen-heterocyclic analogs,
1100 isomers (including optical, positional, or geometric), esters,

1101 ethers, salts, and salts of homologues, nitrogen-heterocyclic
1102 analogs, isomers, esters, or ethers, whenever the existence of
1103 such homologues, nitrogen-heterocyclic analogs, isomers, esters,
1104 ethers, salts, and salts of isomers, esters, or ethers is
1105 possible within the specific chemical class or designation.
1106 Since nomenclature of these synthetically produced cannabinoids
1107 is not internationally standardized and may continually evolve,
1108 these structures or the compounds of these structures shall be
1109 included under this subparagraph, regardless of their specific
1110 numerical designation of atomic positions covered, if it can be
1111 determined through a recognized method of scientific testing or
1112 analysis that the substance contains properties that fit within
1113 one or more of the following categories:
1114 a. Tetrahydrocannabinols.—Any tetrahydrocannabinols
1115 naturally contained in a plant of the genus *Cannabis*, the
1116 synthetic equivalents of the substances contained in the plant
1117 or in the resinous extracts of the genus *Cannabis*, or synthetic
1118 substances, derivatives, and their isomers with similar chemical
1119 structure and pharmacological activity, including, but not
1120 limited to, Delta 9 tetrahydrocannabinols and their optical
1121 isomers, Delta 8 tetrahydrocannabinols and their optical
1122 isomers, Delta 6a,10a tetrahydrocannabinols and their optical
1123 isomers, or any compound containing a tetrahydrobenzo[c]chromene
1124 structure with substitution at either or both the 3-position or
1125 9-position, with or without substitution at the 1-position with

1126 hydroxyl or alkoxy groups, including, but not limited to:
1127 (I) Tetrahydrocannabinol.
1128 (II) HU-210 ((6aR,10aR)-9-(Hydroxymethyl)-6,6-dimethyl-3-
1129 (2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-
1130 ol).
1131 (III) HU-211 ((6aS,10aS)-9-(Hydroxymethyl)-6,6-dimethyl-3-
1132 (2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-
1133 ol).
1134 (IV) JWH-051 ((6aR,10aR)-9-(Hydroxymethyl)-6,6-dimethyl-3-
1135 (2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).
1136 (V) JWH-133 ((6aR,10aR)-6,6,9-Trimethyl-3-(2-methylpentan-
1137 2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).
1138 (VI) JWH-057 ((6aR,10aR)-6,6,9-Trimethyl-3-(2-methyloctan-
1139 2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).
1140 (VII) JWH-359 ((6aR,10aR)-1-Methoxy-6,6,9-trimethyl-3-
1141 (2,3-dimethylpentan-2-yl)-6a,7,10,10a-
1142 tetrahydrobenzo[c]chromene).
1143 (VIII) AM-087 ((6aR,10aR)-3-(2-Methyl-6-bromohex-2-yl)-
1144 6,6,9-trimethyl-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol).
1145 (IX) AM-411 ((6aR,10aR)-3-(1-Adamantyl)-6,6,9-trimethyl-
1146 6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol).
1147 (X) Parahexyl.
1148 b. Naphthoylindoles, Naphthoylindazoles,
1149 Naphthoylcarbazoles, Naphthylmethylindoles,
1150 Naphthylmethylindazoles, and Naphthylmethylcarbazoles.—Any

1151 compound containing a naphthoylindole, naphthoylindazole,
1152 naphthoylcarbazole, naphthylmethylindole,
1153 naphthylmethylindazole, or naphthylmethylcarbazole structure,
1154 with or without substitution on the indole, indazole, or
1155 carbazole ring to any extent, whether or not substituted on the
1156 naphthyl ring to any extent, including, but not limited to:
1157 (I) JWH-007 (1-Pentyl-2-methyl-3-(1-naphthoyl)indole).
1158 (II) JWH-011 (1-(1-Methylhexyl)-2-methyl-3-(1-
1159 naphthoyl)indole).
1160 (III) JWH-015 (1-Propyl-2-methyl-3-(1-naphthoyl)indole).
1161 (IV) JWH-016 (1-Butyl-2-methyl-3-(1-naphthoyl)indole).
1162 (V) JWH-018 (1-Pentyl-3-(1-naphthoyl)indole).
1163 (VI) JWH-019 (1-Hexyl-3-(1-naphthoyl)indole).
1164 (VII) JWH-020 (1-Heptyl-3-(1-naphthoyl)indole).
1165 (VIII) JWH-022 (1-(4-Pentenyl)-3-(1-naphthoyl)indole).
1166 (IX) JWH-071 (1-Ethyl-3-(1-naphthoyl)indole).
1167 (X) JWH-072 (1-Propyl-3-(1-naphthoyl)indole).
1168 (XI) JWH-073 (1-Butyl-3-(1-naphthoyl)indole).
1169 (XII) JWH-080 (1-Butyl-3-(4-methoxy-1-naphthoyl)indole).
1170 (XIII) JWH-081 (1-Pentyl-3-(4-methoxy-1-naphthoyl)indole).
1171 (XIV) JWH-098 (1-Pentyl-2-methyl-3-(4-methoxy-1-
1172 naphthoyl)indole).
1173 (XV) JWH-116 (1-Pentyl-2-ethyl-3-(1-naphthoyl)indole).
1174 (XVI) JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl)indole).
1175 (XVII) JWH-149 (1-Pentyl-2-methyl-3-(4-methyl-1-

1176 naphthoyl)indole).
1177 (XVIII) JWH-164 (1-Pentyl-3-(7-methoxy-1-
1178 naphthoyl)indole).
1179 (XIX) JWH-175 (1-Pentyl-3-(1-naphthylmethyl)indole).
1180 (XX) JWH-180 (1-Propyl-3-(4-propyl-1-naphthoyl)indole).
1181 (XXI) JWH-182 (1-Pentyl-3-(4-propyl-1-naphthoyl)indole).
1182 (XXII) JWH-184 (1-Pentyl-3-[(4-methyl)-1-
1183 naphthylmethyl]indole).
1184 (XXIII) JWH-193 (1-[2-(4-Morpholinyl)ethyl]-3-(4-methyl-1-
1185 naphthoyl)indole).
1186 (XXIV) JWH-198 (1-[2-(4-Morpholinyl)ethyl]-3-(4-methoxy-1-
1187 naphthoyl)indole).
1188 (XXV) JWH-200 (1-[2-(4-Morpholinyl)ethyl]-3-(1-
1189 naphthoyl)indole).
1190 (XXVI) JWH-210 (1-Pentyl-3-(4-ethyl-1-naphthoyl)indole).
1191 (XXVII) JWH-387 (1-Pentyl-3-(4-bromo-1-naphthoyl)indole).
1192 (XXVIII) JWH-398 (1-Pentyl-3-(4-chloro-1-
1193 naphthoyl)indole).
1194 (XXIX) JWH-412 (1-Pentyl-3-(4-fluoro-1-naphthoyl)indole).
1195 (XXX) JWH-424 (1-Pentyl-3-(8-bromo-1-naphthoyl)indole).
1196 (XXXI) AM-1220 (1-[(1-Methyl-2-piperidinyl)methyl]-3-(1-
1197 naphthoyl)indole).
1198 (XXXII) AM-1235 (1-(5-Fluoropentyl)-6-nitro-3-(1-
1199 naphthoyl)indole).
1200 (XXXIII) AM-2201 (1-(5-Fluoropentyl)-3-(1-

1201 naphthoyl)indole).
1202 (XXXIV) Chloro JWH-018 (1-(Chloropentyl)-3-(1-
1203 naphthoyl)indole).
1204 (XXXV) Bromo JWH-018 (1-(Bromopentyl)-3-(1-
1205 naphthoyl)indole).
1206 (XXXVI) AM-2232 (1-(4-Cyanobutyl)-3-(1-naphthoyl)indole).
1207 (XXXVII) THJ-2201 (1-(5-Fluoropentyl)-3-(1-
1208 naphthoyl)indazole).
1209 (XXXVIII) MAM-2201 (1-(5-Fluoropentyl)-3-(4-methyl-1-
1210 naphthoyl)indole).
1211 (XXXIX) EAM-2201 (1-(5-Fluoropentyl)-3-(4-ethyl-1-
1212 naphthoyl)indole).
1213 (XL) EG-018 (9-Pentyl-3-(1-naphthoyl)carbazole).
1214 (XLI) EG-2201 (9-(5-Fluoropentyl)-3-(1-
1215 naphthoyl)carbazole).
1216 c. Naphthoylpyrroles.—Any compound containing a
1217 naphthoylpyrrole structure, with or without substitution on the
1218 pyrrole ring to any extent, whether or not substituted on the
1219 naphthyl ring to any extent, including, but not limited to:
1220 (I) JWH-030 (1-Pentyl-3-(1-naphthoyl)pyrrole).
1221 (II) JWH-031 (1-Hexyl-3-(1-naphthoyl)pyrrole).
1222 (III) JWH-145 (1-Pentyl-5-phenyl-3-(1-naphthoyl)pyrrole).
1223 (IV) JWH-146 (1-Heptyl-5-phenyl-3-(1-naphthoyl)pyrrole).
1224 (V) JWH-147 (1-Hexyl-5-phenyl-3-(1-naphthoyl)pyrrole).
1225 (VI) JWH-307 (1-Pentyl-5-(2-fluorophenyl)-3-(1-

1226 naphthoyl)pyrrole).
1227 (VII) JWH-309 (1-Pentyl-5-(1-naphthalenyl)-3-(1-
1228 naphthoyl)pyrrole).
1229 (VIII) JWH-368 (1-Pentyl-5-(3-fluorophenyl)-3-(1-
1230 naphthoyl)pyrrole).
1231 (IX) JWH-369 (1-Pentyl-5-(2-chlorophenyl)-3-(1-
1232 naphthoyl)pyrrole).
1233 (X) JWH-370 (1-Pentyl-5-(2-methylphenyl)-3-(1-
1234 naphthoyl)pyrrole).
1235 d. Naphthylmethylenindenes.—Any compound containing a
1236 naphthylmethylenindene structure, with or without substitution
1237 at the 3-position of the indene ring to any extent, whether or
1238 not substituted on the naphthyl ring to any extent, including,
1239 but not limited to, JWH-176 (3-Pentyl-1-
1240 (naphthylmethylene)indene).
1241 e. Phenylacetylindoles and Phenylacetylindazoles.—Any
1242 compound containing a phenylacetylindole or phenylacetylindazole
1243 structure, with or without substitution on the indole or
1244 indazole ring to any extent, whether or not substituted on the
1245 phenyl ring to any extent, including, but not limited to:
1246 (I) JWH-167 (1-Pentyl-3-(phenylacetyl)indole).
1247 (II) JWH-201 (1-Pentyl-3-(4-methoxyphenylacetyl)indole).
1248 (III) JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl)indole).
1249 (IV) JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl)indole).
1250 (V) JWH-251 (1-Pentyl-3-(2-methylphenylacetyl)indole).

1251 (VI) JWH-302 (1-Pentyl-3-(3-methoxyphenylacetyl)indole).
1252 (VII) Cannabipiperidiethanone.
1253 (VIII) RCS-8 (1-(2-Cyclohexylethyl)-3-(2-
1254 methoxyphenylacetyl)indole).
1255 f. Cyclohexylphenols.—Any compound containing a
1256 cyclohexylphenol structure, with or without substitution at the
1257 5-position of the phenolic ring to any extent, whether or not
1258 substituted on the cyclohexyl ring to any extent, including, but
1259 not limited to:
1260 (I) CP 47,497 (2-(3-Hydroxycyclohexyl)-5-(2-methyloctan-2-
1261 yl)phenol).
1262 (II) Cannabicyclohexanol (CP 47,497 dimethyloctyl (C8)
1263 homologue).
1264 (III) CP-55,940 (2-(3-Hydroxy-6-propanol-cyclohexyl)-5-(2-
1265 methyloctan-2-yl)phenol).
1266 g. Benzoylindoles and Benzoylindazoles.—Any compound
1267 containing a benzoylindole or benzoylindazole structure, with or
1268 without substitution on the indole or indazole ring to any
1269 extent, whether or not substituted on the phenyl ring to any
1270 extent, including, but not limited to:
1271 (I) AM-679 (1-Pentyl-3-(2-iodobenzoyl)indole).
1272 (II) AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl)indole).
1273 (III) AM-1241 (1-[(N-Methyl-2-piperidinyl)methyl]-3-(2-
1274 iodo-5-nitrobenzoyl)indole).
1275 (IV) Pravadoline (1-[2-(4-Morpholinyl)ethyl]-2-methyl-3-

1276 (4-methoxybenzoyl)indole).
1277 (V) AM-2233 (1-[(N-Methyl-2-piperidinyl)methyl]-3-(2-
1278 iodobenzoyl)indole).
1279 (VI) RCS-4 (1-Pentyl-3-(4-methoxybenzoyl)indole).
1280 (VII) RCS-4 C4 homologue (1-Butyl-3-(4-
1281 methoxybenzoyl)indole).
1282 (VIII) AM-630 (1-[2-(4-Morpholinyl)ethyl]-2-methyl-6-iodo-
1283 3-(4-methoxybenzoyl)indole).
1284 h. Tetramethylcyclopropanoylindoles and
1285 Tetramethylcyclopropanoylindazoles.—Any compound containing a
1286 tetramethylcyclopropanoylindole or
1287 tetramethylcyclopropanoylindazole structure, with or without
1288 substitution on the indole or indazole ring to any extent,
1289 whether or not substituted on the tetramethylcyclopropyl group
1290 to any extent, including, but not limited to:
1291 (I) UR-144 (1-Pentyl-3-(2,2,3,3-
1292 tetramethylcyclopropanoyl)indole).
1293 (II) XLR11 (1-(5-Fluoropentyl)-3-(2,2,3,3-
1294 tetramethylcyclopropanoyl)indole).
1295 (III) Chloro UR-144 (1-(Chloropentyl)-3-(2,2,3,3-
1296 tetramethylcyclopropanoyl)indole).
1297 (IV) A-796,260 (1-[2-(4-Morpholinyl)ethyl]-3-(2,2,3,3-
1298 tetramethylcyclopropanoyl)indole).
1299 (V) A-834,735 (1-[4-(Tetrahydropyranyl)methyl]-3-(2,2,3,3-
1300 tetramethylcyclopropanoyl)indole).

1301 (VI) M-144 (1-(5-Fluoropentyl)-2-methyl-3-(2,2,3,3-
1302 tetramethylcyclopropanoyl)indole).
1303 (VII) FUB-144 (1-(4-Fluorobenzyl)-3-(2,2,3,3-
1304 tetramethylcyclopropanoyl)indole).
1305 (VIII) FAB-144 (1-(5-Fluoropentyl)-3-(2,2,3,3-
1306 tetramethylcyclopropanoyl)indazole).
1307 (IX) XLR12 (1-(4,4,4-Trifluorobutyl)-3-(2,2,3,3-
1308 tetramethylcyclopropanoyl)indole).
1309 (X) AB-005 (1-[(1-Methyl-2-piperidinyl)methyl]-3-(2,2,3,3-
1310 tetramethylcyclopropanoyl)indole).
1311 i. Adamantoylindoles, Adamantoylindazoles, Adamantylindole
1312 carboxamides, and Adamantylindazole carboxamides.—Any compound
1313 containing an adamantoyl indole, adamantoyl indazole, adamantyl
1314 indole carboxamide, or adamantyl indazole carboxamide structure,
1315 with or without substitution on the indole or indazole ring to
1316 any extent, whether or not substituted on the adamantyl ring to
1317 any extent, including, but not limited to:
1318 (I) AKB48 (N-Adamant-1-yl 1-pentylindazole-3-carboxamide).
1319 (II) Fluoro AKB48 (N-Adamant-1-yl 1-
1320 (fluoropentyl)indazole-3-carboxamide).
1321 (III) STS-135 (N-Adamant-1-yl 1-(5-fluoropentyl)indole-3-
1322 carboxamide).
1323 (IV) AM-1248 (1-(1-Methylpiperidine)methyl-3-(1-
1324 adamantoyl)indole).
1325 (V) AB-001 (1-Pentyl-3-(1-adamantoyl)indole).

1326 (VI) APICA (N-Adamant-1-yl 1-pentylindole-3-carboxamide).
1327 (VII) Fluoro AB-001 (1-(Fluoropentyl)-3-(1-
1328 adamantoyl)indole).
1329 j. Quinolinylindolecarboxylates,
1330 Quinolinylindazolecarboxylates, Quinolinylindolecarboxamides,
1331 and Quinolinylindazolecarboxamides.—Any compound containing a
1332 quinolinylindole carboxylate, quinolinylindazole carboxylate,
1333 isoquinolinylindole carboxylate, isoquinolinylindazole
1334 carboxylate, quinolinylindole carboxamide, quinolinylindazole
1335 carboxamide, isoquinolinylindole carboxamide, or
1336 isoquinolinylindazole carboxamide structure, with or without
1337 substitution on the indole or indazole ring to any extent,
1338 whether or not substituted on the quinoline or isoquinoline ring
1339 to any extent, including, but not limited to:
1340 (I) PB-22 (8-Quinolinyl 1-pentylindole-3-carboxylate).
1341 (II) Fluoro PB-22 (8-Quinolinyl 1-(fluoropentyl)indole-3-
1342 carboxylate).
1343 (III) BB-22 (8-Quinolinyl 1-(cyclohexylmethyl)indole-3-
1344 carboxylate).
1345 (IV) FUB-PB-22 (8-Quinolinyl 1-(4-fluorobenzyl)indole-3-
1346 carboxylate).
1347 (V) NPB-22 (8-Quinolinyl 1-pentylindazole-3-carboxylate).
1348 (VI) Fluoro NPB-22 (8-Quinolinyl 1-(fluoropentyl)indazole-
1349 3-carboxylate).
1350 (VII) FUB-NPB-22 (8-Quinolinyl 1-(4-fluorobenzyl)indazole-

1351 3-carboxylate).
1352 (VIII) THJ (8-Quinolinyl 1-pentylindazole-3-carboxamide).
1353 (IX) Fluoro THJ (8-Quinolinyl 1-(fluoropentyl)indazole-3-
1354 carboxamide).
1355 k. Naphthylindolecarboxylates and
1356 Naphthylindazolecarboxylates.—Any compound containing a
1357 naphthylindole carboxylate or naphthylindazole carboxylate
1358 structure, with or without substitution on the indole or
1359 indazole ring to any extent, whether or not substituted on the
1360 naphthyl ring to any extent, including, but not limited to:
1361 (I) NM-2201 (1-Naphthalenyl 1-(5-fluoropentyl)indole-3-
1362 carboxylate).
1363 (II) SDB-005 (1-Naphthalenyl 1-pentylindazole-3-
1364 carboxylate).
1365 (III) Fluoro SDB-005 (1-Naphthalenyl 1-
1366 (fluoropentyl)indazole-3-carboxylate).
1367 (IV) FDU-PB-22 (1-Naphthalenyl 1-(4-fluorobenzyl)indole-3-
1368 carboxylate).
1369 (V) 3-CAF (2-Naphthalenyl 1-(2-fluorophenyl)indazole-3-
1370 carboxylate).
1371 l. Naphthylindole carboxamides and Naphthylindazole
1372 carboxamides.—Any compound containing a naphthylindole
1373 carboxamide or naphthylindazole carboxamide structure, with or
1374 without substitution on the indole or indazole ring to any
1375 extent, whether or not substituted on the naphthyl ring to any

1376 extent, including, but not limited to:
1377 (I) NNEI (N-Naphthalen-1-yl 1-pentylindole-3-carboxamide).
1378 (II) Fluoro-NNEI (N-Naphthalen-1-yl 1-
1379 (fluoropentyl)indole-3-carboxamide).
1380 (III) Chloro-NNEI (N-Naphthalen-1-yl 1-
1381 (chloropentyl)indole-3-carboxamide).
1382 (IV) MN-18 (N-Naphthalen-1-yl 1-pentylindazole-3-
1383 carboxamide).
1384 (V) Fluoro MN-18 (N-Naphthalen-1-yl 1-
1385 (fluoropentyl)indazole-3-carboxamide).
1386 m. Alkylcarbonyl indole carboxamides, Alkylcarbonyl
1387 indazole carboxamides, Alkylcarbonyl indole carboxylates, and
1388 Alkylcarbonyl indazole carboxylates.—Any compound containing an
1389 alkylcarbonyl group, including 1-amino-3-methyl-1-oxobutan-2-yl,
1390 1-methoxy-3-methyl-1-oxobutan-2-yl, 1-amino-1-oxo-3-
1391 phenylpropan-2-yl, 1-methoxy-1-oxo-3-phenylpropan-2-yl, with an
1392 indole carboxamide, indazole carboxamide, indole carboxylate, or
1393 indazole carboxylate, with or without substitution on the indole
1394 or indazole ring to any extent, whether or not substituted on
1395 the alkylcarbonyl group to any extent, including, but not
1396 limited to:
1397 (I) ADBICA, (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-
1398 pentylindole-3-carboxamide).
1399 (II) Fluoro ADBICA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-
1400 yl)-1-(fluoropentyl)indole-3-carboxamide).

1401 (III) Fluoro ABICA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-
1402 1-(fluoropentyl)indole-3-carboxamide).
1403 (IV) AB-PINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-
1404 pentylindazole-3-carboxamide).
1405 (V) Fluoro AB-PINACA (N-(1-Amino-3-methyl-1-oxobutan-2-
1406 yl)-1-(fluoropentyl)indazole-3-carboxamide).
1407 (VI) ADB-PINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-
1408 1-pentylindazole-3-carboxamide).
1409 (VII) Fluoro ADB-PINACA (N-(1-Amino-3,3-dimethyl-1-
1410 oxobutan-2-yl)-1-(fluoropentyl)indazole-3-carboxamide).
1411 (VIII) AB-FUBINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-
1412 1-(4-fluorobenzyl)indazole-3-carboxamide).
1413 (IX) ADB-FUBINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-
1414 yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).
1415 (X) AB-CHMINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-
1416 (cyclohexylmethyl)indazole-3-carboxamide).
1417 (XI) MA-CHMINACA (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-
1418 1-(cyclohexylmethyl)indazole-3-carboxamide).
1419 (XII) MAB-CHMINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-
1420 yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).
1421 (XIII) AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-
1422 pentylindazole-3-carboxamide).
1423 (XIV) Fluoro-AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-
1424 1-(fluoropentyl)indazole-3-carboxamide).
1425 (XV) FUB-AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-(4-

1426 fluorobenzyl)indazole-3-carboxamide).
1427 (XVI) MDMB-CHMINACA (N-(1-Methoxy-3,3-dimethyl-1-oxobutan-
1428 2-yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).
1429 (XVII) MDMB-FUBINACA (N-(1-Methoxy-3,3-dimethyl-1-
1430 oxobutan-2-yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).
1431 (XVIII) MDMB-CHMICA (N-(1-Methoxy-3,3-dimethyl-1-oxobutan-
1432 2-yl)-1-(cyclohexylmethyl)indole-3-carboxamide).
1433 (XIX) PX-1 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-(5-
1434 fluoropentyl)indole-3-carboxamide).
1435 (XX) PX-2 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-(5-
1436 fluoropentyl)indazole-3-carboxamide).
1437 (XXI) PX-3 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-
1438 (cyclohexylmethyl)indazole-3-carboxamide).
1439 (XXII) PX-4 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-(4-
1440 fluorobenzyl)indazole-3-carboxamide).
1441 (XXIII) MO-CHMINACA (N-(1-Methoxy-3,3-dimethyl-1-oxobutan-
1442 2-yl)-1-(cyclohexylmethyl)indazole-3-carboxylate).
1443 n. Cumylindolecarboxamides and Cumylindazolecarboxamides.—
1444 Any compound containing a N-(2-phenylpropan-2-yl) indole
1445 carboxamide or N-(2-phenylpropan-2-yl) indazole carboxamide
1446 structure, with or without substitution on the indole or
1447 indazole ring to any extent, whether or not substituted on the
1448 phenyl ring of the cumyl group to any extent, including, but not
1449 limited to:
1450 (I) CUMYL-PICA (N-(2-Phenylpropan-2-yl)-1-pentylindole-3-

1451 carboxamide).
1452 (II) Fluoro CUMYL-PICA (N-(2-Phenylpropan-2-yl)-1-
1453 (fluoropentyl)indole-3-carboxamide).
1454 o. Other Synthetic Cannabinoids.—Any material, compound,
1455 mixture, or preparation that contains any quantity of a
1456 Synthetic Cannabinoid, as described in sub-subparagraphs a.-n.:
1457 (I) With or without modification or replacement of a
1458 carbonyl, carboxamide, alkylene, alkyl, or carboxylate linkage
1459 between either two core rings, or linkage between a core ring
1460 and group structure, with or without the addition of a carbon or
1461 replacement of a carbon;
1462 (II) With or without replacement of a core ring or group
1463 structure, whether or not substituted on the ring or group
1464 structures to any extent; and
1465 (III) Is a cannabinoid receptor agonist, unless
1466 specifically excepted or unless listed in another schedule or
1467 contained within a pharmaceutical product approved by the United
1468 States Food and Drug Administration.
1469 191. Substituted Cathinones.—Unless specifically excepted,
1470 listed in another schedule, or contained within a pharmaceutical
1471 product approved by the United States Food and Drug
1472 Administration, any material, compound, mixture, or preparation,
1473 including its salts, isomers, esters, or ethers, and salts of
1474 isomers, esters, or ethers, whenever the existence of such salts
1475 is possible within any of the following specific chemical

1476 designations:
1477 a. Any compound containing a 2-amino-1-phenyl-1-propanone
1478 structure;
1479 b. Any compound containing a 2-amino-1-naphthyl-1-
1480 propanone structure; or
1481 c. Any compound containing a 2-amino-1-thiophenyl-1-
1482 propanone structure,
1483
1484 whether or not the compound is further modified:
1485 (I) With or without substitution on the ring system to any
1486 extent with alkyl, alkylthio, thio, fused alkylenedioxy, alkoxy,
1487 haloalkyl, hydroxyl, nitro, fused furan, fused benzofuran, fused
1488 dihydrofuran, fused tetrahydropyran, fused alkyl ring, or halide
1489 substituents;
1490 (II) With or without substitution at the 3-propanone
1491 position with an alkyl substituent or removal of the methyl
1492 group at the 3-propanone position;
1493 (III) With or without substitution at the 2-amino nitrogen
1494 atom with alkyl, dialkyl, acetyl, or benzyl groups, whether or
1495 not further substituted in the ring system; or
1496 (IV) With or without inclusion of the 2-amino nitrogen
1497 atom in a cyclic structure, including, but not limited to:
1498 (A) Methcathinone.
1499 (B) Ethcathinone.
1500 (C) Methylone (3,4-Methylenedioxymethcathinone).

1501 (D) 2,3-Methylenedioxymethcathinone.
1502 (E) MDPV (3,4-Methylenedioxypyrovalerone).
1503 (F) Methylmethcathinone.
1504 (G) Methoxymethcathinone.
1505 (H) Fluoromethcathinone.
1506 (I) Methylethcathinone.
1507 (J) Butylone (3,4-Methylenedioxy-alpha-
1508 methylaminobutyrophenone).
1509 (K) Ethylone (3,4-Methylenedioxy-N-ethylcathinone).
1510 (L) BMDP (3,4-Methylenedioxy-N-benzylcathinone).
1511 (M) Naphyrone (Naphthylpyrovalerone).
1512 (N) Bromomethcathinone.
1513 (O) Buphedrone (alpha-Methylaminobutyrophenone).
1514 (P) Eutylone (3,4-Methylenedioxy-alpha-
1515 ethylaminobutyrophenone).
1516 (Q) Dimethylcathinone.
1517 (R) Dimethylmethcathinone.
1518 (S) Pentylone (3,4-Methylenedioxy-alpha-
1519 methylaminovalerophenone).
1520 (T) Pentedrone (alpha-Methylaminovalerophenone).
1521 (U) MDPPP (3,4-Methylenedioxy-alpha-
1522 pyrrolidinopropiophenone).
1523 (V) MDPBP (3,4-Methylenedioxy-alpha-
1524 pyrrolidinobutyrophenone).
1525 (W) MPPP (Methyl-alpha-pyrrolidinopropiophenone).

1526 (X) PPP (Pyrrolidinopropiophenone).
1527 (Y) PVP (Pyrrolidinovalerophenone) or
1528 (Pyrrolidinopentiophenone).
1529 (Z) MOPPP (Methoxy-alpha-pyrrolidinopropiophenone).
1530 (AA) MPHP (Methyl-alpha-pyrrolidinohexanophenone).
1531 (BB) F-MABP (Fluoromethylaminobutyrophenone).
1532 (CC) Me-EABP (Methylethylaminobutyrophenone).
1533 (DD) PBP (Pyrrolidinobutyrophenone).
1534 (EE) MeO-PBP (Methoxypyrrolidinobutyrophenone).
1535 (FF) Et-PBP (Ethylpyrrolidinobutyrophenone).
1536 (GG) 3-Me-4-MeO-MCAT (3-Methyl-4-Methoxymethcathinone).
1537 (HH) Dimethylone (3,4-Methylenedioxy-N,N-
1538 dimethylcathinone).
1539 (II) 3,4-Methylenedioxy-N,N-diethylcathinone.
1540 (JJ) 3,4-Methylenedioxy-N-acetylcathinone.
1541 (KK) 3,4-Methylenedioxy-N-acetylmethcathinone.
1542 (LL) 3,4-Methylenedioxy-N-acetylethcathinone.
1543 (MM) Methylbuphedrone (Methyl-alpha-
1544 methylaminobutyrophenone).
1545 (NN) Methyl-alpha-methylaminohexanophenone.
1546 (OO) N-Ethyl-N-methylcathinone.
1547 (PP) PHP (Pyrrolidinohexanophenone).
1548 (QQ) PV8 (Pyrrolidinoheptanophenone).
1549 (RR) Chloromethcathinone.
1550 (SS) 4-Bromo-2,5-dimethoxy-alpha-aminoacetophenone.

1551 192. Substituted Phenethylamines.—Unless specifically
1552 excepted or unless listed in another schedule, or contained
1553 within a pharmaceutical product approved by the United States
1554 Food and Drug Administration, any material, compound, mixture,
1555 or preparation, including its salts, isomers, esters, or ethers,
1556 and salts of isomers, esters, or ethers, whenever the existence
1557 of such salts is possible within any of the following specific
1558 chemical designations, any compound containing a phenethylamine
1559 structure, without a beta-keto group, and without a benzyl group
1560 attached to the amine group, whether or not the compound is
1561 further modified with or without substitution on the phenyl ring
1562 to any extent with alkyl, alkylthio, nitro, alkoxy, thio,
1563 halide, fused alkylenedioxy, fused furan, fused benzofuran,
1564 fused dihydrofuran, or fused tetrahydropyran substituents,
1565 whether or not further substituted on a ring to any extent, with
1566 or without substitution at the alpha or beta position by any
1567 alkyl substituent, with or without substitution at the nitrogen
1568 atom, and with or without inclusion of the 2-amino nitrogen atom
1569 in a cyclic structure, including, but not limited to:
1570 a. 2C-B (4-Bromo-2,5-dimethoxyphenethylamine).
1571 b. 2C-E (4-Ethyl-2,5-dimethoxyphenethylamine).
1572 c. 2C-T-4 (4-Isopropylthio-2,5-dimethoxyphenethylamine).
1573 d. 2C-C (4-Chloro-2,5-dimethoxyphenethylamine).
1574 e. 2C-T (4-Methylthio-2,5-dimethoxyphenethylamine).
1575 f. 2C-T-2 (4-Ethylthio-2,5-dimethoxyphenethylamine).

1576 g. 2C-T-7 (4-(n)-Propylthio-2,5-dimethoxyphenethylamine).
1577 h. 2C-I (4-Iodo-2,5-dimethoxyphenethylamine).
1578 i. 2C-D (4-Methyl-2,5-dimethoxyphenethylamine).
1579 j. 2C-H (2,5-Dimethoxyphenethylamine).
1580 k. 2C-N (4-Nitro-2,5-dimethoxyphenethylamine).
1581 l. 2C-P (4-(n)-Propyl-2,5-dimethoxyphenethylamine).
1582 m. MDMA (3,4-Methylenedioxymethamphetamine).
1583 n. MBDB (Methylbenzodioxolylbutanamine) or (3,4-
1584 Methylenedioxy-N-methylbutanamine).
1585 o. MDA (3,4-Methylenedioxyamphetamine).
1586 p. 2,5-Dimethoxyamphetamine.
1587 q. Fluoroamphetamine.
1588 r. Fluoromethamphetamine.
1589 s. MDEA (3,4-Methylenedioxy-N-ethylamphetamine).
1590 t. DOB (4-Bromo-2,5-dimethoxyamphetamine).
1591 u. DOC (4-Chloro-2,5-dimethoxyamphetamine).
1592 v. DOET (4-Ethyl-2,5-dimethoxyamphetamine).
1593 w. DOI (4-Iodo-2,5-dimethoxyamphetamine).
1594 x. DOM (4-Methyl-2,5-dimethoxyamphetamine).
1595 y. PMA (4-Methoxyamphetamine).
1596 z. N-Ethylamphetamine.
1597 aa. 3,4-Methylenedioxy-N-hydroxyamphetamine.
1598 bb. 5-Methoxy-3,4-methylenedioxyamphetamine.
1599 cc. PMMA (4-Methoxymethamphetamine).
1600 dd. N,N-Dimethylamphetamine.

1601 ee. 3,4,5-Trimethoxyamphetamine.
1602 ff. 4-APB (4-(2-Aminopropyl)benzofuran).
1603 gg. 5-APB (5-(2-Aminopropyl)benzofuran).
1604 hh. 6-APB (6-(2-Aminopropyl)benzofuran).
1605 ii. 7-APB (7-(2-Aminopropyl)benzofuran).
1606 jj. 4-APDB (4-(2-Aminopropyl)-2,3-dihydrobenzofuran).
1607 kk. 5-APDB (5-(2-Aminopropyl)-2,3-dihydrobenzofuran).
1608 ll. 6-APDB (6-(2-Aminopropyl)-2,3-dihydrobenzofuran).
1609 mm. 7-APDB (7-(2-Aminopropyl)-2,3-dihydrobenzofuran).
1610 nn. 4-MAPB (4-(2-Methylaminopropyl)benzofuran).
1611 oo. 5-MAPB (5-(2-Methylaminopropyl)benzofuran).
1612 pp. 6-MAPB (6-(2-Methylaminopropyl)benzofuran).
1613 qq. 7-MAPB (7-(2-Methylaminopropyl)benzofuran).
1614 rr. 5-EAPB (5-(2-Ethylaminopropyl)benzofuran).
1615 ss. 5-MAPDB (5-(2-Methylaminopropyl)-2,3-
1616 dihydrobenzofuran),
1617
1618 which does not include phenethylamine, mescaline as described in
1619 subparagraph 20., substituted cathinones as described in
1620 subparagraph 191., N-Benzyl phenethylamine compounds as
1621 described in subparagraph 193., or methamphetamine as described
1622 in subparagraph (2)(c)5. ~~(2)(c)4.~~
1623 193. N-Benzyl Phenethylamine Compounds.—Unless
1624 specifically excepted or unless listed in another schedule, or
1625 contained within a pharmaceutical product approved by the United

1626 States Food and Drug Administration, any material, compound,
1627 mixture, or preparation, including its salts, isomers, esters,
1628 or ethers, and salts of isomers, esters, or ethers, whenever the
1629 existence of such salts is possible within any of the following
1630 specific chemical designations, any compound containing a
1631 phenethylamine structure without a beta-keto group, with
1632 substitution on the nitrogen atom of the amino group with a
1633 benzyl substituent, with or without substitution on the phenyl
1634 or benzyl ring to any extent with alkyl, alkoxy, thio,
1635 alkylthio, halide, fused alkylenedioxy, fused furan, fused
1636 benzofuran, or fused tetrahydropyran substituents, whether or
1637 not further substituted on a ring to any extent, with or without
1638 substitution at the alpha position by any alkyl substituent,
1639 including, but not limited to:
1640 a. 25B-NBOMe (4-Bromo-2,5-dimethoxy-[N-(2-
1641 methoxybenzyl)]phenethylamine).
1642 b. 25B-NBOH (4-Bromo-2,5-dimethoxy-[N-(2-
1643 hydroxybenzyl)]phenethylamine).
1644 c. 25B-NBF (4-Bromo-2,5-dimethoxy-[N-(2-
1645 fluorobenzyl)]phenethylamine).
1646 d. 25B-NBMD (4-Bromo-2,5-dimethoxy-[N-(2,3-
1647 methylenedioxybenzyl)]phenethylamine).
1648 e. 25I-NBOMe (4-Iodo-2,5-dimethoxy-[N-(2-
1649 methoxybenzyl)]phenethylamine).
1650 f. 25I-NBOH (4-Iodo-2,5-dimethoxy-[N-(2-

1651 hydroxybenzyl)]phenethylamine).
1652 g. 25I-NBF (4-Iodo-2,5-dimethoxy-[N-(2-
1653 fluorobenzyl)]phenethylamine).
1654 h. 25I-NBMD (4-Iodo-2,5-dimethoxy-[N-(2,3-
1655 methylenedioxybenzyl)]phenethylamine).
1656 i. 25T2-NBOMe (4-Methylthio-2,5-dimethoxy-[N-(2-
1657 methoxybenzyl)]phenethylamine).
1658 j. 25T4-NBOMe (4-Isopropylthio-2,5-dimethoxy-[N-(2-
1659 methoxybenzyl)]phenethylamine).
1660 k. 25T7-NBOMe (4-(n)-Propylthio-2,5-dimethoxy-[N-(2-
1661 methoxybenzyl)]phenethylamine).
1662 l. 25C-NBOMe (4-Chloro-2,5-dimethoxy-[N-(2-
1663 methoxybenzyl)]phenethylamine).
1664 m. 25C-NBOH (4-Chloro-2,5-dimethoxy-[N-(2-
1665 hydroxybenzyl)]phenethylamine).
1666 n. 25C-NBF (4-Chloro-2,5-dimethoxy-[N-(2-
1667 fluorobenzyl)]phenethylamine).
1668 o. 25C-NBMD (4-Chloro-2,5-dimethoxy-[N-(2,3-
1669 methylenedioxybenzyl)]phenethylamine).
1670 p. 25H-NBOMe (2,5-Dimethoxy-[N-(2-
1671 methoxybenzyl)]phenethylamine).
1672 q. 25H-NBOH (2,5-Dimethoxy-[N-(2-
1673 hydroxybenzyl)]phenethylamine).
1674 r. 25H-NBF (2,5-Dimethoxy-[N-(2-
1675 fluorobenzyl)]phenethylamine).

1676 s. 25D-NBOMe (4-Methyl-2,5-dimethoxy-[N-(2-
1677 methoxybenzyl)]phenethylamine),
1678
1679 which does not include substituted cathinones as described in
1680 subparagraph 191.
1681 194. Substituted Tryptamines.—Unless specifically excepted
1682 or unless listed in another schedule, or contained within a
1683 pharmaceutical product approved by the United States Food and
1684 Drug Administration, any material, compound, mixture, or
1685 preparation containing a 2-(1H-indol-3-yl)ethanamine, for
1686 example tryptamine, structure with or without mono- or di-
1687 substitution of the amine nitrogen with alkyl or alkenyl groups,
1688 or by inclusion of the amino nitrogen atom in a cyclic
1689 structure, whether or not substituted at the alpha position with
1690 an alkyl group, whether or not substituted on the indole ring to
1691 any extent with any alkyl, alkoxy, halo, hydroxyl, or acetoxy
1692 groups, including, but not limited to:
1693 a. Alpha-Ethyltryptamine.
1694 b. Bufotenine.
1695 c. DET (Diethyltryptamine).
1696 d. DMT (Dimethyltryptamine).
1697 e. MET (N-Methyl-N-ethyltryptamine).
1698 f. DALT (N,N-Diallyltryptamine).
1699 g. EiPT (N-Ethyl-N-isopropyltryptamine).
1700 h. MiPT (N-Methyl-N-isopropyltryptamine).

1701 i. 5-Hydroxy-AMT (5-Hydroxy-alpha-methyltryptamine).
1702 j. 5-Hydroxy-N-methyltryptamine.
1703 k. 5-MeO-MiPT (5-Methoxy-N-methyl-N-isopropyltryptamine).
1704 l. 5-MeO-AMT (5-Methoxy-alpha-methyltryptamine).
1705 m. Methyltryptamine.
1706 n. 5-MeO-DMT (5-Methoxy-N,N-dimethyltryptamine).
1707 o. 5-Me-DMT (5-Methyl-N,N-dimethyltryptamine).
1708 p. 5-MeO-DiPT (5-Methoxy-N,N-Diisopropyltryptamine).
1709 q. DiPT (N,N-Diisopropyltryptamine).
1710 r. DPT (N,N-Dipropyltryptamine).
1711 s. 4-Hydroxy-DiPT (4-Hydroxy-N,N-diisopropyltryptamine).
1712 t. 5-MeO-DALT (5-Methoxy-N,N-Diallyltryptamine).
1713 u. 4-AcO-DMT (4-Acetoxy-N,N-dimethyltryptamine).
1714 v. 4-AcO-DiPT (4-Acetoxy-N,N-diisopropyltryptamine).
1715 w. 4-Hydroxy-DET (4-Hydroxy-N,N-diethyltryptamine).
1716 x. 4-Hydroxy-MET (4-Hydroxy-N-methyl-N-ethyltryptamine).
1717 y. 4-Hydroxy-MiPT (4-Hydroxy-N-methyl-N-
1718 isopropyltryptamine).
1719 z. Methyl-alpha-ethyltryptamine.
1720 aa. Bromo-DALT (Bromo-N,N-diallyltryptamine),
1721
1722 which does not include tryptamine, psilocyn as described in
1723 subparagraph 34., or psilocybin as described in subparagraph 33.
1724 195. Substituted Phenylcyclohexylamines.—Unless
1725 specifically excepted or unless listed in another schedule, or

1726 contained within a pharmaceutical product approved by the United
1727 States Food and Drug Administration, any material, compound,
1728 mixture, or preparation containing a phenylcyclohexylamine
1729 structure, with or without any substitution on the phenyl ring,
1730 any substitution on the cyclohexyl ring, any replacement of the
1731 phenyl ring with a thiophenyl or benzothiophenyl ring, with or
1732 without substitution on the amine with alkyl, dialkyl, or alkoxy
1733 substituents, inclusion of the nitrogen in a cyclic structure,
1734 or any combination of the above, including, but not limited to:
1735 a. BTCP (Benzothiophenylcyclohexylpiperidine) or BCP
1736 (Benocyclidine).
1737 b. PCE (N-Ethyl-1-phenylcyclohexylamine)(Ethylamine analog
1738 of phencyclidine).
1739 c. PCPY (N-(1-Phenylcyclohexyl)-pyrrolidine)(Pyrrolidine
1740 analog of phencyclidine).
1741 d. PCPr (Phenylcyclohexylpropylamine).
1742 e. TCP (1-[1-(2-Thienyl)-cyclohexyl]-piperidine)(Thiophene
1743 analog of phencyclidine).
1744 f. PCEEA (Phenylcyclohexyl(ethoxyethylamine)).
1745 g. PCMPA (Phenylcyclohexyl(methoxypropylamine)).
1746 h. Methoxetamine.
1747 i. 3-Methoxy-PCE ((3-Methoxyphenyl)cyclohexylethylamine).
1748 j. Bromo-PCP ((Bromophenyl)cyclohexylpiperidine).
1749 k. Chloro-PCP ((Chlorophenyl)cyclohexylpiperidine).
1750 l. Fluoro-PCP ((Fluorophenyl)cyclohexylpiperidine).

1751 m. Hydroxy-PCP ((Hydroxyphenyl)cyclohexylpiperidine).
1752 n. Methoxy-PCP ((Methoxyphenyl)cyclohexylpiperidine).
1753 o. Methyl-PCP ((Methylphenyl)cyclohexylpiperidine).
1754 p. Nitro-PCP ((Nitrophenyl)cyclohexylpiperidine).
1755 q. Oxo-PCP ((Oxophenyl)cyclohexylpiperidine).
1756 r. Amino-PCP ((Aminophenyl)cyclohexylpiperidine).
1757 196. W-15, 4-chloro-N-[1-(2-phenylethyl)-2-
1758 piperidinylidene]-benzenesulfonamide.
1759 197. W-18, 4-chloro-N-[1-[2-(4-nitrophenyl)ethyl]-2-
1760 piperidinylidene]-benzenesulfonamide.
1761 198. AH-7921, 3,4-dichloro-N-[[1-
1762 (dimethylamino)cyclohexyl]methyl]-benzamide.
1763 199. U47700, trans-3,4-dichloro-N-[2-
1764 (dimethylamino)cyclohexyl]-N-methyl-benzamide.
1765 200. MT-45, 1-cyclohexyl-4-(1,2-diphenylethyl)-piperazine,
1766 dihydrochloride.
1767 (2) SCHEDULE II.—A substance in Schedule II has a high
1768 potential for abuse and has a currently accepted but severely
1769 restricted medical use in treatment in the United States, and
1770 abuse of the substance may lead to severe psychological or
1771 physical dependence. The following substances are controlled in
1772 Schedule II:
1773 (a) Unless specifically excepted or unless listed in
1774 another schedule, any of the following substances, whether
1775 produced directly or indirectly by extraction from substances of

1776 vegetable origin or independently by means of chemical
1777 synthesis:
1778 1. Opium and any salt, compound, derivative, or
1779 preparation of opium, except nalmefene or isoquinoline alkaloids
1780 of opium, including, but not limited to the following:
1781 a. Raw opium.
1782 b. Opium extracts.
1783 c. Opium fluid extracts.
1784 d. Powdered opium.
1785 e. Granulated opium.
1786 f. Tincture of opium.
1787 g. Codeine.
1788 h. Dihydroetorphine.
1789 i.~~h.~~ Ethylmorphine.
1790 j.~~i.~~ Etorphine hydrochloride.
1791 k.~~j.~~ Hydrocodone and hydrocodone combination products.
1792 l.~~k.~~ Hydromorphone.
1793 m.~~l.~~ Levo-alphacetylmethadol (also known as levo-alpha-
1794 acetylmethadol, levomethadyl acetate, or LAAM).
1795 n.~~m.~~ Metopon (methyldihydromorphinone).
1796 o.~~n.~~ Morphine.
1797 p. Oripavine.
1798 q.~~o.~~ Oxycodone.
1799 r.~~p.~~ Oxymorphone.
1800 s.~~q.~~ Thebaine.

1801 2. Any salt, compound, derivative, or preparation of a
1802 substance which is chemically equivalent to or identical with
1803 any of the substances referred to in subparagraph 1., except
1804 that these substances shall not include the isoquinoline
1805 alkaloids of opium.
1806 3. Any part of the plant of the species *Papaver*
1807 *somniferum, L.*
1808 4. Cocaine or ecgonine, including any of their
1809 stereoisomers, and any salt, compound, derivative, or
1810 preparation of cocaine or ecgonine, except that these substances
1811 shall not include ioflupane I 123.
1812 (b) Unless specifically excepted or unless listed in
1813 another schedule, any of the following substances, including
1814 their isomers, esters, ethers, salts, and salts of isomers,
1815 esters, and ethers, whenever the existence of such isomers,
1816 esters, ethers, and salts is possible within the specific
1817 chemical designation:
1818 1. Alfentanil.
1819 2. Alphaprodine.
1820 3. Anileridine.
1821 4. Bezitramide.
1822 5. Bulk propoxyphene (nondosage forms).
1823 6. Carfentanil.
1824 7. Dihydrocodeine.
1825 8. Diphenoxylate.

1826 9. Fentanyl.
1827 10. Isomethadone.
1828 11. Levomethorphan.
1829 12. Levorphanol.
1830 13. Metazocine.
1831 14. Methadone.
1832 15. Methadone-Intermediate,4-cyano-2-
1833 dimethylamino-4,4-diphenylbutane.
1834 16. Moramide-Intermediate,2-methyl-
1835 3-morpholoino-1,1-diphenylpropane-carboxylic acid.
1836 17. Nabilone.
1837 18. Pethidine (meperidine).
1838 19. Pethidine-Intermediate-A,4-cyano-1-
1839 methyl-4-phenylpiperidine.
1840 20. Pethidine-Intermediate-B,ethyl-4-
1841 phenylpiperidine-4-carboxylate.
1842 21. Pethidine-Intermediate-C,1-methyl-4- phenylpiperidine-
1843 4-carboxylic acid.
1844 22. Phenazocine.
1845 23. Phencyclidine.
1846 24. 1-Phenylcyclohexylamine.
1847 25. Piminodine.
1848 26. 1-Piperidinocyclohexanecarbonitrile.
1849 27. Racemethorphan.
1850 28. Racemorphan.

1851 29. Remifentanil.
1852 30.~~29.~~ Sufentanil.
1853 31. Tapentadol.
1854 32. Thiafentanil.
1855 (c) Unless specifically excepted or unless listed in
1856 another schedule, any material, compound, mixture, or
1857 preparation which contains any quantity of the following
1858 substances, including their salts, isomers, optical isomers,
1859 salts of their isomers, and salts of their optical isomers:
1860 1. Amobarbital.
1861 2. Amphetamine.
1862 3. Glutethimide.
1863 4. Lisdexamfetamine.
1864 5.~~4.~~ Methamphetamine.
1865 6.~~5.~~ Methylphenidate.
1866 7.~~6.~~ Pentobarbital.
1867 8.~~7.~~ Phenmetrazine.
1868 9.~~8.~~ Phenylacetone.
1869 10.~~9.~~ Secobarbital.
1870 (d) Dronabinol (synthetic THC) in oral solution in a drug
1871 product approved by the United States Food and Drug
1872 Administration.
1873 (3) SCHEDULE III.—A substance in Schedule III has a
1874 potential for abuse less than the substances contained in
1875 Schedules I and II and has a currently accepted medical use in

1876 treatment in the United States, and abuse of the substance may
1877 lead to moderate or low physical dependence or high
1878 psychological dependence or, in the case of anabolic steroids,
1879 may lead to physical damage. The following substances are
1880 controlled in Schedule III:
1881 (a) Unless specifically excepted or unless listed in
1882 another schedule, any material, compound, mixture, or
1883 preparation which contains any quantity of the following
1884 substances having a depressant or stimulant effect on the
1885 nervous system:
1886 1. Any substance which contains any quantity of a
1887 derivative of barbituric acid, including thiobarbituric acid, or
1888 any salt of a derivative of barbituric acid or thiobarbituric
1889 acid, including, but not limited to, butabarbital and
1890 butalbital.
1891 2. Benzphetamine.
1892 3. Buprenorphine.
1893 4.~~3.~~ Chlorhexadol.
1894 5.~~4.~~ Chlorphentermine.
1895 6.~~5.~~ Clortermine.
1896 7. Embutramide.
1897 8.~~6.~~ Lysergic acid.
1898 9.~~7.~~ Lysergic acid amide.
1899 10.~~8.~~ Methyprylon.
1900 11. Perampanel.

1901 12.~~9.~~ Phendimetrazine.
1902 13.~~10.~~ Sulfondiethylmethane.
1903 14.~~11.~~ Sulfonethylmethane.
1904 15.~~12.~~ Sulfonmethane.
1905 16.~~13.~~ Tiletamine and zolazepam or any salt thereof.
1906 (b) Nalorphine.
1907 (c) Unless specifically excepted or unless listed in
1908 another schedule, any material, compound, mixture, or
1909 preparation containing limited quantities of any of the
1910 following controlled substances or any salts thereof:
1911 1. Not more than 1.8 grams of codeine per 100 milliliters
1912 or not more than 90 milligrams per dosage unit, with an equal or
1913 greater quantity of an isoquinoline alkaloid of opium.
1914 2. Not more than 1.8 grams of codeine per 100 milliliters
1915 or not more than 90 milligrams per dosage unit, with recognized
1916 therapeutic amounts of one or more active ingredients which are
1917 not controlled substances.
1918 3. Not more than 300 milligrams of hydrocodone per 100
1919 milliliters or not more than 15 milligrams per dosage unit, with
1920 a fourfold or greater quantity of an isoquinoline alkaloid of
1921 opium.
1922 4. Not more than 300 milligrams of hydrocodone per 100
1923 milliliters or not more than 15 milligrams per dosage unit, with
1924 recognized therapeutic amounts of one or more active ingredients
1925 that are not controlled substances.

1926 5. Not more than 1.8 grams of dihydrocodeine per 100
1927 milliliters or not more than 90 milligrams per dosage unit, with
1928 recognized therapeutic amounts of one or more active ingredients
1929 which are not controlled substances.
1930 6. Not more than 300 milligrams of ethylmorphine per 100
1931 milliliters or not more than 15 milligrams per dosage unit, with
1932 one or more active, nonnarcotic ingredients in recognized
1933 therapeutic amounts.
1934 7. Not more than 50 milligrams of morphine per 100
1935 milliliters or per 100 grams, with recognized therapeutic
1936 amounts of one or more active ingredients which are not
1937 controlled substances.
1938
1939 For purposes of charging a person with a violation of s. 893.135
1940 involving any controlled substance described in subparagraph 3.
1941 or subparagraph 4., the controlled substance is a Schedule III
1942 controlled substance pursuant to this paragraph but the weight
1943 of the controlled substance per milliliters or per dosage unit
1944 is not relevant to the charging of a violation of s. 893.135.
1945 The weight of the controlled substance shall be determined
1946 pursuant to s. 893.135(6).
1947 (d) Anabolic steroids.
1948 1. The term "anabolic steroid" means any drug or hormonal
1949 substance, chemically and pharmacologically related to
1950 testosterone, other than estrogens, progestins, and

1951 corticosteroids, that promotes muscle growth and includes:
1952 a. Androsterone.
1953 b. Androsterone acetate.
1954 c. Boldenone.
1955 d. Boldenone acetate.
1956 e. Boldenone benzoate.
1957 f. Boldenone undecylenate.
1958 g. Chlorotestosterone (Clostebol).
1959 h. Dehydrochlormethyltestosterone.
1960 i. Dihydrotestosterone (Stanolone).
1961 j. Drostanolone.
1962 k. Ethylestrenol.
1963 l. Fluoxymesterone.
1964 m. Formebulone (Formebolone).
1965 n. Mesterolone.
1966 o. Methandrostenolone (Methandienone).
1967 p. Methandranone.
1968 q. Methandriol.
1969 r. Methenolone.
1970 s. Methyltestosterone.
1971 t. Mibolerone.
1972 u. Nortestosterone (Nandrolone).
1973 v. Norethandrolone.
1974 w. Nortestosterone decanoate.
1975 x. Nortestosterone phenylpropionate.

1976 y. Nortestosterone propionate.
1977 z. Oxandrolone.
1978 aa. Oxymesterone.
1979 bb. Oxymetholone.
1980 cc. Stanozolol.
1981 dd. Testolactone.
1982 ee. Testosterone.
1983 ff. Testosterone acetate.
1984 gg. Testosterone benzoate.
1985 hh. Testosterone cypionate.
1986 ii. Testosterone decanoate.
1987 jj. Testosterone enanthate.
1988 kk. Testosterone isocaproate.
1989 ll. Testosterone oleate.
1990 mm. Testosterone phenylpropionate.
1991 nn. Testosterone propionate.
1992 oo. Testosterone undecanoate.
1993 pp. Trenbolone.
1994 qq. Trenbolone acetate.
1995 rr. Any salt, ester, or isomer of a drug or substance
1996 described or listed in this subparagraph if that salt, ester, or
1997 isomer promotes muscle growth.
1998 2. The term does not include an anabolic steroid that is
1999 expressly intended for administration through implants to cattle
2000 or other nonhuman species and that has been approved by the

2001 United States Secretary of Health and Human Services for such
2002 administration. However, any person who prescribes, dispenses,
2003 or distributes such a steroid for human use is considered to
2004 have prescribed, dispensed, or distributed an anabolic steroid
2005 within the meaning of this paragraph.
2006 (e) Ketamine, including any isomers, esters, ethers,
2007 salts, and salts of isomers, esters, and ethers, whenever the
2008 existence of such isomers, esters, ethers, and salts is possible
2009 within the specific chemical designation.
2010 (f) Dronabinol (synthetic THC) in sesame oil and
2011 encapsulated in a soft gelatin capsule in a drug product
2012 approved by the United States Food and Drug Administration.
2013 (g) Any drug product containing gamma-hydroxybutyric acid,
2014 including its salts, isomers, and salts of isomers, for which an
2015 application is approved under s. 505 of the Federal Food, Drug,
2016 and Cosmetic Act.
2017 (4)(a) SCHEDULE IV.—A substance in Schedule IV has a low
2018 potential for abuse relative to the substances in Schedule III
2019 and has a currently accepted medical use in treatment in the
2020 United States, and abuse of the substance may lead to limited
2021 physical or psychological dependence relative to the substances
2022 in Schedule III.
2023 (b) Unless specifically excepted or unless listed in
2024 another schedule, any material, compound, mixture, or
2025 preparation which contains any quantity of the following

2026 substances, including its salts, isomers, and salts of isomers
2027 whenever the existence of such salts, isomers, and salts of
2028 isomers is possible within the specific chemical designation,
2029 are controlled in Schedule IV:
2030 1. Alfaxalone.
2031 2.~~(a)~~ Alprazolam.
2032 3.~~(b)~~ Barbital.
2033 4.~~(c)~~ Bromazepam.
2034 5.~~(iii)~~ Butorphanol tartrate.
2035 6.~~(d)~~ Camazepam.
2036 7.~~(jjj)~~ Carisoprodol.
2037 8.~~(e)~~ Cathine.
2038 9.~~(f)~~ Chloral betaine.
2039 10.~~(g)~~ Chloral hydrate.
2040 11.~~(h)~~ Chlordiazepoxide.
2041 12.~~(i)~~ Clobazam.
2042 13.~~(j)~~ Clonazepam.
2043 14.~~(k)~~ Clorazepate.
2044 15.~~(l)~~ Clotiazepam.
2045 16.~~(m)~~ Cloxazolam.
2046 17. Dexfenfluramine.
2047 18.~~(n)~~ Delorazepam.
2048 19. Dichloralphenazone.
2049 20.~~(p)~~ Diazepam.
2050 21.~~(q)~~ Diethylpropion.

2051 22. Eluxadoline.
2052 23.~~(r)~~ Estazolam.
2053 24. Eszopiclone.
2054 25.~~(s)~~ Ethchlorvynol.
2055 26.~~(t)~~ Ethinamate.
2056 27.~~(u)~~ Ethyl loflazepate.
2057 28.~~(v)~~ Fencamfamin.
2058 29.~~(w)~~ Fenfluramine.
2059 30.~~(x)~~ Fenproporex.
2060 31.~~(y)~~ Fludiazepam.
2061 32.~~(z)~~ Flurazepam.
2062 33. Fospropofol.
2063 34.~~(aa)~~ Halazepam.
2064 35.~~(bb)~~ Haloxazolam.
2065 36.~~(cc)~~ Ketazolam.
2066 37.~~(dd)~~ Loprazolam.
2067 38.~~(ee)~~ Lorazepam.
2068 39. Lorcaserin.
2069 40.~~(ff)~~ Lormetazepam.
2070 41.~~(gg)~~ Mazindol.
2071 42.~~(hh)~~ Mebutamate.
2072 43.~~(ii)~~ Medazepam.
2073 44.~~(jj)~~ Mefenorex.
2074 45.~~(kk)~~ Meprobamate.
2075 46.~~(ll)~~ Methohexital.

2076 47. ~~(mm)~~ Methylphenobarbital.
2077 48. ~~(nn)~~ Midazolam.
2078 49. Modafinil.
2079 50. ~~(oo)~~ Nimetazepam.
2080 51. ~~(pp)~~ Nitrazepam.
2081 52. ~~(qq)~~ Nordiazepam.
2082 53. ~~(rr)~~ Oxazepam.
2083 54. ~~(ss)~~ Oxazolam.
2084 55. ~~(tt)~~ Paraldehyde.
2085 56. ~~(uu)~~ Pemoline.
2086 57. ~~(vv)~~ Pentazocine.
2087 58. Petrichloral.
2088 59. ~~(ww)~~ Phenobarbital.
2089 60. ~~(xx)~~ Phentermine.
2090 61. ~~(yy)~~ Pinazepam.
2091 62. ~~(zz)~~ Pipradrol.
2092 63. ~~(aaa)~~ Prazepam.
2093 64. ~~(o)~~ Propoxyphene (dosage forms).
2094 65. ~~(bbb)~~ Propylhexedrine, excluding any patent or
2095 proprietary preparation containing propylhexedrine, unless
2096 otherwise provided by federal law.
2097 66. ~~(ccc)~~ Quazepam.
2098 67. Sibutramine.
2099 68. ~~(ccc)~~ SPA[(-)-1 dimethylamino-1, 2
2100 diphenylethane].

2101 69. Suvorexant.
2102 70.~~(fff)~~ Temazepam.
2103 71.~~(ddd)~~ Tetrazepam.
2104 72. Tramadol.
2105 73.~~(ggg)~~ Triazolam.
2106 74. Zaleplon.
2107 75. Zolpidem.
2108 76. Zopiclone.
2109 77.~~(hhh)~~ Not more than 1 milligram of difenoxin and not
2110 less than 25 micrograms of atropine sulfate per dosage unit.
2111 (5) SCHEDULE V.—A substance, compound, mixture, or
2112 preparation of a substance in Schedule V has a low potential for
2113 abuse relative to the substances in Schedule IV and has a
2114 currently accepted medical use in treatment in the United
2115 States, and abuse of such compound, mixture, or preparation may
2116 lead to limited physical or psychological dependence relative to
2117 the substances in Schedule IV.
2118 (a) Substances controlled in Schedule V include any
2119 compound, mixture, or preparation containing any of the
2120 following limited quantities of controlled substances, which
2121 must ~~shall~~ include one or more active medicinal ingredients that
2122 ~~which~~ are not controlled substances in sufficient proportion to
2123 confer upon the compound, mixture, or preparation valuable
2124 medicinal qualities other than those possessed by the controlled
2125 substance alone:

2126 1. Not more than 200 milligrams of codeine per 100
2127 milliliters or per 100 grams.
2128 2. Not more than 100 milligrams of dihydrocodeine per 100
2129 milliliters or per 100 grams.
2130 3. Not more than 100 milligrams of ethylmorphine per 100
2131 milliliters or per 100 grams.
2132 4. Not more than 2.5 milligrams of diphenoxylate and not
2133 less than 25 micrograms of atropine sulfate per dosage unit.
2134 5. Not more than 100 milligrams of opium per 100
2135 milliliters or per 100 grams.
2136 6. Not more than 0.5 milligrams of difenoxin and not less
2137 than 25 micrograms of atropine sulfate per dosage unit.
2138 (b) Unless a specific exception exists or unless listed in
2139 another schedule, any material, compound, mixture, or
2140 preparation that contains any quantity of the following
2141 substances is controlled in Schedule V:
2142 1. Brivaracetam.
2143 2. Ezogabine.
2144 3. Lacosamide.
2145 4. Pregabalin ~~Narcotic drugs. Unless specifically excepted~~
2146 ~~or unless listed in another schedule, any material, compound,~~
2147 ~~mixture, or preparation containing any of the following narcotic~~
2148 ~~drugs and their salts: Buprenorphine~~.
2149 (c) Stimulants. Unless specifically excepted or unless
2150 listed in another schedule, any material, compound, mixture, or

2151 preparation which contains any quantity of the following
2152 substances having a stimulant effect on the central nervous
2153 system, including its salts, isomers, and salts of isomers:
2154 Pyrovalerone.
2155 Section 9. Subsection (1) of section 893.04, Florida
2156 Statutes, is amended to read:
2157 893.04 Pharmacist and practitioner.—
2158 (1) A pharmacist, in good faith and in the course of
2159 professional practice only, may dispense controlled substances
2160 upon a written, ~~or~~ oral, or electronic prescription of a
2161 practitioner, under the following conditions:
2162 (a) Oral prescriptions must be promptly reduced to writing
2163 by the pharmacist or recorded electronically if permitted by
2164 federal law.
2165 (b) The written prescription must be dated and signed by
2166 the prescribing practitioner on the day when issued.
2167 (c) There shall appear on the face of the prescription or
2168 written record thereof for the controlled substance the
2169 following information:
2170 1. The full name and address of the person for whom, or
2171 the owner of the animal for which, the controlled substance is
2172 dispensed.
2173 2. The full name and address of the prescribing
2174 practitioner and the practitioner's federal controlled substance
2175 registry number shall be printed thereon.

2176 3. If the prescription is for an animal, the species of
2177 animal for which the controlled substance is prescribed.
2178 4. The name of the controlled substance prescribed and the
2179 strength, quantity, and directions for use thereof.
2180 5. The number of the prescription, as recorded in the
2181 prescription files of the pharmacy in which it is filled.
2182 6. The initials of the pharmacist filling the prescription
2183 and the date filled.
2184 (d) The prescription shall be retained on file by the
2185 proprietor of the pharmacy in which it is filled for a period of
2186 2 years.
2187 (e) Affixed to the original container in which a
2188 controlled substance is delivered upon a prescription or
2189 authorized refill thereof, as hereinafter provided, there shall
2190 be a label bearing the following information:
2191 1. The name and address of the pharmacy from which such
2192 controlled substance was dispensed.
2193 2. The date on which the prescription for such controlled
2194 substance was filled.
2195 3. The number of such prescription, as recorded in the
2196 prescription files of the pharmacy in which it is filled.
2197 4. The name of the prescribing practitioner.
2198 5. The name of the patient for whom, or of the owner and
2199 species of the animal for which, the controlled substance is
2200 prescribed.

2201 6. The directions for the use of the controlled substance
2202 prescribed in the prescription.
2203 7. A clear, concise warning that it is a crime to transfer
2204 the controlled substance to any person other than the patient
2205 for whom prescribed.
2206 (f) A prescription for a controlled substance listed in
2207 Schedule II may be dispensed only upon a written or electronic
2208 prescription of a practitioner, except that in an emergency
2209 situation, as defined by regulation of the Department of Health,
2210 such controlled substance may be dispensed upon oral
2211 prescription but is limited to a 72-hour supply. A prescription
2212 for a controlled substance listed in Schedule II may not be
2213 refilled.
2214 (g) A prescription for a controlled substance listed in
2215 Schedule III, Schedule IV, or Schedule V may not be filled or
2216 refilled more than five times within a period of 6 months after
2217 the date on which the prescription was written unless the
2218 prescription is renewed by a practitioner.
2219 Section 10. Section 893.055, Florida Statutes, is amended
2220 to read:
2221 (Substantial rewording of section. See
2222 s. 893.055, F.S., for present text.)
2223 893.055 Prescription drug monitoring program.—
2224 (1) As used in this section, the term:
2225 (a) "Active investigation" means an investigation that is

2226 being conducted with a reasonable, good faith belief that it
2227 could lead to the filing of administrative, civil, or criminal
2228 proceedings, or that is ongoing and continuing and for which
2229 there is a reasonable, good faith anticipation of securing an
2230 arrest or prosecution in the foreseeable future.
2231 (b) "Administration" means the obtaining and giving of a
2232 single dose of a controlled substance by a legally authorized
2233 person to a patient for her or his consumption.
2234 (c) "Controlled substance" means a controlled substance
2235 listed in Schedule II, Schedule III, Schedule IV, or Schedule V
2236 of s. 893.03 or 21 U.S.C. s. 812.
2237 (d) "Dispense" means the transfer of possession of one or
2238 more doses of a controlled substance by a dispenser to the
2239 ultimate consumer or to his or her agent.
2240 (e) "Dispenser" means a dispensing health care
2241 practitioner, pharmacy, or pharmacist licensed to dispense
2242 controlled substances in or into this state.
2243 (f) "Health care practitioner" or "practitioner" means any
2244 practitioner licensed under chapter 458, chapter 459, chapter
2245 461, chapter 463, chapter 464, chapter 465, or chapter 466.
2246 (g) "Health care regulatory board" has the same meaning as
2247 in s. 456.001(1).
2248 (h) "Law enforcement agency" means the Department of Law
2249 Enforcement, a sheriff's office in this state, a police
2250 department in this state, or a law enforcement agency of the

2251 Federal Government which enforces the laws of this state or the
2252 United States relating to controlled substances and whose agents
2253 and officers are empowered by law to conduct criminal
2254 investigations and make arrests.
2255 (i) "Pharmacy" includes a community pharmacy, an
2256 institutional pharmacy, a nuclear pharmacy, a special pharmacy,
2257 or an Internet pharmacy that is licensed by the department under
2258 chapter 465 and that dispenses or delivers controlled substances
2259 to an individual or address in this state.
2260 (j) "Prescriber" means a prescribing physician,
2261 prescribing practitioner, or other prescribing health care
2262 practitioner authorized by the laws of this state to order
2263 controlled substances.
2264 (k) "Program manager" means an employee of or a person
2265 contracted by the department who is designated to ensure the
2266 integrity of the prescription drug monitoring program in
2267 accordance with the requirements established in this section.
2268 (2)(a) The department shall maintain an electronic system
2269 to collect and store controlled substance dispensing information
2270 and shall release the information as authorized in this section
2271 and s. 893.0551. The electronic system must:
2272 1. Not infringe upon the legitimate prescribing or
2273 dispensing of a controlled substance by a prescriber or
2274 dispenser acting in good faith and in the course of professional
2275 practice.

2276 2. Be consistent with standards of the American Society
2277 for Automation in Pharmacy.
2278 3. Comply with the Health Insurance Portability and
2279 Accountability Act as it pertains to protected health
2280 information, electronic protected health information, and all
2281 other relevant state and federal privacy and security laws and
2282 regulations.
2283 4. Purge or cause to be purged information in the database
2284 that is more than 4 years old.
2285 (b) The department may collaborate with professional
2286 health care regulatory boards, appropriate organizations, and
2287 other state agencies to identify indicators of controlled
2288 substance abuse.
2289 (3)(a) For each controlled substance dispensed to a
2290 patient in this state, the following information must be
2291 reported by the dispenser to the system as soon thereafter as
2292 possible but no later than the close of the next business day
2293 after the day the controlled substance is dispensed unless an
2294 extension or exemption is approved by the department:
2295 1. The name of the prescribing practitioner, the
2296 practitioner's federal Drug Enforcement Administration
2297 registration number, the practitioner's National Provider
2298 Identification or other appropriate identifier, and the date of
2299 the prescription.
2300 2. The date the prescription was filled and the method of

2301 payment, such as cash by an individual, insurance coverage
2302 through a third party, or Medicaid payment. This paragraph does
2303 not authorize the department to include individual credit card
2304 numbers or other account numbers in the system.
2305 3. The full name, address, telephone number, and date of
2306 birth of the person for whom the prescription was written.
2307 4. The name, national drug code, quantity, and strength of
2308 the controlled substance dispensed.
2309 5. The full name, federal Drug Enforcement Administration
2310 registration number, State of Florida Department of Health
2311 issued pharmacy permit number, and address of the pharmacy or
2312 other location from which the controlled substance was
2313 dispensed. If the controlled substance was dispensed by a
2314 practitioner other than a pharmacist, the practitioner's full
2315 name, address, federal Drug Enforcement Administration
2316 registration number, State of Florida Department of Health
2317 issued license number, and National Provider Identification.
2318 6. Whether the drug was dispensed as an initial
2319 prescription or a refill, and the number of refills ordered.
2320 7. The name of the individual picking up the controlled
2321 substance prescription and type and issuer of the identification
2322 provided.
2323 8. Other appropriate identifying information as determined
2324 by department rule.
2325 (b) The following acts of administration or dispensing are

2326 exempt from the reporting requirements of this subsection:
2327 1. All acts of administration of a controlled substance.
2328 2. The dispensing of a controlled substance in the health
2329 care system of the Department of Corrections.
2330 3. The dispensing of a controlled substance to a person
2331 under the age of 16.
2332 (4) The following persons must be provided direct access
2333 to information in the system:
2334 (a) A prescriber or dispenser or his or her designee.
2335 (b) An employee of the United States Department of
2336 Veterans Affairs, the United States Department of Defense, or
2337 the Indian Health Service who provides health care services
2338 pursuant to such employment and who has the authority to
2339 prescribe or dispense controlled substances shall have access to
2340 the information in the program's system upon verification of
2341 employment.
2342 (c) The program manager or designated program and support
2343 staff to administer the system.
2344 1. In order to calculate performance measures pursuant to
2345 subsection (14), the program manager or program and support
2346 staff members who have been directed by the program manager to
2347 calculate performance measures may have direct access to
2348 information that contains no identifying information of any
2349 patient, physician, health care practitioner, prescriber, or
2350 dispenser.

2351 2. The program manager or designated program and support
2352 staff must provide the department, upon request, data that does
2353 not contain patient, physician, health care practitioner,
2354 prescriber, or dispenser identifying information for public
2355 health care and safety initiatives purposes.
2356 3. The program manager, upon determining a pattern
2357 consistent with the department's rules established under
2358 subsection (16), may provide relevant information to the
2359 prescriber and dispenser.
2360 4. The program manager, upon determining a pattern
2361 consistent with the rules established under subsection (16) and
2362 having cause to believe a violation of s. 893.13(7)(a)8.,
2363 (8)(a), or (8)(b) has occurred, may provide relevant information
2364 to the applicable law enforcement agency.
2365
2366 The program manager and designated program and support staff
2367 must complete a level II background screening.
2368 (5) The following entities may not directly access
2369 information in the system, but may request information from the
2370 program manager or designated program and support staff:
2371 (a) The department and its health care regulatory boards,
2372 as appropriate, for investigations involving licensees
2373 authorized to prescribe or dispense controlled substances.
2374 (b) The Attorney General for Medicaid fraud cases
2375 involving prescribed controlled substances.

2376 (c) A law enforcement agency during active investigations
2377 of potential criminal activity, fraud, or theft regarding
2378 prescribed controlled substances.
2379 (d) A medical examiner when conducting an authorized
2380 investigation under s. 406.11, to determine the cause of death
2381 of an individual.
2382 (e) An impaired practitioner consultant who is retained by
2383 the department under s. 456.076 to review the system information
2384 of an impaired practitioner program participant or a referral
2385 who has agreed to be evaluated or monitored through the program
2386 and who has separately agreed in writing to the consultant's
2387 access to and review of such information.
2388 (f) A patient or the legal guardian or designated health
2389 care surrogate of an incapacitated patient who submits a written
2390 and notarized request that includes the patient's full name,
2391 address, phone number, date of birth, and a copy of a
2392 government-issued photo identification.
2393 (6) The department may enter into one or more reciprocal
2394 agreements or contracts to share prescription drug monitoring
2395 information with other states, districts, or territories if the
2396 prescription drug monitoring programs of such other states,
2397 districts, or territories are compatible with the Florida
2398 program.
2399 (a) In determining compatibility, the department shall
2400 consider:

2401 1. The safeguards for privacy of patient records and the
2402 success of the program in protecting patient privacy.
2403 2. The persons authorized to view the data collected by
2404 the program. Comparable entities and licensed health care
2405 practitioners in other states, districts, or territories of the
2406 United States, law enforcement agencies, the Attorney General's
2407 Medicaid Fraud Control Unit, medical regulatory boards, and, as
2408 needed, management staff that have similar duties as management
2409 staff who work with the prescription drug monitoring program as
2410 authorized in s. 893.0551 are authorized access upon approval by
2411 the department.
2412 3. The schedules of the controlled substances that are
2413 monitored by the program.
2414 4. The data reported to or included in the program's
2415 system.
2416 5. Any implementing criteria deemed essential for a
2417 thorough comparison.
2418 6. The costs and benefits to the state of sharing
2419 prescription information.
2420 (b) The department shall assess the prescription drug
2421 monitoring program's continued compatibility with other states',
2422 districts', or territories' programs every 4 years.
2423 (c) Any agreements or contracts for sharing of
2424 prescription drug monitoring information between the department
2425 and other states, districts, or territories shall contain the

2426 same restrictions and requirements as this section or s.
2427 893.0551, and the information must be provided according to the
2428 department's determination of compatibility.
2429 (7) The department may enter into agreements or contracts
2430 to establish secure connections between the system and a
2431 prescribing or dispensing health care practitioner's electronic
2432 health recordkeeping system. The electronic health recordkeeping
2433 system owner or license holder will be responsible for ensuring
2434 that only authorized individuals have access to prescription
2435 drug monitoring program information.
2436 (8) A prescriber or dispenser or a designee of a
2437 prescriber or dispenser must consult the system to review a
2438 patient's controlled substance dispensing history before
2439 prescribing or dispensing a controlled substance for a patient
2440 age 16 or older. This requirement does not apply when
2441 prescribing or dispensing a nonopioid controlled substance
2442 listed in Schedule V of s. 893.03 or 21 U.S.C. 812. For purposes
2443 of this subsection, a "nonopioid controlled substance" is a
2444 controlled substance that does not contain any amount of a
2445 substance listed as an opioid in s. 893.03 or 21 U.S.C. 812.
2446 (a) The duty to consult the system does not apply when the
2447 system:
2448 1. Is determined by the department to be nonoperational;
2449 or
2450 2. Cannot be accessed by the prescriber or dispenser or a

2451 designee of the prescriber or dispenser because of a temporary
2452 technological or electrical failure.
2453 (b) A prescriber or dispenser or designee of a prescriber
2454 or dispenser who does not consult the system under this
2455 subsection shall document the reason he or she did not consult
2456 the system in the patient's medical record or prescription
2457 record and shall not prescribe or dispense greater than a 3-day
2458 supply of a controlled substance to the patient.
2459 (c) The department shall issue a nondisciplinary citation
2460 to any prescriber or dispenser who fails to consult the system
2461 as required by this subsection for an initial offense. Each
2462 subsequent offense is subject to disciplinary action pursuant to
2463 s. 456.073.
2464 (9) A person who willfully and knowingly fails to report
2465 the dispensing of a controlled substance as required by this
2466 section commits a misdemeanor of the first degree, punishable as
2467 provided in s. 775.082 or s. 775.083.
2468 (10) Information in the prescription drug monitoring
2469 program's system may be released only as provided in this
2470 section and s. 893.0551. The content of the system is intended
2471 to be informational only. Information in the system is not
2472 subject to discovery or introduction into evidence in any civil
2473 or administrative action against a prescriber, dispenser,
2474 pharmacy, or patient arising out of matters that are the subject
2475 of information in the system. The program manager and authorized

2476 persons who participate in preparing, reviewing, issuing, or any
2477 other activity related to management of the system may not be
2478 permitted or required to testify in any such civil or
2479 administrative action as to any findings, recommendations,
2480 evaluations, opinions, or other actions taken in connection with
2481 management of the system.
2482 (11) A prescriber or dispenser, or his or her designee,
2483 may have access to the information under this section which
2484 relates to a patient of that prescriber or dispenser as needed
2485 for the purpose of reviewing the patient's controlled drug
2486 prescription history. A prescriber or dispenser acting in good
2487 faith is immune from any civil, criminal, or administrative
2488 liability that might otherwise be incurred or imposed for
2489 receiving or using information from the prescription drug
2490 monitoring program. This subsection does not create a private
2491 cause of action, and a person may not recover damages against a
2492 prescriber or dispenser authorized to access information under
2493 this subsection for accessing or failing to access such
2494 information.
2495 (12)(a) All costs incurred by the department in
2496 administering the prescription drug monitoring program shall be
2497 funded through federal grants, private funding applied for or
2498 received by the state, or state funds appropriated in the
2499 General Appropriations Act. The department may not:
2500 1. Commit funds for the monitoring program without

2501 ensuring funding is available; or
2502 2. Use funds provided, directly or indirectly, by
2503 prescription drug manufacturers to implement the program.
2504 (b) The department shall cooperate with the direct-support
2505 organization established under subsection (15) in seeking
2506 federal grant funds, other nonstate grant funds, gifts,
2507 donations, or other private moneys for the department if the
2508 costs of doing so are immaterial. Immaterial costs include, but
2509 are not limited to, the costs of mailing and personnel assigned
2510 to research or apply for a grant. The department may
2511 competitively procure and contract pursuant to s. 287.057 for
2512 any goods and services required by this section.
2513 (13) The department shall conduct or participate in
2514 studies to examine the feasibility of enhancing the prescription
2515 drug monitoring program for the purposes of public health
2516 initiatives and statistical reporting. Such studies shall
2517 respect the privacy of the patient, the prescriber, and the
2518 dispenser. Such studies may be conducted by the department or a
2519 contracted vendor in order to:
2520 (a) Improve the quality of health care services and safety
2521 by improving prescribing and dispensing practices for controlled
2522 substances;
2523 (b) Take advantage of advances in technology;
2524 (c) Reduce duplicative prescriptions and the
2525 overprescribing of controlled substances; and

2526 (d) Reduce drug abuse.
2527 (14) The department shall annually report on performance
2528 measures to the Governor, the President of the Senate, and the
2529 Speaker of the House of Representatives by December 1.
2530 Performance measures may include, but are not limited to, the
2531 following outcomes:
2532 (a) Reduction of the rate of inappropriate use of
2533 controlled substances through department education and safety
2534 efforts.
2535 (b) Reduction of the quantity of controlled substances
2536 obtained by individuals attempting to engage in fraud and
2537 deceit.
2538 (c) Increased coordination among partners participating in
2539 the prescription drug monitoring program.
2540 (d) Involvement of stakeholders in achieving improved
2541 patient health care and safety and reduction of controlled
2542 substance abuse and controlled substance diversion.
2543 (15) The department may establish a direct-support
2544 organization to provide assistance, funding, and promotional
2545 support for the activities authorized for the prescription drug
2546 monitoring program.
2547 (a) As used in this subsection, the term "direct-support
2548 organization" means an organization that is:
2549 1. A Florida corporation not for profit incorporated under
2550 chapter 617, exempted from filing fees, and approved by the

2551 Department of State.
2552 2. Organized and operated to conduct programs and
2553 activities; raise funds; request and receive grants, gifts, and
2554 bequests of money; acquire, receive, hold, and invest, in its
2555 own name, securities, funds, objects of value, or other
2556 property, either real or personal; and make expenditures or
2557 provide funding to or for the direct or indirect benefit of the
2558 department in the furtherance of the prescription drug
2559 monitoring program.
2560 (b) The State Surgeon General shall appoint a board of
2561 directors for the direct-support organization.
2562 1. The board of directors shall consist of no fewer than
2563 five members who shall serve at the pleasure of the State
2564 Surgeon General.
2565 2. The State Surgeon General shall provide guidance to
2566 members of the board to ensure that moneys received by the
2567 direct-support organization are not received from inappropriate
2568 sources. Inappropriate sources include, but are not limited to,
2569 donors, grantors, persons, prescription drug manufacturers, or
2570 organizations that may monetarily or substantively benefit from
2571 the purchase of goods or services by the department in
2572 furtherance of the prescription drug monitoring program.
2573 (c) The direct-support organization shall operate under
2574 written contract with the department. The contract must, at a
2575 minimum, provide for:

2576 1. Approval of the articles of incorporation and bylaws of
2577 the direct-support organization by the department.
2578 2. Submission of an annual budget for the approval of the
2579 department.
2580 3. The reversion, without penalty, to the department's
2581 grants and donations trust fund for the administration of the
2582 prescription drug monitoring program of all moneys and property
2583 held in trust by the direct-support organization for the benefit
2584 of the prescription drug monitoring program if the direct-
2585 support organization ceases to exist or if the contract is
2586 terminated.
2587 4. The fiscal year of the direct-support organization,
2588 which must begin July 1 of each year and end June 30 of the
2589 following year.
2590 5. The disclosure of the material provisions of the
2591 contract to donors of gifts, contributions, or bequests,
2592 including such disclosure on all promotional and fundraising
2593 publications, and an explanation to such donors of the
2594 distinction between the department and the direct-support
2595 organization.
2596 6. The direct-support organization's collecting,
2597 expending, and providing of funds to the department for the
2598 development, implementation, and operation of the prescription
2599 drug monitoring program as described in this section. The
2600 direct-support organization may collect and expend funds to be

2601 used for the functions of the direct-support organization's
2602 board of directors, as necessary and approved by the department.
2603 In addition, the direct-support organization may collect and
2604 provide funding to the department in furtherance of the
2605 prescription drug monitoring program by:
2606 a. Establishing and administering the prescription drug
2607 monitoring program's electronic system, including hardware and
2608 software.
2609 b. Conducting studies on the efficiency and effectiveness
2610 of the program to include feasibility studies as described in
2611 subsection (13).
2612 c. Providing funds for future enhancements of the program
2613 within the intent of this section.
2614 d. Providing user training of the prescription drug
2615 monitoring program, including distribution of materials to
2616 promote public awareness and education and conducting workshops
2617 or other meetings for health care practitioners, pharmacists,
2618 and others as appropriate.
2619 e. Providing funds for travel expenses.
2620 f. Providing funds for administrative costs, including
2621 personnel, audits, facilities, and equipment.
2622 g. Fulfilling all other requirements necessary to
2623 implement and operate the program as outlined in this section.
2624 7. Certification by the department that the direct-support
2625 organization is complying with the terms of the contract in a

2626 manner consistent with and in furtherance of the goals and
2627 purposes of the prescription drug monitoring program and in the
2628 best interests of the state. Such certification must be made
2629 annually and reported in the official minutes of a meeting of
2630 the direct-support organization.
2631 (d) The activities of the direct-support organization must
2632 be consistent with the goals and mission of the department, as
2633 determined by the department, and in the best interests of the
2634 state. The direct-support organization must obtain written
2635 approval from the department for any activities in support of
2636 the prescription drug monitoring program before undertaking
2637 those activities.
2638 (e) The direct-support organization shall provide for an
2639 independent annual financial audit in accordance with s.
2640 215.981. Copies of the audit shall be provided to the department
2641 and the Office of Policy and Budget in the Executive Office of
2642 the Governor.
2643 (f) The direct-support organization may not exercise any
2644 power under s. 617.0302(12) or (16).
2645 (g) The direct-support organization is not considered a
2646 lobbying firm within the meaning of s. 11.045.
2647 (h) The department may permit, without charge, appropriate
2648 use of administrative services, property, and facilities of the
2649 department by the direct-support organization, subject to this
2650 section. The use must be directly in keeping with the approved

2651 purposes of the direct-support organization and may not be made
2652 at times or places that would unreasonably interfere with
2653 opportunities for the public to use such facilities for
2654 established purposes. Any moneys received from rentals of
2655 facilities and properties managed by the department may be held
2656 in a separate depository account in the name of the direct-
2657 support organization and subject to the provisions of the letter
2658 of agreement with the department. The letter of agreement must
2659 provide that any funds held in the separate depository account
2660 in the name of the direct-support organization must revert to
2661 the department if the direct-support organization is no longer
2662 approved by the department to operate in the best interests of
2663 the state.
2664 (i) The department may adopt rules under s. 120.54 to
2665 govern the use of administrative services, property, or
2666 facilities of the department or office by the direct-support
2667 organization.
2668 (j) The department may not permit the use of any
2669 administrative services, property, or facilities of the state by
2670 a direct-support organization if that organization does not
2671 provide equal membership and employment opportunities to all
2672 persons regardless of race, color, religion, gender, age, or
2673 national origin.
2674 (k) This subsection is repealed October 1, 2027, unless
2675 reviewed and saved from repeal by the Legislature.

2676 (16) The department shall adopt rules necessary to
2677 implement this section.
2678 Section 11. Section 893.0551, Florida Statutes, is amended
2679 to read:
2680 893.0551 Public records exemption for the prescription
2681 drug monitoring program.—
2682 (1) For purposes of this section, the terms used in this
2683 section have the same meanings as provided in s. 893.055.
2684 (2) The following information of a patient or patient's
2685 agent, a health care practitioner, a dispenser, an employee of
2686 the practitioner who is acting on behalf of and at the direction
2687 of the practitioner, a pharmacist, or a pharmacy that is
2688 contained in records held by the department under s. 893.055 is
2689 confidential and exempt from s. 119.07(1) and s. 24(a), Art. I
2690 of the State Constitution:
2691 (a) Name.
2692 (b) Address.
2693 (c) Telephone number.
2694 (d) Insurance plan number.
2695 (e) Government-issued identification number.
2696 (f) Provider number.
2697 (g) Drug Enforcement Administration number.
2698 (h) Any other unique identifying information or number.
2699 (3) The department shall disclose such ~~confidential and~~
2700 ~~exempt~~ information to the following persons or entities upon

2701 request and after using a verification process to ensure the
2702 legitimacy of the request as provided in s. 893.055:
2703 (a) A health care practitioner, or his or her designee,
2704 who certifies that the information is necessary to provide
2705 medical treatment to a current patient in accordance with ss.
2706 893.04, 893.05, and 893.055.
2707 (b) An employee of the United States Department of
2708 Veterans Affairs, the United States Department of Defense, or
2709 the Indian Health Service who provides health care services
2710 pursuant to such employment and who has the authority to
2711 prescribe or dispense controlled substances shall have access to
2712 the information in the program's system upon verification of
2713 such employment.
2714 (c) The program manager and designated support staff for
2715 administration of the program, and to provide relevant
2716 information to the prescriber, dispenser, and appropriate law
2717 enforcement agencies, in accordance with s. 893.055.
2718 (d) The department and its relevant health care regulatory
2719 boards for investigations involving licensees authorized to
2720 prescribe or dispense controlled substances. The department or
2721 health care regulatory board may request information from the
2722 program but may not have direct access to its system. The
2723 department may provide to a law enforcement agency pursuant to
2724 ss. 456.066 and 456.073 only information that is relevant to the
2725 specific controlled substances investigation that prompted the

2726 request for the information.
2727 (e) ~~(a)~~ The Attorney General or his or her designee when
2728 working on Medicaid fraud cases involving prescribed controlled
2729 substances ~~prescription drugs~~ or when the Attorney General has
2730 initiated a review of specific identifiers of Medicaid fraud or
2731 specific identifiers that warrant a Medicaid investigation
2732 regarding prescribed controlled substances ~~prescription drugs~~.
2733 The Attorney General's Medicaid fraud investigators may not have
2734 direct access to the department's system ~~database~~. The Attorney
2735 General or his or her designee may disclose to a criminal
2736 justice agency, as defined in s. 119.011, only the ~~confidential~~
2737 ~~and exempt~~ information received from the department that is
2738 relevant to an identified active investigation that prompted the
2739 request for the information.
2740 ~~(b) The department's relevant health care regulatory~~
2741 ~~boards responsible for the licensure, regulation, or discipline~~
2742 ~~of a practitioner, pharmacist, or other person who is authorized~~
2743 ~~to prescribe, administer, or dispense controlled substances and~~
2744 ~~who is involved in a specific controlled substances~~
2745 ~~investigation for prescription drugs involving a designated~~
2746 ~~person. The health care regulatory boards may request~~
2747 ~~information from the department but may not have direct access~~
2748 ~~to its database. The health care regulatory boards may provide~~
2749 ~~to a law enforcement agency pursuant to ss. 456.066 and 456.073~~
2750 ~~only information that is relevant to the specific controlled~~

2751 ~~substances investigation that prompted the request for the~~
2752 ~~information.~~
2753 (f) ~~(e)~~ A law enforcement agency that has initiated an
2754 active investigation involving a specific violation of law
2755 regarding prescription drug abuse or diversion of prescribed
2756 controlled substances and that has entered into a user agreement
2757 with the department. A law enforcement agency may request
2758 information from the department but may not have direct access
2759 to its system ~~database~~. The law enforcement agency may disclose
2760 to a criminal justice agency, as defined in s. 119.011, only
2761 ~~confidential and exempt~~ information received from the department
2762 that is relevant to an identified active investigation that
2763 prompted the request for such information.
2764 (g) A district medical examiner or associate medical
2765 examiner, as described in s. 406.06, pursuant to his or her
2766 official duties, as required by s. 406.11, to determine the
2767 cause of death of an individual. Such medical examiners may
2768 request information from the department but may not have direct
2769 access to the system
2770 ~~(d) A health care practitioner, or his or her designee,~~
2771 ~~who certifies that the information is necessary to provide~~
2772 ~~medical treatment to a current patient in accordance with ss.~~
2773 ~~893.05 and 893.055.~~
2774 ~~(e) A pharmacist, or his or her designee, who certifies~~
2775 ~~that the requested information will be used to dispense~~

2776 ~~controlled substances to a current patient in accordance with~~
2777 ~~ss. 893.04 and 893.055.~~
2778 ~~(f) A patient or the legal guardian or designated health~~
2779 ~~care surrogate for an incapacitated patient, if applicable,~~
2780 ~~making a request as provided in s. 893.055(7)(c)4.~~
2781 ~~(g) The patient's pharmacy, prescriber, or dispenser, or~~
2782 ~~the designee of the pharmacy, prescriber, or dispenser, who~~
2783 ~~certifies that the information is necessary to provide medical~~
2784 ~~treatment to his or her current patient in accordance with s.~~
2785 ~~893.055~~.
2786 (h) An impaired practitioner consultant who has been
2787 authorized in writing by a participant in, or by a referral to,
2788 the impaired practitioner program to access and review
2789 information as provided in s. 893.055(5)(e) ~~893.055(7)(c)5~~.
2790 (i) A patient or the legal guardian or designated health
2791 care surrogate for an incapacitated patient, if applicable,
2792 making a request as provided in s. 893.055(5)(f).
2793 (4) If the department determines consistent with its rules
2794 that a pattern of controlled substance abuse exists, the
2795 department may disclose such confidential and exempt information
2796 to the applicable law enforcement agency in accordance with s.
2797 893.055. The law enforcement agency may disclose to a criminal
2798 justice agency, as defined in s. 119.011, only ~~confidential and~~
2799 ~~exempt~~ information received from the department that is relevant
2800 to an identified active investigation that is specific to a

2801 violation of s. 893.13(7)(a)8., s. 893.13(8)(a), or s.
2802 893.13(8)(b).
2803 (5) Before disclosing ~~confidential and exempt~~ information
2804 to a criminal justice agency or a law enforcement agency
2805 pursuant to this section, the disclosing person or entity must
2806 take steps to ensure the continued confidentiality of all
2807 ~~confidential and exempt~~ information. At a minimum, these steps
2808 must include redacting any nonrelevant information.
2809 (6) An agency or person who obtains any ~~confidential and~~
2810 ~~exempt~~ information pursuant to this section must maintain the
2811 confidential and exempt status of that information and may not
2812 disclose such information unless authorized by law. Information
2813 shared with a state attorney pursuant to paragraph (3)(f) ~~(3)(a)~~
2814 or paragraph (3)(h) ~~(3)(c)~~ may be released only in response to a
2815 discovery demand if such information is directly related to the
2816 criminal case for which the information was requested. Unrelated
2817 information may be released only upon an order of a court of
2818 competent jurisdiction.
2819 (7) A person who willfully and knowingly violates this
2820 section commits a felony of the third degree, punishable as
2821 provided in s. 775.082, s. 775.083, or s. 775.084.
2822 Section 12. Paragraphs (a), (c), (d), (e), (f), and (h) of
2823 subsection (1), subsection (2), paragraphs (a) and (b) of
2824 subsection (4), and subsections (5) and (7) of section 893.13,
2825 Florida Statutes, are amended to read:

2826 893.13 Prohibited acts; penalties.—
2827 (1)(a) Except as authorized by this chapter and chapter
2828 499, a person may not sell, manufacture, or deliver, or possess
2829 with intent to sell, manufacture, or deliver, a controlled
2830 substance. A person who violates this provision with respect to:
2831 1. A controlled substance named or described in s.
2832 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2833 ~~(2)(c)4.~~ commits a felony of the second degree, punishable as
2834 provided in s. 775.082, s. 775.083, or s. 775.084.
2835 2. A controlled substance named or described in s.
2836 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2837 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2838 felony of the third degree, punishable as provided in s.
2839 775.082, s. 775.083, or s. 775.084.
2840 3. A controlled substance named or described in s.
2841 893.03(5) commits a misdemeanor of the first degree, punishable
2842 as provided in s. 775.082 or s. 775.083.
2843 (c) Except as authorized by this chapter, a person may not
2844 sell, manufacture, or deliver, or possess with intent to sell,
2845 manufacture, or deliver, a controlled substance in, on, or
2846 within 1,000 feet of the real property comprising a child care
2847 facility as defined in s. 402.302 or a public or private
2848 elementary, middle, or secondary school between the hours of 6
2849 a.m. and 12 midnight, or at any time in, on, or within 1,000
2850 feet of real property comprising a state, county, or municipal

2851 park, a community center, or a publicly owned recreational
2852 facility. As used in this paragraph, the term "community center"
2853 means a facility operated by a nonprofit community-based
2854 organization for the provision of recreational, social, or
2855 educational services to the public. A person who violates this
2856 paragraph with respect to:
2857 1. A controlled substance named or described in s.
2858 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2859 ~~(2)(c)4.~~ commits a felony of the first degree, punishable as
2860 provided in s. 775.082, s. 775.083, or s. 775.084. The defendant
2861 must be sentenced to a minimum term of imprisonment of 3
2862 calendar years unless the offense was committed within 1,000
2863 feet of the real property comprising a child care facility as
2864 defined in s. 402.302.
2865 2. A controlled substance named or described in s.
2866 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2867 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2868 felony of the second degree, punishable as provided in s.
2869 775.082, s. 775.083, or s. 775.084.
2870 3. Any other controlled substance, except as lawfully
2871 sold, manufactured, or delivered, must be sentenced to pay a
2872 $500 fine and to serve 100 hours of public service in addition
2873 to any other penalty prescribed by law.
2874
2875 This paragraph does not apply to a child care facility unless

2876 the owner or operator of the facility posts a sign that is not
2877 less than 2 square feet in size with a word legend identifying
2878 the facility as a licensed child care facility and that is
2879 posted on the property of the child care facility in a
2880 conspicuous place where the sign is reasonably visible to the
2881 public.
2882 (d) Except as authorized by this chapter, a person may not
2883 sell, manufacture, or deliver, or possess with intent to sell,
2884 manufacture, or deliver, a controlled substance in, on, or
2885 within 1,000 feet of the real property comprising a public or
2886 private college, university, or other postsecondary educational
2887 institution. A person who violates this paragraph with respect
2888 to:
2889 1. A controlled substance named or described in s.
2890 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2891 ~~(2)(c)4.~~ commits a felony of the first degree, punishable as
2892 provided in s. 775.082, s. 775.083, or s. 775.084.
2893 2. A controlled substance named or described in s.
2894 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2895 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2896 felony of the second degree, punishable as provided in s.
2897 775.082, s. 775.083, or s. 775.084.
2898 3. Any other controlled substance, except as lawfully
2899 sold, manufactured, or delivered, must be sentenced to pay a
2900 $500 fine and to serve 100 hours of public service in addition

2901 to any other penalty prescribed by law.
2902 (e) Except as authorized by this chapter, a person may not
2903 sell, manufacture, or deliver, or possess with intent to sell,
2904 manufacture, or deliver, a controlled substance not authorized
2905 by law in, on, or within 1,000 feet of a physical place for
2906 worship at which a church or religious organization regularly
2907 conducts religious services or within 1,000 feet of a
2908 convenience business as defined in s. 812.171. A person who
2909 violates this paragraph with respect to:
2910 1. A controlled substance named or described in s.
2911 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2912 ~~(2)(c)4.~~ commits a felony of the first degree, punishable as
2913 provided in s. 775.082, s. 775.083, or s. 775.084.
2914 2. A controlled substance named or described in s.
2915 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2916 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2917 felony of the second degree, punishable as provided in s.
2918 775.082, s. 775.083, or s. 775.084.
2919 3. Any other controlled substance, except as lawfully
2920 sold, manufactured, or delivered, must be sentenced to pay a
2921 $500 fine and to serve 100 hours of public service in addition
2922 to any other penalty prescribed by law.
2923 (f) Except as authorized by this chapter, a person may not
2924 sell, manufacture, or deliver, or possess with intent to sell,
2925 manufacture, or deliver, a controlled substance in, on, or

2926 within 1,000 feet of the real property comprising a public
2927 housing facility at any time. As used in this section, the term
2928 "real property comprising a public housing facility" means real
2929 property, as defined in s. 421.03(12), of a public corporation
2930 created as a housing authority pursuant to part I of chapter
2931 421. A person who violates this paragraph with respect to:
2932 1. A controlled substance named or described in s.
2933 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2934 ~~(2)(c)4.~~ commits a felony of the first degree, punishable as
2935 provided in s. 775.082, s. 775.083, or s. 775.084.
2936 2. A controlled substance named or described in s.
2937 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2938 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2939 felony of the second degree, punishable as provided in s.
2940 775.082, s. 775.083, or s. 775.084.
2941 3. Any other controlled substance, except as lawfully
2942 sold, manufactured, or delivered, must be sentenced to pay a
2943 $500 fine and to serve 100 hours of public service in addition
2944 to any other penalty prescribed by law.
2945 (h) Except as authorized by this chapter, a person may not
2946 sell, manufacture, or deliver, or possess with intent to sell,
2947 manufacture, or deliver, a controlled substance in, on, or
2948 within 1,000 feet of the real property comprising an assisted
2949 living facility, as that term is used in chapter 429. A person
2950 who violates this paragraph with respect to:

2951 1. A controlled substance named or described in s.
2952 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2953 ~~(2)(c)4.~~ commits a felony of the first degree, punishable as
2954 provided in s. 775.082, s. 775.083, or s. 775.084.
2955 2. A controlled substance named or described in s.
2956 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2957 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2958 felony of the second degree, punishable as provided in s.
2959 775.082, s. 775.083, or s. 775.084.
2960 3. Any other controlled substance, except as lawfully
2961 sold, manufactured, or delivered, must be sentenced to pay a
2962 $500 fine and to serve 100 hours of public service in addition
2963 to any other penalty prescribed by law.
2964 (2)(a) Except as authorized by this chapter and chapter
2965 499, a person may not purchase, or possess with intent to
2966 purchase, a controlled substance. A person who violates this
2967 provision with respect to:
2968 1. A controlled substance named or described in s.
2969 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2970 ~~(2)(c)4.~~ commits a felony of the second degree, punishable as
2971 provided in s. 775.082, s. 775.083, or s. 775.084.
2972 2. A controlled substance named or described in s.
2973 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2974 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2975 felony of the third degree, punishable as provided in s.

2976 775.082, s. 775.083, or s. 775.084.
2977 3. A controlled substance named or described in s.
2978 893.03(5) commits a misdemeanor of the first degree, punishable
2979 as provided in s. 775.082 or s. 775.083.
2980 (b) Except as provided in this chapter, a person may not
2981 purchase more than 10 grams of any substance named or described
2982 in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any
2983 mixture containing any such substance. A person who violates
2984 this paragraph commits a felony of the first degree, punishable
2985 as provided in s. 775.082, s. 775.083, or s. 775.084.
2986 (4) Except as authorized by this chapter, a person 18
2987 years of age or older may not deliver any controlled substance
2988 to a person younger than 18 years of age, use or hire a person
2989 younger than 18 years of age as an agent or employee in the sale
2990 or delivery of such a substance, or use such person to assist in
2991 avoiding detection or apprehension for a violation of this
2992 chapter. A person who violates this subsection with respect to:
2993 (a) A controlled substance named or described in s.
2994 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2995 ~~(2)(c)4.~~ commits a felony of the first degree, punishable as
2996 provided in s. 775.082, s. 775.083, or s. 775.084.
2997 (b) A controlled substance named or described in s.
2998 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
2999 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
3000 felony of the second degree, punishable as provided in s.

3001 775.082, s. 775.083, or s. 775.084.
3002
3003 Imposition of sentence may not be suspended or deferred, and the
3004 person so convicted may not be placed on probation.
3005 (5) A person may not bring into this state any controlled
3006 substance unless the possession of such controlled substance is
3007 authorized by this chapter or unless such person is licensed to
3008 do so by the appropriate federal agency. A person who violates
3009 this provision with respect to:
3010 (a) A controlled substance named or described in s.
3011 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
3012 ~~(2)(c)4.~~ commits a felony of the second degree, punishable as
3013 provided in s. 775.082, s. 775.083, or s. 775.084.
3014 (b) A controlled substance named or described in s.
3015 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,
3016 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
3017 felony of the third degree, punishable as provided in s.
3018 775.082, s. 775.083, or s. 775.084.
3019 (c) A controlled substance named or described in s.
3020 893.03(5) commits a misdemeanor of the first degree, punishable
3021 as provided in s. 775.082 or s. 775.083.
3022 (7)
3023 (e) A person or health care practitioner who violates the
3024 provisions of subparagraph (a)13. or paragraph (b) commits a
3025 felony of the second ~~third~~ degree, punishable as provided in s.

3026 775.082, s. 775.083, or s. 775.084, if any controlled substance
3027 that is the subject of the offense is listed in Schedule II,
3028 Schedule III, or Schedule IV.
3029 Section 13. Section 893.147, Florida Statutes, is amended,
3030 to read:
3031 893.147 Use, possession, manufacture, delivery,
3032 transportation, advertisement, or retail sale of drug
3033 paraphernalia, specified machines, and materials.—
3034 (1) USE OR POSSESSION OF DRUG PARAPHERNALIA.—It is
3035 unlawful for any person to use, or to possess with intent to
3036 use, drug paraphernalia:
3037 (a) To plant, propagate, cultivate, grow, harvest,
3038 manufacture, compound, convert, produce, process, prepare, test,
3039 analyze, pack, repack, store, contain, or conceal a controlled
3040 substance in violation of this chapter; or
3041 (b) To inject, ingest, inhale, or otherwise introduce into
3042 the human body a controlled substance in violation of this
3043 chapter.
3044
3045 Any person who violates this subsection is guilty of a
3046 misdemeanor of the first degree, punishable as provided in s.
3047 775.082 or s. 775.083.
3048 (2) MANUFACTURE OR DELIVERY OF DRUG PARAPHERNALIA.—It is
3049 unlawful for any person to deliver, possess with intent to
3050 deliver, or manufacture with intent to deliver drug

3051 paraphernalia, knowing, or under circumstances where one
3052 reasonably should know, that it will be used:
3053 (a) To plant, propagate, cultivate, grow, harvest,
3054 manufacture, compound, convert, produce, process, prepare, test,
3055 analyze, pack, repack, store, contain, or conceal a controlled
3056 substance in violation of this act; or
3057 (b) To inject, ingest, inhale, or otherwise introduce into
3058 the human body a controlled substance in violation of this act.
3059
3060 Any person who violates this subsection is guilty of a felony of
3061 the third degree, punishable as provided in s. 775.082, s.
3062 775.083, or s. 775.084.
3063 (3) DELIVERY OF DRUG PARAPHERNALIA TO A MINOR.—
3064 (a) Any person 18 years of age or over who violates
3065 subsection (2) by delivering drug paraphernalia to a person
3066 under 18 years of age is guilty of a felony of the second
3067 degree, punishable as provided in s. 775.082, s. 775.083, or s.
3068 775.084.
3069 (b) It is unlawful for any person to sell or otherwise
3070 deliver hypodermic syringes, needles, or other objects which may
3071 be used, are intended for use, or are designed for use in
3072 parenterally injecting substances into the human body to any
3073 person under 18 years of age, except that hypodermic syringes,
3074 needles, or other such objects may be lawfully dispensed to a
3075 person under 18 years of age by a licensed practitioner, parent,

3076 or legal guardian or by a pharmacist pursuant to a valid
3077 prescription for same. Any person who violates the provisions of
3078 this paragraph is guilty of a misdemeanor of the first degree,
3079 punishable as provided in s. 775.082 or s. 775.083.
3080 (4) TRANSPORTATION OF DRUG PARAPHERNALIA.—It is unlawful
3081 to use, possess with the intent to use, or manufacture with the
3082 intent to use drug paraphernalia, knowing or under circumstances
3083 in which one reasonably should know that it will be used to
3084 transport:
3085 (a) A controlled substance in violation of this chapter;
3086 or
3087 (b) Contraband as defined in s. 932.701(2)(a)1.
3088
3089 Any person who violates this subsection commits a felony of the
3090 third degree, punishable as provided in s. 775.082, s. 775.083,
3091 or s. 775.084.
3092 (5) ADVERTISEMENT OF DRUG PARAPHERNALIA.—It is unlawful
3093 for any person to place in any newspaper, magazine, handbill, or
3094 other publication any advertisement, knowing, or under
3095 circumstances where one reasonably should know, that the purpose
3096 of the advertisement, in whole or in part, is to promote the
3097 sale of objects designed or intended for use as drug
3098 paraphernalia. Any person who violates this subsection is guilty
3099 of a misdemeanor of the first degree, punishable as provided in
3100 s. 775.082 or s. 775.083.

3101 (6) RETAIL SALE OF DRUG PARAPHERNALIA.—
3102 (a) It is unlawful for a person to knowingly and willfully
3103 sell or offer for sale at retail any drug paraphernalia
3104 described in s. 893.145(12)(a)-(c) or (g)-(m), other than a pipe
3105 that is primarily made of briar, meerschaum, clay, or corn cob.
3106 (b) A person who violates paragraph (a) commits a
3107 misdemeanor of the first degree, punishable as provided in s.
3108 775.082 or s. 775.083, and, upon a second or subsequent
3109 violation, commits a felony of the third degree, punishable as
3110 provided in s. 775.082, s. 775.083, or s. 775.084.
3111 (7) TABLETING MACHINES, ENCAPSULATING MACHINES, AND
3112 CONTROLLED SUBSTANCE COUNTERFEITING MATERIALS.—
3113 (a) Except as provided in paragraph (b), it is unlawful
3114 for any person to possess, purchase, deliver, sell, or possess
3115 with intent to sell or deliver a tableting machine, an
3116 encapsulating machine, or controlled substance counterfeiting
3117 materials knowing, intending, or having reasonable cause to
3118 believe that it will be used to manufacture a controlled
3119 substance or counterfeit controlled substance.
3120 (b)1. A regulated person may possess, purchase, deliver,
3121 sell, or possess with intent to deliver or sell a tableting
3122 machine or encapsulating machine as part of a regulated
3123 transaction with a regular customer or regular importer if he or
3124 she is in compliance with 21 U.S.C. s. 830. For purposes of this
3125 paragraph, the terms "regulated person," "regulated

3126 transaction," "regular customer," and "regular importer" have
3127 the same meanings as provided in 21 U.S.C. s. 802.
3128 2. A person registered under 21 U.S.C. s. 822 may possess,
3129 purchase, deliver, sell, or possess with intent to deliver or
3130 sell a tableting machine or encapsulating machine to manufacture
3131 a controlled substance pursuant to such registration.
3132 3. A person who holds an active, unencumbered license or a
3133 permit under s. 381.986 or chapter 465 may possess, purchase,
3134 deliver, sell, or possess with intent to sell or deliver a
3135 tableting machine or encapsulating machine to manufacture a
3136 controlled substance, if such person is performing functions in
3137 compliance with or under the authority of that license or
3138 permit.
3139 (c) For purposes of this subsection, the term:
3140 1. "Controlled substance" has the same meaning as provided
3141 in s. 893.02(4).
3142 2. "Controlled substance counterfeiting material" means a
3143 punch, die, plate, stone, or other item designed to print,
3144 imprint, or reproduce the trademark, trade name, or other
3145 identifying mark, imprint, or device of another or any likeness
3146 of any of the foregoing upon a drug or container or labeling
3147 thereof so as to render such drug a counterfeit controlled
3148 substance.
3149 3. "Counterfeit controlled substance" has the same meaning
3150 as provided in s. 831.31(2).

3151 4. "Encapsulating machine" means manual, semiautomatic, or
3152 fully automatic equipment that can be used to fill shells or
3153 capsules with powdered or granular solids or semisolid material
3154 to produce coherent solid tablets.
3155 5. "Tableting machine" means manual, semiautomatic, or
3156 fully automatic equipment that can be used to compact or mold
3157 powdered or granular solids or semisolid material to produce
3158 coherent solid tablets.
3159 (d)1. Except as provided in subparagraph 2., a person who
3160 violates this subsection commits a felony of the third degree,
3161 punishable as provided in s. 775.082, s. 775.083, or s. 775.084.
3162 2. Any person who violates this subsection knowing,
3163 intending, or having reasonable cause to believe that such
3164 action will result in the unlawful manufacture of a controlled
3165 substance or counterfeit controlled substance that contains:
3166 a. A substance controlled under s. 893.03(1);
3167 b. Cocaine, as described in s. 893.03(2)(a)4.;
3168 c. Opium or any synthetic or natural salt, compound,
3169 derivative, or preparation of opium;
3170 d. Methadone;
3171 e. Alfentanil, as described in s. 893.03(2)(b)1.;
3172 f. Carfentanil, as described in s. 893.03(2)(b)6.;
3173 g. Fentanyl, as described in s. 893.03(2)(b)9.;
3174 h. Sufentanil, as described in s. 893.03(2)(b)30.; or
3175 i. A controlled substance analog, as described in s.

3176 893.0356, of any substance specified in sub-subparagraphs a.-h.,
3177
3178 commits a felony of the second degree, punishable as provided in
3179 s. 775.082, s. 775.083, or s. 775.084.
3180 Section 14. Effective January 1, 2019, paragraphs (pp) and
3181 (qq) of subsection (1) of section 458.331, Florida Statutes, are
3182 amended to read:
3183 458.331 Grounds for disciplinary action; action by the
3184 board and department.—
3185 (1) The following acts constitute grounds for denial of a
3186 license or disciplinary action, as specified in s. 456.072(2):
3187 (pp) Applicable to a licensee who serves as the designated
3188 physician of a pain-management clinic as defined in s. 458.3265
3189 or s. 459.0137:
3190 1. Registering a pain-management clinic through
3191 misrepresentation or fraud;
3192 2. Procuring, or attempting to procure, the registration
3193 of a pain-management clinic for any other person by making or
3194 causing to be made, any false representation;
3195 3. Failing to comply with any requirement of chapter 499,
3196 the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the
3197 Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq.,
3198 the Drug Abuse Prevention and Control Act; or chapter 893, the
3199 Florida Comprehensive Drug Abuse Prevention and Control Act;
3200 4. Being convicted or found guilty of, regardless of

3201 adjudication to, a felony or any other crime involving moral
3202 turpitude, fraud, dishonesty, or deceit in any jurisdiction of
3203 the courts of this state, of any other state, or of the United
3204 States;
3205 5. Being convicted of, or disciplined by a regulatory
3206 agency of the Federal Government or a regulatory agency of
3207 another state for, any offense that would constitute a violation
3208 of this chapter;
3209 6. Being convicted of, or entering a plea of guilty or
3210 nolo contendere to, regardless of adjudication, a crime in any
3211 jurisdiction of the courts of this state, of any other state, or
3212 of the United States which relates to the practice of, or the
3213 ability to practice, a licensed health care profession;
3214 7. Being convicted of, or entering a plea of guilty or
3215 nolo contendere to, regardless of adjudication, a crime in any
3216 jurisdiction of the courts of this state, of any other state, or
3217 of the United States which relates to health care fraud;
3218 8. Dispensing any medicinal drug based upon a
3219 communication that purports to be a prescription as defined in
3220 s. 465.003(14) or s. 893.02 if the dispensing practitioner knows
3221 or has reason to believe that the purported prescription is not
3222 based upon a valid practitioner-patient relationship; or
3223 9. Failing to timely notify the board of the date of his
3224 or her termination from a pain-management clinic as required by
3225 s. 458.3265(3) ~~458.3265(2)~~.

3226 (qq) Failing to timely notify the department of the theft
3227 of prescription blanks from a pain-management clinic or a breach
3228 of other methods for prescribing within 24 hours as required by
3229 s. 458.3265(3) ~~458.3265(2)~~.
3230 Section 15. Effective January 1, 2019, paragraphs (rr)
3231 and (ss) of subsection (1) of section 459.015, Florida Statutes,
3232 are amended to read:
3233 459.015 Grounds for disciplinary action; action by the
3234 board and department.—
3235 (1) The following acts constitute grounds for denial of a
3236 license or disciplinary action, as specified in s. 456.072(2):
3237 (rr) Applicable to a licensee who serves as the designated
3238 physician of a pain-management clinic as defined in s. 458.3265
3239 or s. 459.0137:
3240 1. Registering a pain-management clinic through
3241 misrepresentation or fraud;
3242 2. Procuring, or attempting to procure, the registration
3243 of a pain-management clinic for any other person by making or
3244 causing to be made, any false representation;
3245 3. Failing to comply with any requirement of chapter 499,
3246 the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the
3247 Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq.,
3248 the Drug Abuse Prevention and Control Act; or chapter 893, the
3249 Florida Comprehensive Drug Abuse Prevention and Control Act;
3250 4. Being convicted or found guilty of, regardless of

3251 adjudication to, a felony or any other crime involving moral
3252 turpitude, fraud, dishonesty, or deceit in any jurisdiction of
3253 the courts of this state, of any other state, or of the United
3254 States;
3255 5. Being convicted of, or disciplined by a regulatory
3256 agency of the Federal Government or a regulatory agency of
3257 another state for, any offense that would constitute a violation
3258 of this chapter;
3259 6. Being convicted of, or entering a plea of guilty or
3260 nolo contendere to, regardless of adjudication, a crime in any
3261 jurisdiction of the courts of this state, of any other state, or
3262 of the United States which relates to the practice of, or the
3263 ability to practice, a licensed health care profession;
3264 7. Being convicted of, or entering a plea of guilty or
3265 nolo contendere to, regardless of adjudication, a crime in any
3266 jurisdiction of the courts of this state, of any other state, or
3267 of the United States which relates to health care fraud;
3268 8. Dispensing any medicinal drug based upon a
3269 communication that purports to be a prescription as defined in
3270 s. 465.003(14) or s. 893.02 if the dispensing practitioner knows
3271 or has reason to believe that the purported prescription is not
3272 based upon a valid practitioner-patient relationship; or
3273 9. Failing to timely notify the board of the date of his
3274 or her termination from a pain-management clinic as required by
3275 s. 459.0137(3) ~~459.0137(2)~~.

3276 (ss) Failing to timely notify the department of the theft
3277 of prescription blanks from a pain-management clinic or a breach
3278 of other methods for prescribing within 24 hours as required by
3279 s. 459.0137(3) ~~459.0137(2)~~.
3280 Section 16. Paragraph (b) of subsection (4) of section
3281 463.0055, Florida Statutes, is amended to read:
3282 463.0055 Administration and prescription of ocular
3283 pharmaceutical agents.—
3284 (4) A certified optometrist shall be issued a prescriber
3285 number by the board. Any prescription written by a certified
3286 optometrist for an ocular pharmaceutical agent pursuant to this
3287 section shall have the prescriber number printed thereon. A
3288 certified optometrist may not administer or prescribe:
3289 (b) A controlled substance for the treatment of chronic
3290 nonmalignant pain as defined in s. 456.44(1)(f) ~~456.44(1)(e)~~.
3291 Section 17. Paragraph (a) of subsection (1) of section
3292 782.04, Florida Statutes, is amended to read:
3293 782.04 Murder.—
3294 (1)(a) The unlawful killing of a human being:
3295 1. When perpetrated from a premeditated design to effect
3296 the death of the person killed or any human being;
3297 2. When committed by a person engaged in the perpetration
3298 of, or in the attempt to perpetrate, any:
3299 a. Trafficking offense prohibited by s. 893.135(1),
3300 b. Arson,

3301 c. Sexual battery,
3302 d. Robbery,
3303 e. Burglary,
3304 f. Kidnapping,
3305 g. Escape,
3306 h. Aggravated child abuse,
3307 i. Aggravated abuse of an elderly person or disabled
3308 adult,
3309 j. Aircraft piracy,
3310 k. Unlawful throwing, placing, or discharging of a
3311 destructive device or bomb,
3312 l. Carjacking,
3313 m. Home-invasion robbery,
3314 n. Aggravated stalking,
3315 o. Murder of another human being,
3316 p. Resisting an officer with violence to his or her
3317 person,
3318 q. Aggravated fleeing or eluding with serious bodily
3319 injury or death,
3320 r. Felony that is an act of terrorism or is in furtherance
3321 of an act of terrorism, including a felony under s. 775.30, s.
3322 775.32, s. 775.33, s. 775.34, or s. 775.35, or
3323 s. Human trafficking; or
3324 3. Which resulted from the unlawful distribution by a
3325 person 18 years of age or older of any of the following

3326 substances, or mixture containing any of the following
3327 substances, when such substance or mixture is proven to be the
3328 proximate cause of the death of the user:
3329 a. A substance controlled under s. 893.03(1);
3330 b. Cocaine, as described in s. 893.03(2)(a)4.;
3331 c. Opium or any synthetic or natural salt, compound,
3332 derivative, or preparation of opium;
3333 d. Methadone;
3334 e. Alfentanil, as described in s. 893.03(2)(b)1.;
3335 f. Carfentanil, as described in s. 893.03(2)(b)6.;
3336 g. Fentanyl, as described in s. 893.03(2)(b)9.;
3337 h. Sufentanil, as described in s. 893.03(2)(b)30.
3338 ~~893.03(2)(b)29.~~; or
3339 i. A controlled substance analog, as described in s.
3340 893.0356, of any substance specified in sub-subparagraphs a.-h.,
3341
3342 is murder in the first degree and constitutes a capital felony,
3343 punishable as provided in s. 775.082.
3344 Section 18. Paragraphs (c) and (f) of subsection (1) of
3345 section 893.135, Florida Statutes, are amended to read:
3346 893.135 Trafficking; mandatory sentences; suspension or
3347 reduction of sentences; conspiracy to engage in trafficking.—
3348 (1) Except as authorized in this chapter or in chapter 499
3349 and notwithstanding the provisions of s. 893.13:
3350 (c)1. A person who knowingly sells, purchases,

3351 manufactures, delivers, or brings into this state, or who is
3352 knowingly in actual or constructive possession of, 4 grams or
3353 more of any morphine, opium, hydromorphone, or any salt,
3354 derivative, isomer, or salt of an isomer thereof, including
3355 heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or
3356 (3)(c)4., or 4 grams or more of any mixture containing any such
3357 substance, but less than 30 kilograms of such substance or
3358 mixture, commits a felony of the first degree, which felony
3359 shall be known as "trafficking in illegal drugs," punishable as
3360 provided in s. 775.082, s. 775.083, or s. 775.084. If the
3361 quantity involved:
3362 a. Is 4 grams or more, but less than 14 grams, such person
3363 shall be sentenced to a mandatory minimum term of imprisonment
3364 of 3 years and shall be ordered to pay a fine of $50,000.
3365 b. Is 14 grams or more, but less than 28 grams, such
3366 person shall be sentenced to a mandatory minimum term of
3367 imprisonment of 15 years and shall be ordered to pay a fine of
3368 $100,000.
3369 c. Is 28 grams or more, but less than 30 kilograms, such
3370 person shall be sentenced to a mandatory minimum term of
3371 imprisonment of 25 years and shall be ordered to pay a fine of
3372 $500,000.
3373 2. A person who knowingly sells, purchases, manufactures,
3374 delivers, or brings into this state, or who is knowingly in
3375 actual or constructive possession of, 14 grams or more of

3376 hydrocodone, as described in s. 893.03(2)(a)1.k.
3377 ~~893.03(2)(a)1.j.~~, codeine, as described in s. 893.03(2)(a)1.g.,
3378 or any salt thereof, or 14 grams or more of any mixture
3379 containing any such substance, commits a felony of the first
3380 degree, which felony shall be known as "trafficking in
3381 hydrocodone," punishable as provided in s. 775.082, s. 775.083,
3382 or s. 775.084. If the quantity involved:
3383 a. Is 14 grams or more, but less than 28 grams, such
3384 person shall be sentenced to a mandatory minimum term of
3385 imprisonment of 3 years and shall be ordered to pay a fine of
3386 $50,000.
3387 b. Is 28 grams or more, but less than 50 grams, such
3388 person shall be sentenced to a mandatory minimum term of
3389 imprisonment of 7 years and shall be ordered to pay a fine of
3390 $100,000.
3391 c. Is 50 grams or more, but less than 200 grams, such
3392 person shall be sentenced to a mandatory minimum term of
3393 imprisonment of 15 years and shall be ordered to pay a fine of
3394 $500,000.
3395 d. Is 200 grams or more, but less than 30 kilograms, such
3396 person shall be sentenced to a mandatory minimum term of
3397 imprisonment of 25 years and shall be ordered to pay a fine of
3398 $750,000.
3399 3. A person who knowingly sells, purchases, manufactures,
3400 delivers, or brings into this state, or who is knowingly in

3401 actual or constructive possession of, 7 grams or more of
3402 oxycodone, as described in s. 893.03(2)(a)1.q. ~~893.03(2)(a)1.o.~~,
3403 or any salt thereof, or 7 grams or more of any mixture
3404 containing any such substance, commits a felony of the first
3405 degree, which felony shall be known as "trafficking in
3406 oxycodone," punishable as provided in s. 775.082, s. 775.083, or
3407 s. 775.084. If the quantity involved:
3408 a. Is 7 grams or more, but less than 14 grams, such person
3409 shall be sentenced to a mandatory minimum term of imprisonment
3410 of 3 years and shall be ordered to pay a fine of $50,000.
3411 b. Is 14 grams or more, but less than 25 grams, such
3412 person shall be sentenced to a mandatory minimum term of
3413 imprisonment of 7 years and shall be ordered to pay a fine of
3414 $100,000.
3415 c. Is 25 grams or more, but less than 100 grams, such
3416 person shall be sentenced to a mandatory minimum term of
3417 imprisonment of 15 years and shall be ordered to pay a fine of
3418 $500,000.
3419 d. Is 100 grams or more, but less than 30 kilograms, such
3420 person shall be sentenced to a mandatory minimum term of
3421 imprisonment of 25 years and shall be ordered to pay a fine of
3422 $750,000.
3423 4.a. A person who knowingly sells, purchases,
3424 manufactures, delivers, or brings into this state, or who is
3425 knowingly in actual or constructive possession of, 4 grams or

3426 more of:
3427 (I) Alfentanil, as described in s. 893.03(2)(b)1.;
3428 (II) Carfentanil, as described in s. 893.03(2)(b)6.;
3429 (III) Fentanyl, as described in s. 893.03(2)(b)9.;
3430 (IV) Sufentanil, as described in s. 893.03(2)(b)30.
3431 ~~893.03(2)(b)29.~~;
3432 (V) A fentanyl derivative, as described in s.
3433 893.03(1)(a)62.;
3434 (VI) A controlled substance analog, as described in s.
3435 893.0356, of any substance described in sub-sub-subparagraphs
3436 (I)-(V); or
3437 (VII) A mixture containing any substance described in sub-
3438 sub-subparagraphs (I)-(VI),
3439
3440 commits a felony of the first degree, which felony shall be
3441 known as "trafficking in fentanyl," punishable as provided in s.
3442 775.082, s. 775.083, or s. 775.084.
3443 b. If the quantity involved under sub-subparagraph a.:
3444 (I) Is 4 grams or more, but less than 14 grams, such
3445 person shall be sentenced to a mandatory minimum term of
3446 imprisonment of 3 years, and shall be ordered to pay a fine of
3447 $50,000.
3448 (II) Is 14 grams or more, but less than 28 grams, such
3449 person shall be sentenced to a mandatory minimum term of
3450 imprisonment of 15 years, and shall be ordered to pay a fine of

3451 $100,000.
3452 (III) Is 28 grams or more, such person shall be sentenced
3453 to a mandatory minimum term of imprisonment of 25 years, and
3454 shall be ordered to pay a fine of $500,000.
3455 5. A person who knowingly sells, purchases, manufactures,
3456 delivers, or brings into this state, or who is knowingly in
3457 actual or constructive possession of, 30 kilograms or more of
3458 any morphine, opium, oxycodone, hydrocodone, codeine,
3459 hydromorphone, or any salt, derivative, isomer, or salt of an
3460 isomer thereof, including heroin, as described in s.
3461 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 30 kilograms or
3462 more of any mixture containing any such substance, commits the
3463 first degree felony of trafficking in illegal drugs. A person
3464 who has been convicted of the first degree felony of trafficking
3465 in illegal drugs under this subparagraph shall be punished by
3466 life imprisonment and is ineligible for any form of
3467 discretionary early release except pardon or executive clemency
3468 or conditional medical release under s. 947.149. However, if the
3469 court determines that, in addition to committing any act
3470 specified in this paragraph:
3471 a. The person intentionally killed an individual or
3472 counseled, commanded, induced, procured, or caused the
3473 intentional killing of an individual and such killing was the
3474 result; or
3475 b. The person's conduct in committing that act led to a

3476 natural, though not inevitable, lethal result,
3477
3478 such person commits the capital felony of trafficking in illegal
3479 drugs, punishable as provided in ss. 775.082 and 921.142. A
3480 person sentenced for a capital felony under this paragraph shall
3481 also be sentenced to pay the maximum fine provided under
3482 subparagraph 1.
3483 6. A person who knowingly brings into this state 60
3484 kilograms or more of any morphine, opium, oxycodone,
3485 hydrocodone, codeine, hydromorphone, or any salt, derivative,
3486 isomer, or salt of an isomer thereof, including heroin, as
3487 described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or
3488 60 kilograms or more of any mixture containing any such
3489 substance, and who knows that the probable result of such
3490 importation would be the death of a person, commits capital
3491 importation of illegal drugs, a capital felony punishable as
3492 provided in ss. 775.082 and 921.142. A person sentenced for a
3493 capital felony under this paragraph shall also be sentenced to
3494 pay the maximum fine provided under subparagraph 1.
3495 (f)1. Any person who knowingly sells, purchases,
3496 manufactures, delivers, or brings into this state, or who is
3497 knowingly in actual or constructive possession of, 14 grams or
3498 more of amphetamine, as described in s. 893.03(2)(c)2., or
3499 methamphetamine, as described in s. 893.03(2)(c)5.
3500 ~~893.03(2)(c)4.~~, or of any mixture containing amphetamine or

3501 methamphetamine, or phenylacetone, phenylacetic acid,
3502 pseudoephedrine, or ephedrine in conjunction with other
3503 chemicals and equipment utilized in the manufacture of
3504 amphetamine or methamphetamine, commits a felony of the first
3505 degree, which felony shall be known as "trafficking in
3506 amphetamine," punishable as provided in s. 775.082, s. 775.083,
3507 or s. 775.084. If the quantity involved:
3508 a. Is 14 grams or more, but less than 28 grams, such
3509 person shall be sentenced to a mandatory minimum term of
3510 imprisonment of 3 years, and the defendant shall be ordered to
3511 pay a fine of $50,000.
3512 b. Is 28 grams or more, but less than 200 grams, such
3513 person shall be sentenced to a mandatory minimum term of
3514 imprisonment of 7 years, and the defendant shall be ordered to
3515 pay a fine of $100,000.
3516 c. Is 200 grams or more, such person shall be sentenced to
3517 a mandatory minimum term of imprisonment of 15 calendar years
3518 and pay a fine of $250,000.
3519 2. Any person who knowingly manufactures or brings into
3520 this state 400 grams or more of amphetamine, as described in s.
3521 893.03(2)(c)2., or methamphetamine, as described in s.
3522 893.03(2)(c)5. ~~893.03(2)(c)4.~~, or of any mixture containing
3523 amphetamine or methamphetamine, or phenylacetone, phenylacetic
3524 acid, pseudoephedrine, or ephedrine in conjunction with other
3525 chemicals and equipment used in the manufacture of amphetamine

3526 or methamphetamine, and who knows that the probable result of
3527 such manufacture or importation would be the death of any person
3528 commits capital manufacture or importation of amphetamine, a
3529 capital felony punishable as provided in ss. 775.082 and
3530 921.142. Any person sentenced for a capital felony under this
3531 paragraph shall also be sentenced to pay the maximum fine
3532 provided under subparagraph 1.
3533 Section 19. Paragraphs (b) through (e) and (g) of
3534 subsection (3) of section 921.0022, Florida Statutes, are
3535 amended to read:
3536 921.0022 Criminal Punishment Code; offense severity
3537 ranking chart.—
3538 (3) OFFENSE SEVERITY RANKING CHART
3539 (b) LEVEL 2
3540
3541

Florida Statute	Felony Degree	Description
379.2431 (1)(e)3.	3rd	Possession of 11 or fewer marine turtle eggs in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)4.	3rd	Possession of more than 11 marine turtle eggs in violation

		of the Marine Turtle Protection Act.
403.413(6)(c)	3rd	Dumps waste litter exceeding 500 lbs. in weight or 100 cubic feet in volume or any quantity for commercial purposes, or hazardous waste.
517.07(2)	3rd	Failure to furnish a prospectus meeting requirements.
590.28(1)	3rd	Intentional burning of lands.
784.05(3)	3rd	Storing or leaving a loaded firearm within reach of minor who uses it to inflict injury or death.
787.04(1)	3rd	In violation of court order, take, entice, etc., minor beyond state limits.
806.13(1)(b)3.	3rd	Criminal mischief; damage $1,000 or more to public communication

		or any other public service.
810.061(2)	3rd	Impairing or impeding telephone or power to a dwelling; facilitating or furthering burglary.
810.09(2)(e)	3rd	Trespassing on posted commercial horticulture property.
812.014(2)(c)1.	3rd	Grand theft, 3rd degree; $300 or more but less than $5,000.
812.014(2)(d)	3rd	Grand theft, 3rd degree; $100 or more but less than $300, taken from unenclosed curtilage of dwelling.
812.015(7)	3rd	Possession, use, or attempted use of an antishoplifting or inventory control device countermeasure.
817.234(1)(a)2.	3rd	False statement in support of insurance claim.

3556

817.481(3)(a)	3rd	Obtain credit or purchase with false, expired, counterfeit, etc., credit card, value over $300.

3557

817.52(3)	3rd	Failure to redeliver hired vehicle.

3558

817.54	3rd	With intent to defraud, obtain mortgage note, etc., by false representation.

3559

817.60(5)	3rd	Dealing in credit cards of another.

3560

817.60(6)(a)	3rd	Forgery; purchase goods, services with false card.

3561

817.61	3rd	Fraudulent use of credit cards over $100 or more within 6 months.

3562

826.04	3rd	Knowingly marries or has sexual intercourse with person to whom

		related.
831.01	3rd	Forgery.
831.02	3rd	Uttering forged instrument; utters or publishes alteration with intent to defraud.
831.07	3rd	Forging bank bills, checks, drafts, or promissory notes.
831.08	3rd	Possessing 10 or more forged notes, bills, checks, or drafts.
831.09	3rd	Uttering forged notes, bills, checks, drafts, or promissory notes.
831.11	3rd	Bringing into the state forged bank bills, checks, drafts, or notes.
832.05(3)(a)	3rd	Cashing or depositing item with intent to defraud.

843.08	3rd	False personation.
893.13(2)(a)2.	3rd	Purchase of any s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs other than cannabis.
893.147(2)	3rd	Manufacture or delivery of drug paraphernalia.

(c) LEVEL 3

Florida Statute	Felony Degree	Description
119.10(2)(b)	3rd	Unlawful use of confidential information from police reports.
316.066	3rd	Unlawfully obtaining or using

(3)(b)-(d)		confidential crash reports.
316.193(2)(b)	3rd	Felony DUI, 3rd conviction.
316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.

327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.
376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.
379.2431 (1)(e)5.	3rd	Taking, disturbing, mutilating, destroying, causing to be destroyed, transferring, selling, offering to sell, molesting, or harassing marine turtles, marine turtle eggs, or marine turtle nests in violation of the Marine Turtle Protection Act.

379.2431 (1)(e)6.	3rd	Possessing any marine turtle species or hatchling, or parts thereof, or the nest of any marine turtle species described in the Marine Turtle Protection Act.
379.2431 (1)(e)7.	3rd	Soliciting to commit or conspiring to commit a violation of the Marine Turtle Protection Act.
400.9935(4)(a) or (b)	3rd	Operating a clinic, or offering services requiring licensure, without a license.
400.9935(4)(e)	3rd	Filing a false license application or other required information or failing to report information.
440.1051(3)	3rd	False report of workers' compensation fraud or retaliation for making such a report.

3598

501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.

3599

624.401(4)(a)	3rd	Transacting insurance without a certificate of authority.

3600

624.401(4)(b)1.	3rd	Transacting insurance without a certificate of authority; premium collected less than $20,000.

3601

626.902(1)(a) & (b)	3rd	Representing an unauthorized insurer.

3602

697.08	3rd	Equity skimming.

3603

790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.

3604

806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or

		equipment used in firefighting.
806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.
812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.
812.0145(2)(c)	3rd	Theft from person 65 years of age or older; $300 or more but less than $10,000.
815.04(5)(b)	2nd	Computer offense devised to defraud or obtain property.
817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.

3611

817.233	3rd	Burning to defraud insurer.

3612

817.234 (8)(b) & (c)	3rd	Unlawful solicitation of persons involved in motor vehicle accidents.

3613

817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.

3614

817.236	3rd	Filing a false motor vehicle insurance application.

3615

817.2361	3rd	Creating, marketing, or presenting a false or fraudulent motor vehicle insurance card.

3616

817.413(2)	3rd	Sale of used goods as new.

3617

828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or death.

3618

831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to

			defraud or possessing a counterfeit payment instrument.
3619			
	831.29	2nd	Possession of instruments for counterfeiting driver licenses or identification cards.
3620			
	838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
3621			
	843.19	3rd	Injure, disable, or kill police dog or horse.
3622			
	860.15(3)	3rd	Overcharging for repairs and parts.
3623			
	870.01(2)	3rd	Riot; inciting or encouraging.
3624			
	893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs).

3625

893.13(1)(d)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of university.

3626

893.13(1)(f)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of public housing facility.

3627

893.13(4)(c)	3rd	Use or hire of minor; deliver to minor other controlled substances.

3628

893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.

3629

893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.
893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.
893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner's practice.

893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner's practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.
893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for a fictitious person.
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.
944.47 (1)(a)1. & 2.	3rd	Introduce contraband to correctional facility.

944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.721	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).

(d) LEVEL 4

Florida Statute	Felony Degree	Description
316.1935(3)(a)	2nd	Driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.

499.0051(1)	3rd	Failure to maintain or deliver transaction history, transaction information, or transaction statements.
499.0051(5)	2nd	Knowing sale or delivery, or possession with intent to sell, contraband prescription drugs.
517.07(1)	3rd	Failure to register securities.
517.12(1)	3rd	Failure of dealer, associated person, or issuer of securities to register.
784.07(2)(b)	3rd	Battery of law enforcement officer, firefighter, etc.
784.074(1)(c)	3rd	Battery of sexually violent predators facility staff.

3654 784.075 3rd Battery on detention or commitment facility staff.

3655 784.078 3rd Battery of facility employee by throwing, tossing, or expelling certain fluids or materials.

3656 784.08(2)(c) 3rd Battery on a person 65 years of age or older.

3657 784.081(3) 3rd Battery on specified official or employee.

3658 784.082(3) 3rd Battery by detained person on visitor or other detainee.

3659 784.083(3) 3rd Battery on code inspector.

3660 784.085 3rd Battery of child by throwing, tossing, projecting, or expelling certain fluids or

materials.

3661

787.03(1) 3rd Interference with custody; wrongly takes minor from appointed guardian.

3662

787.04(2) 3rd Take, entice, or remove child beyond state limits with criminal intent pending custody proceedings.

3663

787.04(3) 3rd Carrying child beyond state lines with criminal intent to avoid producing child at custody hearing or delivering to designated person.

3664

787.07 3rd Human smuggling.

3665

790.115(1) 3rd Exhibiting firearm or weapon within 1,000 feet of a school.

3666

790.115(2)(b) 3rd Possessing electric

			weapon or device, destructive device, or other weapon on school property.
790.115(2)(c)	3rd	Possessing firearm on school property.	
800.04(7)(c)	3rd	Lewd or lascivious exhibition; offender less than 18 years.	
810.02(4)(a)	3rd	Burglary, or attempted burglary, of an unoccupied structure; unarmed; no assault or battery.	
810.02(4)(b)	3rd	Burglary, or attempted burglary, of an unoccupied conveyance; unarmed; no assault or battery.	
810.06	3rd	Burglary; possession of tools.	

3672

810.08(2)(c)	3rd	Trespass on property, armed with firearm or dangerous weapon.

3673

812.014(2)(c)3.	3rd	Grand theft, 3rd degree $10,000 or more but less than $20,000.

3674

812.014 (2)(c)4.-10.	3rd	Grand theft, 3rd degree, a will, firearm, motor vehicle, livestock, etc.

3675

812.0195(2)	3rd	Dealing in stolen property by use of the Internet; property stolen $300 or more.

3676

817.505(4)(a)	3rd	Patient brokering.

3677

817.563(1)	3rd	Sell or deliver substance other than controlled substance agreed upon, excluding s. 893.03(5)

			drugs.
3678			
	817.568(2)(a)	3rd	Fraudulent use of personal identification information.
3679			
	817.625(2)(a)	3rd	Fraudulent use of scanning device, skimming device, or reencoder.
3680			
	817.625(2)(c)	3rd	Possess, sell, or deliver skimming device.
3681			
	828.125(1)	2nd	Kill, maim, or cause great bodily harm or permanent breeding disability to any registered horse or cattle.
3682			
	837.02(1)	3rd	Perjury in official proceedings.
3683			
	837.021(1)	3rd	Make contradictory statements in official proceedings.

3684 838.022 3rd Official misconduct.

3685 839.13(2)(a) 3rd Falsifying records of an individual in the care and custody of a state agency.

3686 839.13(2)(c) 3rd Falsifying records of the Department of Children and Families.

3687 843.021 3rd Possession of a concealed handcuff key by a person in custody.

3688 843.025 3rd Deprive law enforcement, correctional, or correctional probation officer of means of protection or communication.

3689 843.15(1)(a) 3rd Failure to appear while on bail for felony (bond estreature or bond jumping).

3690

847.0135(5)(c)	3rd	Lewd or lascivious exhibition using computer; offender less than 18 years.

3691

874.05(1)(a)	3rd	Encouraging or recruiting another to join a criminal gang.

3692

893.13(2)(a)1.	2nd	Purchase of cocaine (or other s. 893.03(1)(a), (b), or (d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs).

3693

914.14(2)	3rd	Witnesses accepting bribes.

3694

914.22(1)	3rd	Force, threaten, etc., witness, victim, or informant.

3695

914.23(2)	3rd	Retaliation against a witness, victim, or

			informant, no bodily injury.
918.12	3rd	Tampering with jurors.	
934.215	3rd	Use of two-way communications device to facilitate commission of a crime.	

(e) LEVEL 5

Florida Statute	Felony Degree	Description
316.027(2)(a)	3rd	Accidents involving personal injuries other than serious bodily injury, failure to stop; leaving scene.
316.1935(4)(a)	2nd	Aggravated fleeing or eluding.

316.80(2)	2nd	Unlawful conveyance of fuel; obtaining fuel fraudulently.
322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.
327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.
379.365(2)(c)1.	3rd	Violation of rules relating to: willful molestation of stone crab traps, lines, or buoys; illegal bartering, trading, or sale, conspiring or aiding in such barter, trade, or sale, or supplying, agreeing to supply, aiding in supplying, or giving away stone crab trap tags or certificates; making, altering, forging, counterfeiting, or reproducing stone crab trap tags; possession of forged, counterfeit, or imitation stone

			crab trap tags; and engaging in the commercial harvest of stone crabs while license is suspended or revoked.
3712			
	379.367(4)	3rd	Willful molestation of a commercial harvester's spiny lobster trap, line, or buoy.
3713			
	379.407(5)(b)3.	3rd	Possession of 100 or more undersized spiny lobsters.
3714			
	381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
3715			
	440.10(1)(g)	2nd	Failure to obtain workers' compensation coverage.
3716			
	440.105(5)	2nd	Unlawful solicitation for the purpose of making workers' compensation claims.
3717			
	440.381(2)	2nd	Submission of false, misleading, or incomplete information with the purpose of avoiding or

		reducing workers' compensation premiums.
624.401(4)(b)2.	2nd	Transacting insurance without a certificate or authority; premium collected $20,000 or more but less than $100,000.
626.902(1)(c)	2nd	Representing an unauthorized insurer; repeat offender.
790.01(2)	3rd	Carrying a concealed firearm.
790.162	2nd	Threat to throw or discharge destructive device.
790.163(1)	2nd	False report of bomb, explosive, weapon of mass destruction, or use of firearms in violent manner.
790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
790.23	2nd	Felons in possession of

			firearms, ammunition, or electronic weapons or devices.
3725			
	796.05(1)	2nd	Live on earnings of a prostitute; 1st offense.
3726			
	800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years of age.
3727			
	800.04(7)(b)	2nd	Lewd or lascivious exhibition; offender 18 years of age or older.
3728			
	806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.
3729			
	812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more but less than $50,000.
3730			
	812.015(8)	3rd	Retail theft; property stolen is valued at $300 or more and one

		or more specified acts.
812.019(1)	2nd	Stolen property; dealing in or trafficking in.
812.131(2)(b)	3rd	Robbery by sudden snatching.
812.16(2)	3rd	Owning, operating, or conducting a chop shop.
817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.
817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
817.2341(1), (2)(a) & (3)(a)	3rd	Filing false financial statements, making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity.
817.568(2)(b)	2nd	Fraudulent use of personal

			identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $5,000 or more or use of personal identification information of 10 or more persons.
3738	817.611(2)(a)	2nd	Traffic in or possess 5 to 14 counterfeit credit cards or related documents.
3739	817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device, skimming device, or reencoder.
3740	825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
3741	827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a

		child.
827.071(5)	3rd	Possess, control, or intentionally view any photographic material, motion picture, etc., which includes sexual conduct by a child.
839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.
843.01	3rd	Resist officer with violence to person; resist arrest with violence.
847.0135(5)(b)	2nd	Lewd or lascivious exhibition using computer; offender 18 years or older.
847.0137 (2) & (3)	3rd	Transmission of pornography by electronic device or equipment.

847.0138 (2) & (3)	3rd	Transmission of material harmful to minors to a minor by electronic device or equipment.
874.05(1)(b)	2nd	Encouraging or recruiting another to join a criminal gang; second or subsequent offense.
874.05(2)(a)	2nd	Encouraging or recruiting person under 13 years of age to join a criminal gang.
893.13(1)(a)1.	2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs).
893.13(1)(c)2.	2nd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs) within 1,000 feet of a

			child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
3752			
	893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000 feet of university.
3753			
	893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.
3754			
	893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s.

		893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000 feet of public housing facility.
893.13(4)(b)	2nd	Use or hire of minor; deliver to minor other controlled substance.
893.1351(1)	3rd	Ownership, lease, or rental for trafficking in or manufacturing of controlled substance.

(g) LEVEL 7

Florida Statute	Felony Degree	Description
316.027(2)(c)	1st	Accident involving death, failure to stop; leaving scene.

316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.

3768

409.920 (2)(b)1.a.	3rd	Medicaid provider fraud; $10,000 or less.

3769

409.920 (2)(b)1.b.	2nd	Medicaid provider fraud; more than $10,000, but less than $50,000.

3770

456.065(2)	3rd	Practicing a health care profession without a license.

3771

456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.

3772

458.327(1)	3rd	Practicing medicine without a license.

3773

459.013(1)	3rd	Practicing osteopathic medicine without a license.

3774

460.411(1)	3rd	Practicing chiropractic

			medicine without a license.
461.012(1)	3rd	Practicing podiatric medicine without a license.	
462.17	3rd	Practicing naturopathy without a license.	
463.015(1)	3rd	Practicing optometry without a license.	
464.016(1)	3rd	Practicing nursing without a license.	
465.015(2)	3rd	Practicing pharmacy without a license.	
466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.	
467.201	3rd	Practicing midwifery without a license.	

468.366	3rd	Delivering respiratory care services without a license.
483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
483.901(7)	3rd	Practicing medical physics without a license.
484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
484.053	3rd	Dispensing hearing aids without a license.
494.0018(2)	1st	Conviction of any violation of chapter 494 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.

560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by a money services business.
560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver license or identification card; other registration violations.

775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
782.071	2nd	Killing of a human being or unborn child by the operation of a motor vehicle in a

			reckless manner (vehicular homicide).
3797			
	782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
3798			
	784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
3799			
	784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
3800			
	784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
3801			
	784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
3802			
	784.048(7)	3rd	Aggravated stalking;

			violation of court order.
3803			
	784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
3804			
	784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
3805			
	784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
3806			
	784.081(1)	1st	Aggravated battery on specified official or employee.
3807			
	784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
3808			
	784.083(1)	1st	Aggravated battery on code inspector.
3809			

787.06(3)(a)2.	1st	Human trafficking using coercion for labor and services of an adult.
787.06(3)(e)2.	1st	Human trafficking using coercion for labor and services by the transfer or transport of an adult from outside Florida to within the state.
790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or

			attempting to commit a felony.
3815			
	790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
3816			
	790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
3817			
	790.23	1st,PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.
3818			
	794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18 years of age.

3819

796.05(1)	1st	Live on earnings of a prostitute; 2nd offense.

3820

796.05(1)	1st	Live on earnings of a prostitute; 3rd and subsequent offense.

3821

800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim younger than 12 years of age; offender younger than 18 years of age.

3822

800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years of age; offender 18 years of age or older.

3823

800.04(5)(e)	1st	Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years;

			offender 18 years or older; prior conviction for specified sex offense.
3824			
	806.01(2)	2nd	Maliciously damage structure by fire or explosive.
3825			
	810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
3826			
	810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
3827			
	810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
3828			
	810.02(3)(e)	2nd	Burglary of authorized emergency vehicle.
3829			
	812.014(2)(a)1.	1st	Property stolen, valued at $100,000 or more or a semitrailer deployed

			by a law enforcement officer; property stolen while causing other property damage; 1st degree grand theft.
3830			
	812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
3831			
	812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
3832			
	812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
3833			
	812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or

			more.
3834			
	812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
3835			
	812.131(2)(a)	2nd	Robbery by sudden snatching.
3836			
	812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
3837			
	817.034(4)(a)1.	1st	Communications fraud, value greater than $50,000.
3838			
	817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
3839			
	817.234(9)	2nd	Organizing, planning, or participating in an

			intentional motor vehicle collision.
817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.	
817.2341 (2)(b) & (3)(b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.	
817.535(2)(a)	3rd	Filing false lien or other unauthorized document.	
817.611(2)(b)	2nd	Traffic in or possess 15 to 49 counterfeit credit cards or related documents.	
825.102(3)(b)	2nd	Neglecting an elderly person	

			or disabled adult causing great bodily harm, disability, or disfigurement.
825.103(3)(b)	2nd		Exploiting an elderly person or disabled adult and property is valued at $10,000 or more, but less than $50,000.
827.03(2)(b)	2nd		Neglect of a child causing great bodily harm, disability, or disfigurement.
827.04(3)	3rd		Impregnation of a child under 16 years of age by person 21 years of age or older.
837.05(2)	3rd		Giving false information about alleged capital felony to a law enforcement officer.

838.015	2nd	Bribery.	
838.016	2nd	Unlawful compensation or reward for official behavior.	
838.021(3)(a)	2nd	Unlawful harm to a public servant.	
838.22	2nd	Bid tampering.	
843.0855(2)	3rd	Impersonation of a public officer or employee.	
843.0855(3)	3rd	Unlawful simulation of legal process.	
843.0855(4)	3rd	Intimidation of a public officer or employee.	
847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.	
847.0135(4)	2nd	Traveling to meet a minor to commit an	

			unlawful sex act.
872.06	2nd		Abuse of a dead human body.
874.05(2)(b)	1st		Encouraging or recruiting person under 13 to join a criminal gang; second or subsequent offense.
874.10	1st,PBL		Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.
893.13(1)(c)1.	1st		Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~) within 1,000 feet of a child care facility, school, or

			state, county, or municipal park or publicly owned recreational facility or community center.
3862			
	893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~, within 1,000 feet of property used for religious services or a specified business site.
3863			
	893.13(4)(a)	1st	Use or hire of minor; deliver to minor other controlled substance.
3864			
	893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.

3865

893.135 (1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.

3866

893.135 (1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams.

3867

893.135 (1)(c)2.a.	1st	Trafficking in hydrocodone, 14 grams or more, less than 28 grams.

3868

893.135 (1)(c)2.b.	1st	Trafficking in hydrocodone, 28 grams or more, less than 50 grams.

3869

893.135 (1)(c)3.a.	1st	Trafficking in oxycodone, 7 grams or more, less than 14 grams.

3870

893.135 (1)(c)3.b.	1st	Trafficking in oxycodone, 14 grams or more, less than 25 grams.

3871

893.135 (1)(c)4.b.(I)	1st	Trafficking in fentanyl, 4 grams or more, less than 14 grams.
893.135 (1)(d)1.a.	1st	Trafficking in phencyclidine, 28 grams or more, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, 200 grams or more, less than 5 kilograms.
893.135(1)(f)1.	1st	Trafficking in amphetamine, 14 grams or more, less than 28 grams.
893.135 (1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
893.135 (1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5

			kilograms.
3877			
893.135 (1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.	
3878			
893.135 (1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.	
3879			
893.135 (1)(m)2.a.	1st	Trafficking in synthetic cannabinoids, 280 grams or more, less than 500 grams.	
3880			
893.135 (1)(m)2.b.	1st	Trafficking in synthetic cannabinoids, 500 grams or more, less than 1,000 grams.	
3881			
893.135 (1)(n)2.a.	1st	Trafficking in n-benzyl phenethylamines, 14 grams or more, less than 100 grams.	
3882			
893.1351(2)	2nd	Possession of place for trafficking in or	

			manufacturing of controlled substance.
3883			
	896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.
3884			
	896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
3885			
	943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
3886			
	943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.

3887

943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.

3888

943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.

3889

943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.

3890

944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.

3891

944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking

			of a digitized photograph.
944.607(12)	3rd		Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
944.607(13)	3rd		Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.
985.4815(10)	3rd		Sexual offender; failure to submit to the taking of a digitized photograph.
985.4815(12)	3rd		Failure to report or providing false information about a sexual offender; harbor or conceal a sexual

		offender.
985.4815(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.

3896
3897
3898
3899
3900 Section 20. For the 2018-2019 fiscal year:
3901 (1) The nonrecurring sum of $27,035,532 is appropriated
3902 from the Federal Grants Trust Fund to the Department of Children
3903 and Families for expenditure of funds related to the second year
3904 of the State Targeted Response to the Opioid Crisis grant, to
3905 increase access to treatment, reduce unmet treatment needs, and
3906 reduce opioid overdose-related deaths through prevention,
3907 treatment, and recovery activities.
3908 (2) To enhance the entire substance abuse continuum of
3909 care, the sum of $14,626,911 in recurring funds is appropriated
3910 from the General Revenue Fund to the Department of Children and
3911 Families for community-based services to address the opioid
3912 crisis, including, but not limited to, outreach, addiction
3913 treatment, and recovery support services. Funding under this

3914 subsection shall be used to expand capacity to increase access
3915 to and reduce waitlists for treatment; increase efforts to
3916 effectively engage and retain in treatment youth, pregnant
3917 women, high-risk populations, and high utilizers of acute care
3918 services; and further develop a recovery-based model of care.
3919 Funding for specific services may include, but are not limited
3920 to, case management, residential services, outpatient services,
3921 aftercare services, and medication-assisted treatment.
3922 Medication-assisted treatment may include, but is not limited
3923 to, methadone, buprenorphine, and naltrexone extended release
3924 injectable.
3925 (3) The recurring sum of $5,000,000 from the General
3926 Revenue Fund is appropriated to the Department of Health for the
3927 purchase of emergency opioid antagonists to be made available to
3928 emergency responders.
3929 (4) The recurring sum of $6 million from the General
3930 Revenue Fund is appropriated to the Office of State Court
3931 Administrator for medication-assisted treatment of substance
3932 abuse disorders in individuals involved in the criminal justice
3933 system, individuals who have a high likelihood of becoming
3934 involved in the criminal justice system, or individuals who are
3935 in court-ordered, community-based drug treatment. Such
3936 medication-assisted treatment may include, but is not limited
3937 to, methadone, buprenorphine, and naltrexone extended release
3938 injectable.

3939 (5) The sums of $873,089 in recurring funds and $117,700
3940 in nonrecurring funds are appropriated from the General Revenue
3941 Fund to the Department of Health for improvements to the
3942 Prescription Drug Monitoring Program system pursuant to s.
3943 893.055, Florida Statutes.
3944 Section 21. Except as otherwise expressly provided in this
3945 act, this act shall take effect July 1, 2018.

An act relating to pharmacies; amending s. 465.003, F.S.; revising and providing definitions; amending s. 465.004, F.S.; revising the membership of the Board of Pharmacy; amending s. 465.019, F.S.; establishing Class III institutional pharmacies; providing requirements for such pharmacies; conforming provisions to changes made by the act; amending s. 465.0252, F.S.; revising notice requirements to conform to changes made by the act; amending s. 499.003, F.S.; providing and revising definitions; amending s. 499.01, F.S.; authorizing the distribution of medicinal drugs and prepackaged drug products without a specified permit under certain conditions; deleting a provision exempting certain drug repackagers from specified permit requirements; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (7) and (13) of section 465.003, Florida Statutes, are amended, and subsections (21) and (22) are added to that section, to read:

465.003 Definitions.—As used in this chapter, the term:

(7) "Institutional formulary system" means a method

26 whereby the medical staff evaluates, appraises, and selects
27 those medicinal drugs or proprietary preparations which in the
28 medical staff's clinical judgment are most useful in patient
29 care, and which are available for dispensing by a practicing
30 pharmacist in a Class II or Class III institutional pharmacy.
31 (13) "Practice of the profession of pharmacy" includes
32 compounding, dispensing, and consulting concerning contents,
33 therapeutic values, and uses of any medicinal drug; consulting
34 concerning therapeutic values and interactions of patent or
35 proprietary preparations, whether pursuant to prescriptions or
36 in the absence and entirely independent of such prescriptions or
37 orders; and conducting other pharmaceutical services. For
38 purposes of this subsection, "other pharmaceutical services"
39 means the monitoring of the patient's drug therapy and assisting
40 the patient in the management of his or her drug therapy, and
41 includes review of the patient's drug therapy and communication
42 with the patient's prescribing health care provider as licensed
43 under chapter 458, chapter 459, chapter 461, or chapter 466, or
44 similar statutory provision in another jurisdiction, or such
45 provider's agent or such other persons as specifically
46 authorized by the patient, regarding the drug therapy. However,
47 nothing in this subsection may be interpreted to permit an
48 alteration of a prescriber's directions, the diagnosis or
49 treatment of any disease, the initiation of any drug therapy,
50 the practice of medicine, or the practice of osteopathic

51 medicine, unless otherwise permitted by law. "Practice of the
52 profession of pharmacy" also includes any other act, service,
53 operation, research, or transaction incidental to, or forming a
54 part of, any of the foregoing acts, requiring, involving, or
55 employing the science or art of any branch of the pharmaceutical
56 profession, study, or training, and shall expressly permit a
57 pharmacist to transmit information from persons authorized to
58 prescribe medicinal drugs to their patients. The practice of the
59 profession of pharmacy also includes the administration of
60 vaccines to adults pursuant to s. 465.189 and the preparation of
61 prepackaged drug products in facilities holding Class III
62 institutional pharmacy permits.
63 (21) "Central distribution facility" means a facility
64 under common control with a hospital holding a Class III
65 institutional pharmacy permit that may dispense, distribute,
66 compound, or fill prescriptions for medicinal drugs; prepare
67 prepackaged drug products; and conduct other pharmaceutical
68 services.
69 (22) "Common control" means the power to direct or cause
70 the direction of the management and policies of a person or an
71 organization, whether by ownership of stock, voting rights,
72 contract, or otherwise.
73 Section 2. Subsection (2) of section 465.004, Florida
74 Statutes, is amended to read:
75 465.004 Board of Pharmacy.—

76 (2) Seven members of the board must be licensed
77 pharmacists who are residents of this state and who have been
78 engaged in the practice of the profession of pharmacy in this
79 state for at least 4 years and, to the extent practicable,
80 represent the various pharmacy practice settings. Of the
81 pharmacist members, two must be currently engaged in the
82 practice of pharmacy in a community pharmacy, two must be
83 currently engaged in the practice of pharmacy in a Class II,
84 ~~institutional pharmacy or a~~ Modified Class II, or Class III
85 institutional pharmacy, and three must be pharmacists licensed
86 in this state irrespective of practice setting. The remaining
87 two members must be residents of the state who have never been
88 licensed as pharmacists and who are in no way connected with the
89 practice of the profession of pharmacy. No person may be
90 appointed as a consumer member who is in any way connected with
91 a drug manufacturer or wholesaler. At least one member of the
92 board must be 60 years of age or older. The Governor shall
93 appoint members to the board in accordance with this subsection
94 as members' terms expire or as a vacancy occurs until the
95 composition of the board complies with the requirements of this
96 subsection.
97 Section 3. Subsections (4) and (6) of section 465.019,
98 Florida Statutes, are amended, and paragraph (d) is added to
99 subsection (2) of that section, to read:
100 465.019 Institutional pharmacies; permits.—

101 (2) The following classes of institutional pharmacies are
102 established:
103 (d)1. "Class III institutional pharmacies" are those
104 institutional pharmacies, including central distribution
105 facilities, affiliated with a hospital that provide the same
106 services that are authorized by a Class II institutional
107 pharmacy permit. Class III institutional pharmacies may also:
108 a. Dispense, distribute, compound, and fill prescriptions
109 for medicinal drugs.
110 b. Prepare prepackaged drug products.
111 c. Conduct other pharmaceutical services for the
112 affiliated hospital and for entities under common control that
113 are each permitted under this chapter to possess medicinal
114 drugs.
115 d. Provide the services in sub-subparagraphs a.-c. to an
116 entity under common control which holds an active health care
117 clinic establishment permit as required under s. 499.01(2)(r).
118 2. A Class III institutional pharmacy shall maintain
119 policies and procedures addressing:
120 a. The consultant pharmacist responsible for
121 pharmaceutical services.
122 b. Safe practices for the preparation, dispensing,
123 prepackaging, distribution, and transportation of medicinal
124 drugs and prepackaged drug products.
125 c. Recordkeeping to monitor the movement, distribution,

126 and transportation of medicinal drugs and prepackaged drug
127 products.
128 d. Recordkeeping of pharmacy staff responsible for each
129 step in the preparation, dispensing, prepackaging,
130 transportation, and distribution of medicinal drugs and
131 prepackaged drug products.
132 e. Medicinal drugs and prepackaged drug products that may
133 not be safely distributed among Class III institutional
134 pharmacies.
135 (4) Medicinal drugs shall be dispensed in an institutional
136 pharmacy to outpatients only when that institution has secured a
137 community pharmacy permit from the department. However, an
138 individual licensed to prescribe medicinal drugs in this state
139 may dispense up to a 24-hour supply of a medicinal drug to any
140 patient of an emergency department of a hospital that operates a
141 Class II or Class III institutional pharmacy, provided that the
142 physician treating the patient in such hospital's emergency
143 department determines that the medicinal drug is warranted and
144 that community pharmacy services are not readily accessible,
145 geographically or otherwise, to the patient. Such dispensing
146 from the emergency department must be in accordance with the
147 procedures of the hospital. For any such patient for whom a
148 medicinal drug is warranted for a period to exceed 24 hours, an
149 individual licensed to prescribe such drug must dispense a 24-
150 hour supply of such drug to the patient and must provide the

151 patient with a prescription for such drug for use after the
152 initial 24-hour period. The board may adopt rules necessary to
153 carry out the provisions of this subsection.
154 (6) In a Class II or Class III institutional pharmacy, an
155 institutional formulary system may be adopted with approval of
156 the medical staff for the purpose of identifying those medicinal
157 drugs, proprietary preparations, biologics, biosimilars, and
158 biosimilar interchangeables that may be dispensed by the
159 pharmacists employed in such institution. A facility with a
160 Class II or Class III institutional pharmacy permit which is
161 operating under the formulary system shall establish policies
162 and procedures for the development of the system in accordance
163 with the joint standards of the American Hospital Association
164 and American Society of Hospital Pharmacists for the utilization
165 of a hospital formulary system, which formulary shall be
166 approved by the medical staff.
167 Section 4. Subsection (3) of section 465.0252, Florida
168 Statutes, is amended to read:
169 465.0252 Substitution of interchangeable biosimilar
170 products.—
171 (3) A pharmacist who practices in a Class II, ~~or~~ Modified
172 Class II, or Class III institutional pharmacy shall comply with
173 the notification provisions of paragraph (2)(c) by entering the
174 substitution in the institution's written medical record system
175 or electronic medical record system.

176 Section 5. Subsection (39) of section 499.003, Florida
177 Statutes, is amended, and paragraphs (w) and (x) are added to
178 subsection (48) of that section, to read:
179 499.003 Definitions of terms used in this part.—As used in
180 this part, the term:
181 (39) "Prepackaged drug product" means a drug that
182 originally was in finished packaged form sealed by a
183 manufacturer and that is placed in a properly labeled container
184 by a pharmacy or practitioner authorized to dispense pursuant to
185 chapter 465 for the purpose of dispensing or by a facility
186 holding a Class III institutional pharmacy permit ~~in the~~
187 ~~establishment in which the prepackaging occurred~~.
188 (48) "Wholesale distribution" means the distribution of a
189 prescription drug to a person other than a consumer or patient,
190 or the receipt of a prescription drug by a person other than the
191 consumer or patient, but does not include:
192 (w) A hospital covered by s. 340B of the Public Health
193 Service Act, 42 U.S.C. s. 256b, that arranges for a prescription
194 drug wholesale distributor to distribute prescription drugs
195 covered under that act directly to a contract pharmacy. Such
196 hospital is exempt from obtaining a restricted prescription drug
197 distributor permit under s. 499.01(2)(h).
198 (x) The dispensing or distribution of a medicinal drug by
199 a Class III institutional pharmacy pursuant to s. 465.019.
200 Section 6. Paragraphs (b) and (h) of subsection (2) and

201 subsection (5) of section 499.01, Florida Statutes, are amended
202 to read:
203 499.01 Permits.—
204 (2) The following permits are established:
205 (b) Prescription drug repackager permit.—A prescription
206 drug repackager permit is required for any person that
207 repackages a prescription drug in this state.
208 1. A person that operates an establishment permitted as a
209 prescription drug repackager may engage in distribution of
210 prescription drugs repackaged at that establishment and must
211 comply with all of the provisions of this part and the rules
212 adopted under this part that apply to a prescription drug
213 manufacturer.
214 2. A prescription drug repackager must comply with all
215 appropriate state and federal good manufacturing practices.
216 3. A prescription drug repackager permit is not required
217 for distributing medicinal drugs or prepackaged drug products
218 between entities under common control which each hold either an
219 active Class III institutional pharmacy permit under chapter 465
220 or an active health care clinic establishment permit under
221 paragraph (2)(r). For purposes of this subparagraph, the term
222 "common control" has the same meaning as in s. 499.003(48)(a)3.
223 (h) Restricted prescription drug distributor permit.—
224 1. A restricted prescription drug distributor permit is
225 required for:

226 a. Any person located in this state who engages in the
227 distribution of a prescription drug, which distribution is not
228 considered "wholesale distribution" under s. 499.003(48)(a).
229 b. Any person located in this state who engages in the
230 receipt or distribution of a prescription drug in this state for
231 the purpose of processing its return or its destruction if such
232 person is not the person initiating the return, the prescription
233 drug wholesale supplier of the person initiating the return, or
234 the manufacturer of the drug.
235 c. A blood establishment located in this state which
236 collects blood and blood components only from volunteer donors
237 as defined in s. 381.06014 or pursuant to an authorized
238 practitioner's order for medical treatment or therapy and
239 engages in the wholesale distribution of a prescription drug not
240 described in s. 499.003(48)(j) to a health care entity. A mobile
241 blood unit operated by a blood establishment permitted under
242 this sub-subparagraph is not required to be separately
243 permitted. The health care entity receiving a prescription drug
244 distributed under this sub-subparagraph must be licensed as a
245 closed pharmacy or provide health care services at that
246 establishment. The blood establishment must operate in
247 accordance with s. 381.06014 and may distribute only:
248 (I) Prescription drugs indicated for a bleeding or
249 clotting disorder or anemia;
250 (II) Blood-collection containers approved under s. 505 of

251 the federal act;
252 (III) Drugs that are blood derivatives, or a recombinant
253 or synthetic form of a blood derivative;
254 (IV) Prescription drugs that are identified in rules
255 adopted by the department and that are essential to services
256 performed or provided by blood establishments and authorized for
257 distribution by blood establishments under federal law; or
258 (V) To the extent authorized by federal law, drugs
259 necessary to collect blood or blood components from volunteer
260 blood donors; for blood establishment personnel to perform
261 therapeutic procedures under the direction and supervision of a
262 licensed physician; and to diagnose, treat, manage, and prevent
263 any reaction of a volunteer blood donor or a patient undergoing
264 a therapeutic procedure performed under the direction and
265 supervision of a licensed physician,
266
267 as long as all of the health care services provided by the blood
268 establishment are related to its activities as a registered
269 blood establishment or the health care services consist of
270 collecting, processing, storing, or administering human
271 hematopoietic stem cells or progenitor cells or performing
272 diagnostic testing of specimens if such specimens are tested
273 together with specimens undergoing routine donor testing. The
274 blood establishment may purchase and possess the drugs described
275 in this sub-subparagraph without a health care clinic

276 establishment permit.
277 2. Storage, handling, and recordkeeping of these
278 distributions by a person required to be permitted as a
279 restricted prescription drug distributor must be in accordance
280 with the requirements for wholesale distributors under s.
281 499.0121.
282 3. A person who applies for a permit as a restricted
283 prescription drug distributor, or for the renewal of such a
284 permit, must provide to the department the information required
285 under s. 499.012.
286 4. The department may adopt rules regarding the
287 distribution of prescription drugs by hospitals, health care
288 entities, charitable organizations, other persons not involved
289 in wholesale distribution, and blood establishments, which rules
290 are necessary for the protection of the public health, safety,
291 and welfare.
292 5. A restricted prescription drug distributor permit is
293 not required for distributions between pharmacies that each hold
294 an active permit under chapter 465, have a common ownership, and
295 are operating in a freestanding end-stage renal dialysis clinic,
296 if such distributions are made to meet the immediate emergency
297 medical needs of specifically identified patients and do not
298 occur with such frequency as to amount to the regular and
299 systematic supplying of that drug between the pharmacies. The
300 department shall adopt rules establishing when the distribution

301 of a prescription drug under this subparagraph amounts to the
302 regular and systematic supplying of that drug.
303 6. A restricted prescription drug distributor permit is
304 not required for distributing medicinal drugs or prepackaged
305 drug products between entities under common control that each
306 hold either an active Class III institutional pharmacy permit
307 under chapter 465 or an active health care clinic establishment
308 permit under paragraph (2)(r). For purposes of this
309 subparagraph, the term "common control" has the same meaning as
310 in s. 499.003(48)(a)3.
311 ~~(5) A prescription drug repackager permit issued under~~
312 ~~this part is not required for a restricted prescription drug~~
313 ~~distributor permitholder that is a health care entity to~~
314 ~~repackage prescription drugs in this state for its own use or~~
315 ~~for distribution to hospitals or other health care entities in~~
316 ~~the state for their own use, pursuant to s. 499.003(48)(a)3.,~~
317 ~~if:~~
318 ~~(a) The prescription drug distributor notifies the~~
319 ~~department, in writing, of its intention to engage in~~
320 ~~repackaging under this exemption, 30 days before engaging in the~~
321 ~~repackaging of prescription drugs at the permitted~~
322 ~~establishment;~~
323 ~~(b) The prescription drug distributor is under common~~
324 ~~control with the hospitals or other health care entities to~~
325 ~~which the prescription drug distributor is distributing~~

326 ~~prescription drugs. As used in this paragraph, "common control"~~
327 ~~means the power to direct or cause the direction of the~~
328 ~~management and policies of a person or an organization, whether~~
329 ~~by ownership of stock, voting rights, contract, or otherwise;~~
330 ~~(c) The prescription drug distributor repackages the~~
331 ~~prescription drugs in accordance with current state and federal~~
332 ~~good manufacturing practices; and~~
333 ~~(d) The prescription drug distributor labels the~~
334 ~~prescription drug it repackages in accordance with state and~~
335 ~~federal laws and rules.~~
336
337 ~~The prescription drug distributor is exempt from the product~~
338 ~~registration requirements of s. 499.015 with regard to the~~
339 ~~prescription drugs that it repackages and distributes under this~~
340 ~~subsection. A prescription drug distributor that repackages and~~
341 ~~distributes prescription drugs under this subsection to a not-~~
342 ~~for-profit rural hospital, as defined in s. 395.602, is not~~
343 ~~required to comply with paragraph (c) or paragraph (d), but must~~
344 ~~provide to each health care entity for which it repackages, for~~
345 ~~each prescription drug that is repackaged and distributed, the~~
346 ~~information required by department rule for labeling~~
347 ~~prescription drugs. The department shall adopt rules to ensure~~
348 ~~the safety and integrity of prescription drugs repackaged and~~
349 ~~distributed under this subsection, including rules regarding~~
350 ~~prescription drug manufacturing and labeling requirements.~~

351 Section 7. This act shall take effect July 1, 2018.

TAB #2

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Toward uniform standards for pharmacy technicians: Summary of the 2017 Pharmacy Technician Stakeholder Consensus Conference

William A. Zellmer, Everett B. McAllister*, Janet A. Silvester, Peter H. Vlasses

ARTICLE INFO

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Keywords:
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state regulation of pharmacy technicians
uniform national standards for pharmacy technicians

In pursuit of a path toward resolving unsettled issues related to pharmacy technicians, the Pharmacy Technician Certification Board (PTCB) sponsored a stakeholder consensus conference on February 14–16, 2017, in Irving, Texas. Planned in collaboration with the Accreditation Council for Pharmacy Education (ACPE) and the American Society of Health-System Pharmacists (ASHP)[a] and under the guidance of an advisory committee representing all major branches of pharmacy, this invitational event yielded important recommendations concerning the definition, education,[b] entry-level requirements, advanced practice, certification, and regulation of pharmacy technicians.

The 89 invited participants in the conference (eAppendix A) included pharmacists and technicians from various types of practice and educational settings, pharmacy association executives, regulators, and representatives of the general public. Approximately 350 individuals participated remotely in the plenary sessions of the conference through a Web link.[c]

Design of the conference

In consultation with the advisory committee, the conference planners established objectives for the event (sidebar), designed a preconference survey that was sent to pharmacy opinion leaders and conference participants, established the event agenda, selected speakers, identified invitees, and recommended readings for participant review in advance of the event. (Some key readings are cited here.[1-4]) Individuals engaged in planning and conducting the conference are listed in eAppendix B.

The program consisted of 5 plenary sessions (each focused on separate facets of the conference objectives), 3 work-group sessions (during which conferees divided into 4 groups to discuss specific issues and draft related recommendations), and a final session for polling of conference attendees on level of agreement or disagreement with recommendations from the work groups.

Conference opening

Everett B. McAllister, chief executive officer and executive director of PTCB, reviewed the objectives of the conference and referred to "the struggles boards of pharmacy, technician educators, and employers face…partly because we don't have a good career plan for technicians." He added, "The time has come to identify realistic and achievable pathways for

This article will appear in the September 1, 2017, issue of *AJHP*.

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[a] ACPE and ASHP jointly sponsor the Pharmacy Technician Accreditation Commission, which is the accrediting review committee for pharmacy technician education programs.

[b] The term *pharmacy technician education* is used in this report to encompass the full breadth of academic, simulated experiential, and practice-setting experiential education of pharmacy technicians.

[c] Web participants could ask questions or make comments in writing during the discussion portion of plenary sessions; they did not vote in the polling process at the end of the conference.

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Conference Objectives

The aim of the conference was to explore consensus on

1. The necessity of public confidence in pharmacy's process for ensuring the competency of pharmacy technicians.
2. An optimal level of basic ("generalist") knowledge, skills, and abilities that pharmacy technicians should have regardless of practice site.
3. An optimal definition of entry-level (generalist) pharmacy technician practice with respect to (a) legally recognized scope of practice, (b) educational requirements, (c) training requirements, (d) certification requirements, and (e) state board of pharmacy registration or licensure.
4. The desirability and feasibility of developing a process for recognizing competencies of pharmacy technicians beyond entry-level practice.
5. The desirability and feasibility of minimizing variability among the states in the definition and regulation of pharmacy technicians.
6. The entities that potentially could take responsibility for any changes in pharmacy's process for ensuring the competency of pharmacy technicians.

Conference Advisory Committee

Jason Ausili, Pharm.D.
Director, Pharmacy Affairs
National Association of Chain Drug Stores
Malcolm Broussard, B.S.
Executive Director
Louisiana Board of Pharmacy
Al Carter, Pharm.D., M.S.
Senior Director, Pharmacy Regulatory Affairs
CVS Health
Charles E. Daniels, B.S.Pharm., Ph.D.
Pharmacist-In-Chief and Associate Dean
University of California San Diego
Kenneth Mark Ey, B.S.Pharm.
Vice President of Operations
CARE Pharmacies Cooperative
Diane Halvorson, RPhTech, CPhT
Lead Pharmacy Technician
Vibra Hospital Fargo
Pharmacy Technician Member
North Dakota State Board of Pharmacy
Timothy R. Koch, B.S.Pharm., P.D., C.H.C.
Senior Director, Pharmacy Practice Compliance
Walmart Corporate Office
Janet M. Liles, M.S., CPhT
Executive Director
Pharmacy Technician Educators Council
Scott A. Meyers, B.S.Pharm., M.S., FASHP
Executive Vice President
Illinois Council of Health-System Pharmacists
Matthew Osterhaus, B.S.Pharm.
Coowner
Osterhaus Pharmacy
Jon Roth, B.S., M.S., FAPhA, FASHP
Chief Executive Officer
California Pharmacists Association
Steve Rough, B.S.Pharm., M.S., FASHP
Director of Pharmacy
University of Wisconsin, Madison School of Pharmacy
Rafael Saenz, Pharm.D., M.S., FASHP
Administrator, Pharmacy Services
University of Virginia Health System

technicians that support medication safety and protect our patients." Commenting on PTCB's decision to suspend implementation of its 2020 accredited-education requirement for technicians seeking PTCB certification,[5] McAllister said that the results of the conference will help determine future plans for PTCB program changes.

Framing key issues

Two speakers framed the key issues of the conference from separate perspectives—those of the pharmacy profession and the public. The first perspective was provided by **Michael A. Moné**, a vice president at Cardinal Health, president of the Ohio Board of Pharmacy, and a member of the ACPE board of directors. Moné said, "Pharmacists must facilitate the advancement of pharmacy technicians…further enabling pharmacists to achieve their rightful place as healthcare providers." Commenting on the profession's obligation to assure the public of the competency of technicians, Moné remarked, "The process of providing the public with…guarantees of trustworthiness already exists in the form of the accreditation, education, examination, and licensure model" that is applied to pharmacists. He concluded, "Our charge at this conference is to come to consensus [on what the public expects], how to meet those expectations, and what we must implement in order to deliver the value we promise to the healthcare system, the profession, and patients." (The full text of Moné's remarks is published in *AJHP*.[6])

Christopher Jerry, head of the Emily Jerry Foundation, spoke from the public perspective and drew on the personal tragedy of having lost a young daughter to a fatal compounding error by a pharmacy technician. Commenting on the history of pharmacy-related medication errors, Jerry said that opportunities for such errors are likely to increase given the risks associated with new medications and the expanded use of medications. Jerry said that although the public expects all healthcare workers to be well educated, this basic expectation is not being met in the case of pharmacy technicians. He was critical of the fact that there are no uniform state requirements for ensuring the competency of technicians, which he attributed in part to a lack of public awareness about the scope of technician responsibilities. Jerry said that uniformly trained, competent pharmacy technicians would free up pharmacists to provide more patient consultations, which are proven to reduce medication errors.

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Key Points

- A national consensus conference engaged all sectors of pharmacy in identifying points of agreement regarding entry-level requirements for pharmacy technicians.
- State variability in the regulation of pharmacy technicians poses risks for patients and the profession of pharmacy.
- Conferees were polled on their extent of agreement or disagreement with 59 statements related to unsettled pharmacy technician issues.
- Conferees agreed that a task analysis should be the basis for accredited technician education, technician certification, and state regulation of technicians.
- Conferees recommended the creation of a broad coalition to pursue the recommendations of the conference.

"Optimizing the contributions of technicians in pharmacy practice" was the theme of talks by Michael A. Moné (left), speaking from the perspective of the pharmacy profession, and Christopher Jerry, speaking from the public-interest perspective.

Insights from preconference surveys

William A. Zellmer, a consultant who helped plan the conference, summarized the results of the preconference surveys. The opinion-leader survey showed strong agreement, across all sectors of pharmacy, with 7 statements; these statements were considered "foundational precepts" for the conference (sidebar). The 9 survey items that had substantial variability in level of agreement among sectors of pharmacy were taken into account when planning the agenda of the conference. Zellmer said that the comments many respondents made to supplement their answers to the survey suggest that there is room for finding common ground on unsettled technician issues.

Snapshots of the pharmacy technician workforce

Updated PTCB job analysis

The director of certification programs at PTCB, **Levi Boren**, discussed PTCB's 2016 technician job analysis, which will be used in guiding test content and requirements for the Certified Pharmacy Technician credential. More than 44,000 pharmacy technicians answered 1 of 2 surveys in the job analysis, which assessed how frequently specific tasks are performed and probed the importance of specific knowledge, skills, abilities, and other characteristics (KSAOs) in performing the work of technicians.

Based on the job analysis, questions in future editions of the Pharmacy Technician Certification Examination will be distributed across 4 domains: medications (40%), patient safety and quality assurance (26%), order entry and processing (21%), and federal requirements (13%). (The current exam has 9 domains.) The new exam will focus only on core KSAOs relevant to entry-level practice in both of the largest sectors of pharmacy—community/retail and hospital/health-system practice. PTCB will analyze the job analysis results to assess the appropriate precertification educational requirements. Boren said that PTCB intends to develop future certification programs in advanced community pharmacy practice and sterile compounding.

Everett B. McAllister (at the lectern) moderated the panel discussion on snapshots of the pharmacy technician workforce. Seated (left to right) are Levi Boren, William Schimmel, Janet Silvester, and Jason Ausili.

Trends in technician education

ASHP's vice president of accreditation services, **Janet A. Silvester**, pointed out that there is no single defined path for an individual to prepare to become a pharmacy technician, and there is no uniform national educational requirement. Most pharmacy technicians have received primarily on-the-job training. This is in sharp contrast to the educational requirements for comparable healthcare occupations (e.g., clinical laboratory technician, 2–4 years of education; dental assistant, 1–2 years; physical therapy assistant, 2 years).

Accredited distance-education programs for pharmacy technicians are increasing access to standards-based education. The accreditation standard was recently amended for flexibility related to the number of experiential sites and the pharmacy compounding requirement. The 271 accredited programs are estimated to represent about one fourth of pharmacy technician education programs. Accredited programs graduate approximately 18,000 technicians per year; based on a 2016 ASHP survey, these programs appear to have capacity to expand enrollment by 60%.

Technician education by chain drugstores

The director of pharmacy affairs for the National Association of Chain Drug Stores (NACDS), **Jason Ausili**, reported on a

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Foundational Precepts for the Conference[a,b]

1. Pharmacy supportive personnel encompass different types of workers, ranging from individuals with clerical duties to individuals (pharmacy technicians) who assist pharmacists with their professional responsibilities.[c]
2. The profession of pharmacy has an obligation to make certain that pharmacy technicians are educated and regulated in a manner that ensures public safety.
3. In the interest of public safety, state boards of pharmacy have an obligation to regulate the scope of practice of pharmacy technicians.
4. In the interest of public safety, state boards of pharmacy have an obligation to establish the minimum qualifications of pharmacy technicians.[d]
5. In the interest of public safety, state boards of pharmacy have an obligation to define the nature of licensed-pharmacist oversight of pharmacy technicians.[e]
6. There are "generalist" (entry-level) knowledge, skills, and abilities that all pharmacy technicians should have, regardless of practice site.[f]
7. Additional certification programs should be developed to allow pharmacy technicians to demonstrate competence beyond entry level.

[a] Based on a preconference survey of pharmacy opinion leaders. Recipients of this survey were selected by member organizations of the Joint Commission of Pharmacy Practitioners.

[b] There was at least 90% agreement with these 7 items among respondents (except as noted in footnotes c–f) in the following pharmacy sectors: independent pharmacies (42 respondents), chain drugstores (38), hospital pharmacies (128), educational institutions (90), regulatory agencies (29), and pharmacy association staff (24).

[c] 89% of respondents from chain drugstores agreed with this item.

[d] 87% of respondents from associations agreed with this item.

[e] 84% of respondents from chain drugstores agreed with this item.

[f] 83% of respondents from associations agreed with this item.

small survey of NACDS members. Among the 24 respondents, 3 said they used primarily an accredited program for educating technicians, 12 used primarily standardized nonaccredited on-the-job training, and 9 provided on-the-job training (no standardization indicated). Sixteen respondents indicated that the number of candidates for technician positions was insufficient to meet their business needs. With respect to the turnover rate among technicians, 10 respondents said it was a nonissue; 9, a manageable issue; and 5, excessive. Fifteen respondents said that their needs were not being met with respect to hiring educated technicians.

Optimal requirements for entry-level practice

Three speakers from different sectors of pharmacy addressed the question, "What knowledge, skills, and abilities must be achieved by individuals who wish to be credentialed as a pharmacy technician for entry-level practice?" The goals in the accreditation standards for pharmacy technician education were a point of reference for their remarks.[7]

Timothy R. Koch, senior director of pharmacy practice compliance for Walmart, explained that his company has 2 types of technician education programs: 1 designed specifically to satisfy its business needs (160 hours didactic, 80 hours experiential, 3.5 hours simulated skills development) and another accredited by ASHP–ACPE (minimum of 160 hours didactic, 80 hours simulated skills development, 160 hours experiential education, and 200 hours allocated among didactic, simulated, and experiential education). The didactic portion of both programs is the same. The accredited program, which is used to meet requirements in 2 states, mandates education in sterile compounding, which is not relevant to the company's current or future retail pharmacy operations, according to Koch. He said that the requirements for the accredited program have helped the company improve its shorter, primary program. Because of the certification success rate of graduates of the shorter program, it has not been feasible to justify accredited education for all technicians. Koch voiced support for standardization of entry-level education for technicians but not at the level required in the current accreditation standards. He supported technician certification but expressed doubt about the necessity of the full scope of knowledge, skills, and abilities currently covered in the certification exam. He said that registration or licensure of technicians should absolutely be required.

Rafael Saenz, administrator of pharmacy services at the University of Virginia Health System, based his remarks on the belief that the value of pharmacists "lies primarily in their ability and time spent in direct patient care, touching patients, patient education, and ensuring better patient outcomes." From the perspective of a pharmacy practice leader who wants to free up pharmacists for patient care, Saenz outlined technician knowledge and skills in "must have" and "like to have" categories. Noting that it is common for pharmacy technicians to move from one sector of practice to another, he argued that fundamental concepts in the compounding of nonsterile, sterile, and chemotherapy/hazardous products should be included in entry-level education. Saenz said he believes the various sectors of practice are not far apart in their thinking about a single entry-level standard for pharmacy technician education, certification, and registration.

"Optimal requirements for pharmacy technicians in entry-level practice" was addressed by (left to right) Tim Koch, Rafael Saenz, and Matt Osterhaus.

Matthew Osterhaus, pharmacist and owner of an independent pharmacy in a small community in Iowa, said that personal and interpersonal skills of pharmacy technicians are very important in his practice setting. Other vital skills include professional knowledge and the processing and handling of medication orders. Not required for entry-level practice in his setting are education in anatomy, physiology, and pharmacology and understanding of issues in the profession, nontraditional roles, emerging therapies, and sterile and nonsterile compounding. Osterhaus believes that tech-check-tech, medication reconciliation, assistance with medication therapy management, and compounding should be considered advanced technician practice. He stated that variability in the needs among practice sites must be considered when establishing standards for technician education. Osterhaus indicated support for certification and state registration for entry-level practice; he suggested that add-on credentials should be developed for compounding and handling durable medical equipment.

Advanced pharmacy technician practice

Four speakers discussed advanced pharmacy technician practice, including whether related standards and credentials should be developed. **Al Carter,** senior director of pharmacy regulatory affairs for CVS Health, discussed the range of practice settings (and the related variety of technician responsibilities) in his company: retail stores (dispensing), specialty pharmacies (dispensing and collaboration with pharmacists and patients on clinical issues), home infusion (compounding), and mail order (central processing and dispensing). Potential advanced responsibilities for technicians in large corporate pharmacy environments include tech-check-tech, accepting oral orders, transferring prescriptions, remote order processing, point-of-care testing, and vaccine administration. Carter said there would be immense value in greater uniformity among the states in how they address technician issues. He asked the audience to consider whether the time will come when technicians have authority to perform whatever tasks pharmacists delegate to them.

Dan Luce, national director of pharmacy affairs for Walgreens, discussed potential advanced roles for pharmacy technicians based on his perspectives as a chain drugstore executive and former board of pharmacy member. He stated that many experienced technicians are capable of performing advanced roles in pharmacy department management, using barcode technology for product verification, triaging pharmacist-administered services, administering vaccines, and managing call centers and centralized dispensing operations. Luce said that fears about potential pharmacist job loss and compromised safety stemming from an increased technician-to-pharmacist ratio have proved to be unfounded in states where ratios have increased. He suggested that it may be necessary to establish education and credentialing requirements for advanced-practice technicians to address concerns that regulators or legislators are likely to have about expanding technicians' scope of practice. Advanced roles would help with career development among technicians and allow pharmacists to focus to a greater extent on patient care. He asked rhetorically if pharmacy will be ready to allow pharmacists to delegate any nonjudgmental task to technicians and, if that is done, who will hold liability for the technicians' work.

Steve Rough, director of pharmacy at University of Wisconsin Health, described the 700-hour accredited technician education program at his health system. The health system's 4-level career ladder for technicians is designed to foster professional commitment and provide increased compensation as individuals take on more responsibility. Training is provided for technicians who desire to advance to a higher level. Rough advocated (1) accredited education, certification, and licensure for all technicians, (2) certification as a prerequisite for advanced practice, (3) maintenance of entry-level certification after moving into advanced practice, and (4) development of credentials (accredited education and certification) for advanced roles. He suggested that some supportive positions in pharmacy that do not involve handling medications could be given a title other than "technician" (e.g., "pharmacy clerk") in the interest of moving toward consensus.

Left to right, Al Carter, Dan Luce, Steve Rough, and Anthony Pudlo spoke on "opportunities related to advanced technician practice."

Anthony Pudlo, vice president of professional affairs for the Iowa Pharmacy Association, described the demonstration project in his state to assess tech-check-tech (more appropriately designated as "technician product verification") in the community pharmacy prescription dispensing process. Thus far in the research, there has been no difference in error rate compared with baseline, and greater pharmacist time has been devoted to patient care activities. Community pharmacists in Iowa, through multiple avenues, are experiencing increased opportunities for payment for patient care services, and they will require more time for providing such services, which warrants an expansion of technician product verification. Because of the success of the demonstration project, legislation will be pursued to expand pharmacy technician product verification to include community pharmacy practice in Iowa.

Models for moving forward

Susan James, director of competence programs for the Ontario College of Pharmacists (a registering and regulating body for pharmacy), was the lead speaker on a panel showcasing how certain provinces or states have advanced their requirements for pharmacy technicians. As the result of a process that began around 2005, pharmacy technicians in Ontario now must complete a nationally accredited education program (minimum of 940 hours) and pass a national entry-to-practice examination.[8,9] Pharmacy technicians (a title restricted to registered individuals) are able to perform all technical aspects of product preparation and drug distribution, including independent checking of the final product for release to the patient; they are held accountable as autonomous health professionals. Technicians are not allowed to

provide therapeutic or clinical services that are within the scope of the pharmacist. Pharmacies in Canada are estimated to employ about 8 times as many pharmacy assistants as pharmacy technicians; there are no standards for pharmacy assistants. Pharmacy technicians can check and manage the work of pharmacy assistants.

Diane Halvorson, lead pharmacy technician at Vibra Hospital, Fargo, and a member of the North Dakota State Board of Pharmacy, said that it was through the leadership of pharmacy technicians that her state was able to achieve mandatory accredited education and mandatory PTCB certification for registered technicians. The state is pursuing an expansion of technician roles related to the screening and dispensing of prescription refills. She urged the National Association of Boards of Pharmacy to include explicit standards for pharmacy technician scope of practice, education, and certification in its model state pharmacy act. Based on North Dakota's experience, Halvorson said that in order to move toward uniform national standards, pharmacy technicians should be an active part of the change process, and there should be sharp focus on patient safety.

Malcolm Broussard, executive director of the Louisiana Board of Pharmacy, noted that his state will require (effective January 2018) accredited education and PTCB certification for registration as a pharmacy technician. He suggested that the way forward, nationally, will depend on the answers to 3 questions: (1) What pharmacy tasks should be restricted to pharmacists? (2) What pharmacy tasks should be restricted to pharmacists or technicians? and (3) Should the standards for technician education cover the gamut of technician roles or should a distinction be made between entry-level tasks and advanced tasks? Broussard said that pharmacy should have only 1 accreditation process for technician education and only 1 certification process.

Alex Adams, executive director, Idaho State Board of Pharmacy, discussed his state's recent expansion of the scope of practice for certified technicians. In making its changes, Idaho considered evidence that 44% of pharmacists' time was spent on tasks that could be delegated to competent technicians. Tasks that pharmacists are permitted to delegate to certified technicians (in some cases requiring special training) are in 2 categories: *medication dispensing support* (accept oral prescriptions, clarify technical elements of prescriptions, transfer prescriptions, search the prescription drug monitoring program database, and perform final verification of filled prescriptions that have undergone drug-use review by a pharmacist) and *technical support for pharmacist clinical services* (administer vaccines, administer simple [Clinical Laboratory Improvement Amendment-waived] clinical tests, conduct basic physical assessments, and conduct medication histories).

Peter Vlasses (at the lectern) moderated the panel discussion on "models for moving forward on pharmacy technician issues." The speakers were (left to right) Susan James, Diane Halvorson, Malcolm Broussard, and Alex Adams.

Consensus recommendations

Four work groups involving all invited conferees met in 3 sessions throughout the conference to formulate recommendations on issues related to pharmacy technicians. Each group had balanced representation from all sectors of pharmacy and was led by a facilitator–recorder team. The topic assignments were the same for all groups. After the last work group session, the facilitator–recorder teams met with other conference staff to consolidate and prepare recommendations for polling.

At the final plenary session, participants indicated their level of agreement or disagreement with 59 recommendations created by the work groups. Using a Web-based application, polling was conducted on a 4-point scale: strongly agree, agree, disagree, or strongly disagree.[d,e] The polling results are presented in Tables 1–7.[f]

Defining pharmacy technicians

Most conferees agreed with the need to create a legal definition of pharmacy technicians (Table 1, items 1.1 and 1.2) and to restrict the use of that occupational title to those who have met specified qualifications (item 1.3). In consideration of 2 alternative approaches for technician task analyses (as the basis for national standards), there was greater support for an inclusive all-settings assessment (item 1.4) versus separate assessments for different sectors of practice (item 1.5).

Education of pharmacy technicians

Most conferees agreed that national standards should guide technician education (Table 2, item 2.1) and that technician education programs should be accredited (item 2.4). There was further agreement that the national standards should focus on the outcomes of education, allowing a certain degree of programmatic flexibility in how those outcomes are achieved (item 2.5).

Entry-level knowledge, skills, and abilities

Conferees voted on the specific knowledge, skills, and abilities that should be achieved by those who wish to be credentialed as a pharmacy technician for entry-level practice (Table 3). These domains apply to education and to competency assessment (certification) of pharmacy technicians. All of the 18 areas polled received majority agreement, but about one third of conferees disagreed with 2 areas—"demonstrate understanding of nontraditional roles" (item 3.5) and "billing" (item 3.12).

Certification of pharmacy technicians

There was strong support for requiring national certification of technicians ahead of state board of pharmacy

[d] Individuals who were involved in planning or staffing the conference were excluded from the polling.

[e] The 2 attendees from NACDS excused themselves from the polling.

[f] There was no predetermined definition of consensus related to level of agreement on polling items. The conference organizers will be guided by the overall polling results in planning how to pursue uniform standards for pharmacy technicians.

Table 1
Defining Pharmacy Technicians: Results of Conference Polling

Issue	% Respondents[a]			
	Strongly Agree	Agree	Disagree	Strongly Disagree
1.1 The profession of pharmacy should develop a contemporary definition of entry-level pharmacy technicians that differentiates them from other pharmacy supportive personnel.	61	33	4	1
1.2 State boards of pharmacy should adopt standardized terminology that defines different categories of pharmacy supportive personnel and their associated scope of work.	48	35	8	8
1.3 State boards of pharmacy should protect the title of pharmacy technician, ensuring that only those that have completed required education may use the title.	63	28	7	3
1.4 A national task analysis should be used to inform the development of national standards, in an objective and data-driven manner, related to the competencies/credentials of entry-level pharmacy technicians.	68	30	1	0
1.5 A separate task analysis of pharmacy technicians should be conducted within different pharmacy practice sectors to develop a cross-walk process for determination of common core competencies.	34	44	15	7

[a] The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

registration or licensure (Table 4, item 4.1), and there was clear *disagreement* that this should be done without a specified educational requirement (item 4.2). Maintenance of national certification as a requirement for continued registration or licensure was supported (item 4.3).

State laws and regulations on pharmacy technicians

Nearly all conferees agreed that variability in state regulations regarding technicians should be minimized (Table 5, item 5.1) and that technician practice should be under the purview of the pharmacist (item 5.5). Most conferees agreed that national standards should not prevent states from innovating and expanding technicians' scope of practice beyond established entry-level standards in the interest of improving patient safety and care (item 5.3).

Advanced pharmacy technician practice

Conferees generally agreed that the profession of pharmacy's immediate priority, with respect to technician issues, should be development of standards related to entry-level education (Table 6, item 6.2) and that advanced roles for technicians (and related education and credentials) will evolve over time (items 6.3 and 6.4).

Moving forward on pharmacy technician issues

All participants in the polling agreed that the conference planners should establish a coalition of stakeholders to pursue the consensus recommendations from the conference (Table 7, item 7.5). Most conferees agreed that participants in this stakeholder event have a responsibility to work toward achieving the consensus recommendations (item 7.7).

Table 2
Pharmacy Technician Education: Results of Conference Polling

Issue	% Respondents[a]			
	Strongly Agree	Agree	Disagree	Strongly Disagree
2.1 The profession of pharmacy should move urgently towards the development and adoption of national standards for pharmacy technician education.	72	23	4	1
2.2 The profession of pharmacy should set a target for implementation of the national standard for pharmacy technician education at 3 to 5 years after adoption of the standard.	51	35	13	1
2.3 Technician education programs should be based on national standards, be foundational across all practice settings, and provide room for innovation and flexibility.	79	17	4	0
2.4 Technician education programs should be accredited and based on defensible standards developed using stakeholder input, taking into account diversity of practice environments.	71	26	3	0
2.5 In the development of national standards for technician education, there should be a focus on outcomes and flexibility in terms of process.	46	51	3	0
2.6 The number of required education hours for pharmacy technicians should be determined based upon the defined entry-level core knowledge, skills, and abilities.	51	39	6	4
2.7 The entrustable professional activities that can be performed by an entry-level pharmacy technician after completion of a standardized education program should be defined.	40	35	15	10
2.8 Employees seeking the entry-level pharmacy technician designation should be required to complete a nationally accredited education program. (See also item 4.2.)	63	21	8	8
2.9 Employees seeking the entry-level pharmacy technician designation should be considered technicians-in-training during the period of completion of education and certification, all of which must be completed in less than 2 years.	44	44	7	4

[a] The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

Table 3
Required Knowledge, Skills, and Abilities of Entry-Level Pharmacy Technicians: Results of Conference Polling

Issue	% Respondents[a]			
	Strongly Agree	Agree	Disagree	Strongly Disagree
3.1 Personal and interprofessional knowledge and skills	70	24	3	3
3.2 Professional knowledge and skills	70	20	5	4
3.3 Calculations	83	15	0	1
3.4 Basic pharmacology	55	35	7	3
3.5 Demonstrate understanding of nontraditional roles	19	45	27	8
3.6 Processing orders	85	12	1	1
3.7 Patient and medication safety	87	13	0	0
3.8 Understanding sterile and non-sterile compounding	39	49	6	7
3.9 Medication use process	67	31	1	1
3.10 Screen prescriptions for completion and accuracy, but not crossing the line into clinical topics such as drug interactions, dosage ranges, etc.	62	34	1	3
3.11 Information technology in general and in the context of medication safety elements	68	31	1	0
3.12 Billing	28	41	24	7
3.13 Quality principles	58	39	3	0
3.14 Regulatory	66	34	0	0
3.15 Maintenance of confidentiality	97	3	0	0
3.16 Ability to reconstitute and compound simple non-sterile preparations using USP's definitions	59	34	4	3
3.17 Proper handling of hazardous drugs	66	28	4	1
3.18 Inventory management	47	42	5	5

[a] The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

Conference wrap-up

The following 5 conferees offered brief reflections on the conference: **Anthony Provenzano** (vice president, pharmacy compliance and government affairs, Albertsons Companies), **Lisa Schwartz** (senior director, professional affairs, National Community Pharmacists Association), **Charles Daniels** (pharmacist-in-chief and associate dean, University of California San Diego), **Janet Liles** (executive director, Pharmacy Technician Educators Council), and **Carmen Catizone** (executive director, National Association of Boards of Pharmacy). They commented on the event's value in candidly exploring unsettled issues and reaching conceptual agreement on important changes that should be pursued relating to the education, certification, and registration or licensure of pharmacy technicians. They emphasized the urgency of building on this stakeholder consensus event and not allowing momentum to diminish.

Representatives of the conference planning organizations—**Everett B. McAllister**, **Janet A. Silvester**, and **Peter H. Vlasses** (ACPE executive director)—thanked the participants for their constructive engagement and expressed commitment to marshaling forces for pursuing the changes identified at the conference in the interest of patient safety and pharmacy's service to the public.

Larry Wagenknecht, chief executive officer of the Michigan Pharmacists Association and chair of the PTCB board of governors, alluded to numerous previous attempts to build national consensus on standards for pharmacy technicians and asked, "What will be different this time?" His answer: "We now have a different understanding of where we need to be as a profession and the important role that well-qualified

Table 4
Certification of Pharmacy Technicians: Results of Conference Polling

Issue	% Respondents[a]			
	Strongly Agree	Agree	Disagree	Strongly Disagree
4.1 State boards of pharmacy should require new pharmacy technicians to obtain national certification for registration or licensure.	75	14	5	5
4.2 Entry-level pharmacy technicians should be required to complete a national pharmacy technician certification program, without a specified education requirement. (See also item 2.8.)	7	10	28	56
4.3 State boards of pharmacy should require pharmacy technicians to maintain national certification for continued registration or licensure.	60	19	12	8
4.4 PTCB should initiate conversations with boards of pharmacy regarding the recent updates in the PTCB exam blueprint, i.e., the decreased number of domains from nine to four, and the modification in the level of emphasis on sterile compounding.	33	48	12	7
4.5 State boards of pharmacy should provide a system to recognize experienced pharmacy technicians while not compromising the basic competencies required of a certified pharmacy technician.	29	49	19	3

[a] The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

Table 5
State Laws and Regulations on Pharmacy Technicians: Results of Conference Polling

Issue	% Respondents[a]			
	Strongly Agree	Agree	Disagree	Strongly Disagree
5.1 The variability of state regulations regarding pharmacy technicians should be minimized, while maintaining the required standards to ensure patient safety.	63	36	1	0
5.2 The level of urgency for achieving state-to-state consistency in regulation of pharmacy technicians' scope of practice, education, certification, and licensure or regulation is high.	62	25	12	1
5.3 National standards should not prevent states from innovating and expanding technicians' scope of practice beyond established entry-level standards in the interest of improving patient safety and care.	87	10	3	0
5.4 Evolution of state-level laws and regulations regarding pharmacy technicians should be founded on ensuring patient/public safety.	87	11	1	0
5.5 National standards should be framed in the context of pharmacy technician practice being under the purview of the pharmacist.	68	30	1	0
5.6 State boards of pharmacy should require pharmacy technicians to be licensed based on specific criteria including accountability and administrative liability.	30	37	22	10
5.7 Registration should be required for all individuals who embark upon their initial entry into the profession of pharmacy.	58	30	4	7
5.8 State boards of pharmacy should require that pharmacy technicians complete continuing education or other professional development activities for continued registration or licensure.	72	28	0	0
5.9 State boards of pharmacy should include a pharmacy technician on the board.	59	29	9	4

[a] The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

pharmacy technicians must play in helping us reach that place." He declared that PTCB is committed to collaborating with the full range of stakeholders to achieve uniform nationwide standards for pharmacy technicians.

Disclosures

Mr. Zellmer provides contractual services for the American Society of Health-System Pharmacists (ASHP), serves on the *AJHP* Editorial Board, and consulted on the planning of the Pharmacy Technician Stakeholder Consensus Conference. Mr. McAllister is employed by the Pharmacy Technician Certification Board (PTCB). Dr. Silvester is employed by ASHP. Dr. Vlasses is employed by the Accreditation Council for Pharmacy Education (ACPE).

The PTCB certifies pharmacy technicians and provided financial support for the 2017 Pharmacy Technician Stakeholder Consensus Conference. ASHP provides continuing education for pharmacy technicians, is an owner of PTCB, and holds a permanent seat on the PTCB board of directors. ASHP and ACPE jointly sponsor the Pharmacy Technician Accreditation Commission, which is the accrediting review commitee for pharmacy technician education programs.

Additional information

This article will also appear as a Web publication of the *Journal of the American Pharmacists Association*.

Table 6
Advanced Pharmacy Technician Practice: Results of Conference Polling

Issue	% Respondents[a]			
	Strongly Agree	Agree	Disagree	Strongly Disagree
6.1 The pharmacy profession should clearly articulate and communicate the vision for advanced pharmacy technician practice and disseminate the vision to appropriate stakeholders.	67	30	3	0
6.2 The pharmacy profession should maintain focus and energy toward developing entry-level standards for technician education, with the expectation that advanced-level competencies will evolve over time.	67	25	6	1
6.3 Bridging programs should be developed and offered to build competencies of pharmacy technicians who are currently in the workforce and who would like to advance their skills.	56	40	3	1
6.4 Specific advanced-level educational programming for pharmacy technicians is needed, available, and will continue to evolve as needs within the profession are identified (e.g., sterile compounding, controlled substances, risk management, quality assurance, informatics).	66	30	3	1
6.5 In developing standards for advanced pharmacy technicians, the pharmacy profession must recognize that there are technicians currently practicing at this level and acknowledge the appropriate pathway for their continued development.	67	32	1	0
6.6 The profession of pharmacy should develop credentials for technicians who perform advanced roles beyond entry-level practice.	43	46	10	1

[a] The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

Table 7
Moving Forward on Pharmacy Technician Issues: Results of Conference Polling

Issue	% Respondents[a]			
	Strongly Agree	Agree	Disagree	Strongly Disagree
7.1 The profession of pharmacy must be transparent in its message about pharmacy technicians, communicating the priority of public/patient safety, taking ownership of identified issues, assuming commitment to change, ensuring accountability, and reinforcing the positive contributions of pharmacy technicians to achieving optimal medication use.	75	22	1	1
7.2 The profession of pharmacy should develop a communications plan to disseminate its vision for pharmacy technicians and achieve buy-in from all stakeholders (e.g., pharmacists, pharmacy technicians, legislative and regulatory bodies, employers, payers, public, etc.).	73	26	2	0
7.3 The profession of pharmacy should advocate for the removal of pharmacist-to-technician ratios based on existing evidence.	52	25	15	7
7.4 Encourage pharmacy technician inclusion, representation, and membership in professional pharmacy organizations (at state and national levels).	73	24	2	2
7.5 The conference planners should establish a coalition with broad representation to take forth the recommendations from the Pharmacy Technician Stakeholder Consensus Conference.	77	23	0	0
7.6 The Joint Commission of Pharmacy Practitioners should take responsibility for ensuring appropriate priority and accountability in follow-up of conference recommendations, possibly collaborating with organizations such as the Council on Credentialing in Pharmacy, the Institute for Safe Medication Practices, and the National Conference of State Legislators.	39	49	1	10
7.7 All participants in the Pharmacy Technician Stakeholder Consensus Conference have a responsibility to work toward achieving the consensus recommendations from the conference.	62	27	8	3

[a] The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

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Advancing technician practice: Deliberations of a regulatory board

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A B S T R A C T

In 2016, the Idaho State Board of Pharmacy (U.S.) undertook a major rulemaking initiative to advance pharmacy practice by broadening the ability of pharmacists to delegate tasks to pharmacy technicians. The new rules of the Board thus moved the locus of control in technician scope of practice from law to pharmacist delegation. Pharmacist delegation is individualistic and takes into account the individual technician's capabilities, the pharmacist's comfort level, facility policies, and the risk mitigation strategies present at the facility, among other factors. State law limits, by contrast, are rigid and can mean that pharmacists are unable to delegate tasks that are or could otherwise be within the abilities of their technicians.

The expanded technician duties are in two domains: 1) medication dispensing support (e.g., tech-check-tech, accepting verbal prescriptions, transferring prescriptions, and performing remote data entry); and 2) technical support for pharmacist clinical services (e.g., administering immunizations). This commentary reviews the evidence behind these expanded duties, as well as the key regulatory decision points for each task. The Board's rules and approach may prove useful to other states and even other governing bodies outside the U.S. as they consider similar issues.

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In 2016, the Idaho State Board of Pharmacy undertook a major rulemaking initiative to advance pharmacy practice in the state.[1] Specifically, the new rules broaden the ability of pharmacists to delegate tasks to technicians under their supervision. The expanded technician duties are in two domains: 1) medication dispensing support (e.g., tech-check-tech, accepting verbal prescriptions, transferring prescriptions, and performing remote data entry); and 2) technical support for pharmacist clinical services (e.g., administering immunizations). This manuscript describes the Board's approach to its rulemaking in hopes that it will be helpful to other jurisdictions considering similar issues.

1. Regulating technician practice

The regulation of pharmacy technicians is broadly focused on promoting safe and effective pharmacy practice while protecting the public health. States typically regulate technicians in two ways: 1) entry barriers; and 2) scope of practice restrictions.

1.1. Entry barriers

Entry barriers are designed to ensure a minimum level of competency of individuals holding a license or registration. Currently, Idaho law requires pharmacy technicians to meet the following requirements as a condition of registration: minimum age (18 years), education (high school graduate or equivalent), and training (hold a national certification through one of two national certifying bodies). Some exceptions are made on a case-by-case basis, and a technician-in-training registration category offers individuals up to three years to obtain the requisite certification.

1.2. Scope of practice restrictions

In a traditional sense, “there are no functions unique to pharmacy technicians; ” rather, all technician roles are a subset of pharmacist roles and occur under the supervision of a pharmacist.[2] For a technician to perform a task, it must be legally permissible and delegated to him or her by a supervising pharmacist. In general, the legal scope of technician practice is defined in prohibitive terms in that pharmacists are prohibited from delegating – and thus technicians are prohibited from performing – certain roles and responsibilities that may be otherwise performed by pharmacists or interns. Idaho is consistent with most U.S. states in that technicians are prohibited from performing tasks that require professional judgment (drug utilization review, clinical conflict resolution, and patient counseling). States vary to the extent they restrict other activities.

Thus there are two levels of control on technician scope of practice: state law limits and pharmacist delegation decisions. Even if state law does not prohibit delegation of a specific task or function to a technician, a pharmacist may use his or her professional judgment to decide *not* to delegate a specific task to a specific technician.

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Table 1
Summary of evidence on expanded technician roles.

Task	Brief Summary of Evidence
Tech-Check-Tech	The literature base supporting tech-check-tech in *institutional* settings spans nearly four decades. Across 11 studies in a systematic review, pharmacy technicians performed as accurately as pharmacists in final verification duties (99.6% vs. 99.3%, respectively) while freeing pharmacists for advanced clinical services (10 hours per month to 1 hour per day).[4,5] Two additional studies on institutional TCT have been published since the systematic review, demonstrating similar safety-related outcomes while achieving even greater yields in terms of time available for pharmacist clinical services (50 hours more per month to 5.75 hours more per day).[6,7] Published evidence on TCT in *community* pharmacy settings spans 14 years and four studies.[8] In the two studies that reported explicit accuracy rates, pharmacy technicians performed on par with pharmacists in one, and statistically outperformed pharmacists in the other (99.445 vs. 99.73%, $p = 0.484$; 99.95 vs. 99.74, $p < 0.05$) while simultaneously increasing the amount of time pharmacists have available for providing clinical services (5.3%–19.18% of the pharmacists' workday).[9–11]
Accept Verbal Prescriptions Transfer Prescription Orders	Wakefield and Wakefield found the topic of verbal orders has not been studied in depth and the current body of evidence is anecdotal.[12] The lone study connecting verbal orders to safety found that verbal orders actually decreased the risk of error compared to handwritten orders.[13] Given that 17 states have allowed these activities (in some instances for up to 40 years), and apparently high uptake of this activity by technicians in practice (63% in one study), the lack of evidence on patient safety issues gave the Board comfort that these activities may be safely and appropriately delegated if paired with strong practice policies and procedures.[14,15]
Administer Immunizations	Given that no states currently allow technicians to administer vaccines, it should be of little surprise that we were unable to find any technician-specific immunizations studies.[16] Parallels can still be drawn from the literature however. Studies have demonstrated that untrained laypersons can safely and effectively self-administer intranasal and intradermal vaccines while achieving statistically similar levels of immune response.[17–19] Laypersons also successfully self-administer medication through intramuscular and subcutaneous routes (e.g., patients with diabetes).

2. Approach to advancing technician scope of practice

While Idaho law has increased the entry barriers for technicians over time, the scope of practice restrictions had remained generally unchained since the 1970's. To begin the process of modernization, Board staff performed an environmental scan to identify what activities technicians were performing in other states that were expressly prohibited in Idaho law. A series of eight listening sessions were then held throughout the state in March and April 2016 to gain public feedback early in the process. Board staff reviewed the expanded technician duties, described the existing literature and findings from other state boards of pharmacy, and asked attendees their feedback. Several key themes emerged across the listening sessions:

1. Pharmacists generally reflected support for expanding the role of *appropriately trained* technicians. Some pharmacists did note concerns for their own liability as technician roles expand. To sort out these concerns, the Board engaged a former executive of a national pharmacist liability insurer. The executive noted that liability insurance rates have not increased for either pharmacist or pharmacies in the states that have already expanded technician roles as Idaho is considering.[3]
2. Pharmacists reported variability in technician qualifications for expanded duties, and noted that it is critical to ensure assignment of function remains with the pharmacist. The Board agreed with this sentiment, and retained its existing rule that a technician must not perform and task or function connected with pharmacy operations "unless the technician is authorized by the assigning pharmacist." The Board occasionally would hear from a pharmacist who stated they would never trust their technicians to perform specific duties under consideration. The assignment of function rule offered them a simple solution: do not delegate the task. Similarly, an occasional technician would indicate they would not want to perform a specific task. In both instances, it did not seem reasonable to not allow *any* technician in the state to perform a specific task just because some pharmacists or technicians were uncomfortable with the thought. Such regulation to the lowest common denominator is rarely in the public interest.
3. Technicians reflected excitement about the prospects of new roles and career opportunities. Many saw new tasks as an opportunity to grow and develop. Some envisioned the development of a career ladder that would help recruit and retain top technician talent, and that technicians would be rewarded for taking on value-added skills. Of note, some technicians expressed frustration that they had maxed out in their current roles despite being willing to learn new tasks.

3. Core elements of new rules

The Board's new rules focus on two domains: 1) medication dispensing support and 2) technical support for pharmacist clinical services. To be clear, the tasks enumerated in the new rules for technicians are not designed to be exhaustive. The Board's focus was on loosening restrictions currently listed in rule. It is known that technicians can and do play more extensive tasks, particularly with regard to clinical service support (medication reconciliation, basic physical assessment, point-of-care testing). There were no restrictions on these activities in existing Idaho law, and thus the Board determined no changes were necessary to enable delegation of these tasks.

The Board was committed to letting evidence drive decision-making. A summary of the available evidence for each task is provided in Table 1.[4–19] The availability of published literature varied by task, though some states have successful track records with each task – in some instances for up to forty years. The Board rules enable each of the expanded duties to be delegated to *certified* technicians (not trainees) at the discretion of the supervising pharmacist. Key decision points regarding each task are reviewed in Table 2.[20–23]

1. Tech-Check-Tech (e.g., "Accuracy Checking")

Tech-check-tech (TCT) is a practice model in which an advanced pharmacy technician performs final verification on a product for floor and ward stock, or for products that have previously been reviewed for clinical appropriateness by a pharmacist.[4] Idaho's rules now allow tech-check-tech in *any* practice setting, not just acute care hospitals (as was previously the case).[1] Accuracy checking may only be conducted by a certified technician who has undergone site-specific training. Technicians may perform TCT on any drug except compound products. Pharmacies must adopt a quality assurance program that includes unannounced monitoring and evaluation of each accuracy checking technician at least quarterly for the first year and then annually thereafter. Pharmacies must remediate or remove from checking duty any technician who

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Table 2
Summary of key decision points in rulemaking.

Service	Key Decision Points
Tech-Check-Tech	a. **Nomenclature.** The rule update rebranded TCT as an "accuracy checking technician program" and the technicians performing final product verification were termed "accuracy checking technicians (ACT)." This terminology was adopted from a recent pilot project in New Zealand, and was chosen as the Board felt it more accurately captures the spirit of such a program. For example, TCT implies a technician can only check a fellow technician, whereas the Board envisions a technician having the ability to also check a student pharmacist, an automated dispensing system, or other technology-assisted filling equipment.
	b. **Practice Setting.** Previous Board rule allowed TCT in "acute care" hospitals, though a waiver had also been granted to allow it in a psychiatric hospital as well. The Board decided to make this rule practice-site agnostic as product verification is functionally the same regardless of setting. Frost and Adams reviewed the conceptual differences in TCT programs between institutional and community settings (unit dose vs. bulk containers; daily dose vs. 30- or 90-day supply; dispensing to other health professionals vs. the ultimate user, etc).[14] Thus, there are some safety valves in institutional practice that do not directly carry over to community settings. As a result the Board did add a technology requirement specific to community settings: "Retail pharmacies implementing an accuracy checking technician program must use an electronic verification system that confirms the drug stock selected to fill the prescription is the same as indicated on the prescription label. Each prescription prepared for dispensing under an accuracy checking program must be electronically verified and electronically documented."
	c. **Covered Drugs.** The previous rule was limited to unit dose medications and this requirement was struck, enabling TCT to be leveraged for any medications (including those in bulk containers). The only drugs excluded by law are compounded products, given the potential safety risk these present. While other states carve out controlled substances from TCT, the Idaho rules do not. In addition, prior rule language exempted medications "if the alteration of a unit dose or the combination of unit doses is required." This language was struck, opening the door for TCT to be used for innovative packaging models (e.g., daily blister packs).
	d. **Student Pharmacist Participation.** In general, student pharmacists can perform any activity under the supervision of a pharmacist with the exception of final verification. Rule language was added to specifically enable student pharmacists to participate fully in the ACT program with the same limitations and requirements as ACTs.
Accepting Verbal Prescriptions and Transferring Prescriptions	a. **Controlled Substances.** Federal law seemed ambiguous on if a technician could accept a verbal or perform a transfer for controlled substances. In communicating with the DEA, the agency's policy staff agreed with the Board's interpretation that a technician could accept a verbal or perform a transfer if technicians are specifically authorized by the state to perform this activity. Thus, the Board put no restrictions on drugs in law and instead left this to the discretion of the supervising pharmacist.
	b. **Practice Policies and Procedures.** The Board heard concerns that verbal orders have the potential to be misunderstood or misheard, creating an error cascade that is difficult for the pharmacist to catch during drug utilization review. Most concerns revolve around the technician reducing to writing the wrong drug name or wrong drug dose. The Institute for Safe Medication PRACTICE has shared best practices for receiving verbal orders that may mitigate the risk of these events occurring, such as requiring read-back, spell-back techniques, requiring the indication, etc.[20–22] The Board did not require such practices in law, and instead left these to the discretion of the supervising pharmacist.
	c. **Parties to Communication.** The prior Board rule allowed student pharmacists to transfer prescriptions as long as one of the parties involved in the communication was a pharmacist. This was amended, and in the revised rule a technician could communicate a transfer to another technician or a student pharmacist.
Remote Data Entry	a. **Ratio.** Idaho currently has a maximum ratio of six technicians and interns per pharmacist. As such, one decision point was if a remote data entry technician should count against this ratio. The Board ultimately carved technicians working in such a manner out of the ratio as the goal is to defray workload on pharmacists, and it would be logistically difficult to identify whose ratio the technician should count against since they may be servicing multiple pharmacies simultaneously.
	b. **Pharmacist on Duty.** Current law states that a pharmacist must not enter a pharmacy unless the pharmacist is on duty. The Board discussed whether or not a remote data entry technician could perform work if a pharmacist was not a duty. The Board determined that a technician practicing in such a manner could perform work before a pharmacy is open for business or after hours. All of the work completed ultimately feeds into a queue that a pharmacist must check, hence the exemption.
	c. **Inspection.** All pharmacy locations are subject to inspection by Board staff, remote data entry locations included. Because some remote entry sites may be at an individual's home, specific language was added to the rule to set clear expectations that such sites could be subject to unannounced inspections, albeit unlikely.
Administer Immunizations	a. **Training.** Existing Board rule set forth in granular detail the training requirements necessary for pharmacists to immunize. The most commonly used program is a 20-h certificate training program hosted by the American Pharmacists Association. This course covers basic immunology, recommended vaccine schedules, immunization assessment and counseling, etc.[27] Only a small portion of this program is devoted to actual immunization administration technique. Given that pharmacists play a much broader role with vaccines than technicians – making the clinical decision to prescribe the right vaccine to the right patient at the right time – the Board felt that a program that was more targeted to the actual administration step would likely be more appropriate and thus opened the door to the development of new training programs more targeted to the administration role technicians would actually play.
	In addition, the rules require a technician to hold a current certification in basic life support by the American Heart Association or a comparable provider. The training must include cardiopulmonary resuscitation and automated electronic defibrillator training. Further, the program must have a hands-on skills assessment by an authorized instructor.

does not meet minimum performance standards of the facility.

2. Accepting Verbal Prescriptions and Transferring Prescriptions

Idaho's new rules allow a certified technician to receive a verbal prescription drug order from a prescriber or their agent and reduce the order to writing.[1] The rule also permits a certified technician to transfer prescription drug order information for the purpose of filling or refilling the medication. Such a transfer may occur verbally, electronically, or via fax. No restrictions were placed in law, but several extra-legal factors may come into play. For example, the Joint Commission standards deter the use of verbal orders for high-risk products such as chemotherapy.[24] The Board heard more concerns from pharmacists about technicians accepting verbal orders than any other task under consideration, but the Board believed that robust practice policies and procedures

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such as read-back/spell-back, requiring the indication, etc., can be instituted to reduce the risk for error.[20–22]

3. Remote Data Entry

The Idaho rules would allow a pharmacy located in Idaho to employ one or more certified technicians to perform data entry in remote practice sites (e.g., a home) located in Idaho. No drug inventory may be kept at a remote practice site, and audit trail documentation shall be maintained to identify the person responsible for each aspect of the prescription preparation. The computer used at a remote data entry site must be able to establish a secure connection to the home pharmacy system, and no patient information can be stored at the remote site. The allowance to work from a home setting or a non-pharmacy setting differentiate remote data entry from workload balancing efforts that allow staff located in other pharmacies to pick up the slack for allied pharmacies. While three states currently allow remote data entry by technicians, interest in this area is likely to grow in the years ahead as a resolution supporting the concept was passed at the 2016 NABP Annual Meeting.[25]

4. Administer Immunizations

Idaho's new rules allow pharmacists to delegate the technical task of vaccine *administration* (inserting the syringe into the patient's arm and pressing down on the plunger) to a certified technician who has completed training in appropriate immunization administration techniques and who holds certification in basic life support for healthcare professionals. Idaho is the first state to allow technicians to *administer* vaccines. Technicians already play critical roles related to vaccine advocacy and perform nearly every other technical task including selecting the proper needle gauge and length, loading the syringe, and safely disposing of needles and syringes, among other duties.[26–28] Thus it was not a stretch to add the administration step. In addition, the Board heard from technicians who previously served as medical assistants and were entrusted to administer immunizations in physician offices, but were not permitted to do the same in a pharmacy.

4. Discussion

Regulating pharmacy technician scope of practice is a balancing act. It is imperative to ensure that the tasks performed by technicians are safe and appropriate for their level of education and training. If a state is too strict in law, however, it can mean that pharmacists spend a substantial fraction of their workday performing technician-like duties, denying patients the clinical expertise of pharmacists.

The new rules of the Board moved the locus of control in technician scope of practice from law to pharmacist delegation. Pharmacist delegation is individualistic, and takes into account the individual technician's capabilities, the pharmacist's comfort level, facility policies, the risk mitigation strategies present at the facility, among other factors.[29] State law limits, by contrast, are one-size-fits-all, and can mean that pharmacists are unable to delegate tasks that are or could otherwise be within the abilities of their technicians.

A unique aspect of the Board's discussions was that they focused on scope of practice, and not on additional entry barriers (specifically education or training). It was even acknowledged that technicians are not currently trained for some of the tasks under consideration. The Board felt that limitations on scope of practice may prevent technicians or employers from investing time and money into training on tasks that are legally prohibited from being performed. As one example, once technicians were allowed to administer immunizations, a training program was quickly developed and marketed by an academic institution.[30] The Board envisions additional education and training programs emerging to meet the other tasks included in the rules.

Permissive rules enabling pharmacist discretion in delegation can create additional opportunities to divide the labor that occurs in the pharmacy in a manner that optimally deploys both professions in the interest of patient care. The Board's overall approach to rulemaking was to remove legal barriers and empower the pharmacist as the decision-maker with respect to delegation. This approach more closely reflects the medical model of practice, and avoids the rabbit hole of over-regulating technician practice to the detriment of patient care. The Board's rules and approach may prove useful to other states as they consider similar issues.

Conflicts of interest

None.

Disclaimer

The views expressed in this manuscript are those of the author alone, and do not necessarily reflect those of their employer.

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Pharmacy technician self-efficacies: Insight to aid future education, staff development, and workforce planning

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ABSTRACT

Background: The roles of pharmacy technicians are increasingly prominent given pharmacy's transition to patient-centered activities and evolving scopes of practice in many U.S. states and throughout the world.

Objectives: The aims of this study were to assess U.S. pharmacy technicians' self-efficacies for and attitudes toward performing current and emerging roles in hospital and in community pharmacy and to identify factors related to pharmacy technician self-efficacies in these roles.

Methods: A total of 5000 pharmacy technicians from 8 U.S. states were sent an electronic survey eliciting data on current involvement, self-efficacies, and attitudes for practicing in an expansive list of practice activities. The 8 states from which the sample was drawn were selected from a stratified randomized procedure using U.S. Census Bureau geographically defined regions. Pre-notification and response reminders were employed. Data were analyzed descriptively and with univariate, inferential tests, as appropriate, to determine associations with commitment, practice environment, experience level, and other variables.

Results: Of the 612 participants who responded, 494 were currently working as a technician and not enrolled in a PharmD program of study. Participants reported various activities in which they were highly engaged. Overall, attitudes toward performing most of the activities and self-efficacies were quite favorable, even for those activities in which technicians were currently less involved. There were some notable differences between technicians practicing in community versus hospital settings. Years of experience, profession commitment, and advanced employee ranking were associated with higher levels of self-efficacy, overall.

Conclusions: This initial examination of pharmacy technician self-efficacies identified areas that along with other factors could help employers with further expanding technician practice activities and vocational institutions with considerations for education and development of these key members of the workforce. The results would suggest technicians to be ready for continued evolution in their practice.

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1. Introduction

Attention has been recently afforded to pharmacy technicians and other workforce cadres in discussions of pharmacy practice. This attention comes after years of relative omission, particularly when considering that the practice of support staff would naturally mature if pharmacists are to delegate some of their previous responsibilities to engage in more patient-centered care.[1,2] Much recent literature has focused on role expansions for technicians. In the United States (U.S.), this has most recently been codified in various State Board of Pharmacy statutes allowing for "check-tech-check", wherein technicians have the final review of refill prescription orders for accuracy.[3] This follows a designated CheckTech position authorized in the United Kingdom (U.K.) for nearly a decade[4] and a study in New Zealand demonstrating the effectiveness of a similar program with evidence that as a result, pharmacists actually shifted considerable amounts of time in practice from dispensing to patient-focused activities.[5] Recently, some U.S. states have either passed or are considering legislative rules allowing technicians to administer immunizations, such as for influenza inoculation.[6]

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The recent expansion of legal and regulatory scopes of practice for technicians follows a couple of decades where the roles of technicians were piloted and implemented on a limited basis, often to a particular health system. Examples of such roles include technician involvement in tobacco cessation programs,[7] naloxone distribution,[8] medication safety director,[9] medication reconciliation,[10] and medication-history taking,[11] to name but a few. These roles all represent expansions of technician responsibility and autonomy, even if not necessarily emblematic of regulatory or legal practice change.

Whether regulatory or not, and even whether the expanded role(s) underscore significant increases in cognitive workload and judgment, there is debate about technician education, training, and skills development that has been ongoing for quite some time.[12] On a global level, this can be witnessed by the myriad approaches taken in both developed and in developing nations, where education requirements vary from standardized education in Denmark to what is akin to apprenticeship, elsewhere.[13] Within the U.S., calls for standardization and elevation of education and training have been made repeatedly.[14]

While preliminary evidence suggests technicians generally embrace new roles[15] and are effective in their performance,[16] there has been no research evaluating on a broader scale their willingness to take on emerging responsibilities and their confidence in doing so. For that matter, there has been very little if any research evaluating technicians' self-efficacy in their performance of current responsibilities. Self-efficacy is an important construct implicated in attitude, performance, and behavior change.[17] Self-efficacy has been examined in pharmacists and demonstrated to be critical in their proficiency for delivering patient care.[18,19] Additionally, identification of areas where self-efficacy is lacking can become the backbone of future educational interventions and perhaps even help identify areas for restructure of technician vocational education, on-the-job training, and professional revalidation.[20]

These lines of thought regarding self-efficacy in technician practice come in light of emerging data on pharmacy workforce cadres.[21] Pharmacy support staff have varied roles worldwide, where some technicians are basically the only dispenser of medications in certain under-developed nations, to others where they have taken on a more clinical role examined specifically for their part in safety within the medication use process.[13] From a global perspective, technicians take on varied roles and education training in certain settings, even while in some countries such as Denmark, all technicians (pharmaconomists) are educated entirely at one institution nationwide, regardless of setting.[22] In the U.S., technicians ostensibly have different roles than other pharmacy support staff, such as clerical personnel; however, it has been noted that at least among the lay clients (patients), there is often difficulty distinguishing one staff member type from another and that their roles might not always be clearly delineated.[23]

Very few studies have examined, or compared responsibilities and attitudes between technicians in various practice settings. While some technicians might have practiced in various settings throughout their career, others might very well have been in either hospital or community practice for an extensive period of time. The two settings vary considerably, with the pharmacy technician, particularly in the U.S., responsible for customer service and an integrated series of steps involved in the prescription dispensing process, whereas hospital pharmacy technicians interact little with the public/patients, yet have a wider range of responsibilities beyond medication dispensing, owing to the complexity of distribution, storage, inventory, and record-keeping inherent to the hospital setting.

To that end, the aims of this study were to assess U.S. pharmacy technicians' self-efficacies for and attitudes toward performing current and emerging roles in hospital and in community pharmacy and to identify factors related to pharmacy technician self-efficacies in these roles.

2. Methods

2.1. Design and sample

Institutional review board (IRB) exemption for study procedures were granted by the universities home to the investigators of this study. The study design was cross-sectional, featuring use of a survey to a stratified randomized sample of technicians from 8 U.S. states. Using a sample size calculation recommended by Dillman et al.,[24] an estimated 384 respondents were deemed required to meet the study objectives. Assuming a response rate of approximately 10%, the researchers conservatively sought contact information from 5000 subjects from these states. Selection at the state level was performed with geographic diversity as a key tenet. The U.S. is divided into 4 geographic regions by the U.S. Census Bureau: Northeast, Southeast, Midwest, and West. Two states from each of those regions were sampled. The State Boards of Pharmacy from those states selected were contacted to provide its registry of technicians. If the State Board was unable to provide such a registry in an appropriate form (eg, Excel spreadsheet or comma, delimited electronic format), or if the registry was cost-prohibitive (over $500), then another state from that geographic region was sampled. Once the registry of all technicians from all 8 states was acquired, the total number of registrants (eligible respondents) was determined by summing them; and that sum served as a denominator to calculate an equal proportion of the sample from each state. The study subjects were then selected from each state using a random number generator program that provided the numbers corresponding to the record number of each state registry.

The survey was designed and implemented using Qualtrics technology.[25] The procedures for survey conduct were in accordance with recommendations by Dillman et al.[24] to maximize rate of return. Sampled subjects received a pre-notification email approximately 9–10 days prior to launch of the survey, with an option to contact a research investigator to opt out with their preference not to participate. In doing so, those who opted out were replaced by the next individual from their same state of residence by the next registrant from the random number generator. Eleven respondents opted out and were replaced, in addition to another 94 whose pre-notification were returned as undeliverable. Respondents then received the survey via an email link along with a cover letter. The cover letter explained the salience of the study in advancing pharmacy technician professionalization, education, and preparation for future practice, as well as proper consent and assurances via IRB approval. The sampled technicians then received three additional reminder emails approximately one week apart, with the survey coming to a close on 1 March 2017.

2.2. Study variables

Self-efficacy in performing roles/activities was assessed using 10-point scales of confidence wherein respondents indicated such as it pertains to them currently performing the role. This mechanism of measurement is adopted from Bandura's self-efficacy theory[17] using a similar approach to assess confidence specific to a certain task or behavior. This is apt for measuring affinity toward roles or tasks that are situation-specific and takes into account perceived difficulty, as opposed to self-esteem, which is an overall evaluation of one's worth, otherwise known as the self-concept.[26] For the same set of tasks/roles (36 for community pharmacy and 36 for hospital pharmacy, with those like totals being coincidental),

respondents also indicated the extent to which they are currently involved in that activity, the extent they would like to be involved in that activity, and their attitude toward that activity. These variables are components of the theory of planned behavior (TPB).[27] While this study was not aimed to test the explanatory power of TPB among technicians, it was believed that current involvement and attitude toward the role/activity would provide key insights into their self-efficacy for performing it. Level of involvement was measured on a 4-point scale from "not at all" to "very often", as was their desire for level of involvement. Attitude toward the activity was measured on a 4-point scale of importance ("not at all important" to "very important"). A list of activities upon which to measure self-efficacy was derived from the literature, borrowing much from a previous study of pharmacist workforce, which itself was taken from a previous Pharmacy Technician Certification Board (PTCB) task analysis unique for technicians in institutional and community practice settings.[1] This list of activities was derived in conjunction with members of PTCB, American Association of Colleges of Pharmacy, American Pharmacists Association, and American Society of Health-System Pharmacists, all comprising the Pharmacy Workforce Center. This was supplemented with additional activities suggested in recent literature, specifically responsibilities identified in a study of technicians from developed nations globally[28] and from one U.S. state (Idaho) whose Board of Pharmacy had just recently updated the scope of practice for technicians to be among the most progressive in the U.S.[29] Total self-efficacy scores were derived by summing the individual self-efficacy responses to each of the activities for hospital and for community pharmacy technicians. Using skip logic, technicians from community pharmacy were automatically directed to only the community pharmacy list of activities, as was the case similarly for those in hospital practice. Level of involvement and preference for level of involvement was also summed across all activities. Technicians in other practice environments did not participate in this component of the survey; the Qualtrics technology employed skip logic to take respondents from these other settings directly to the end of the survey.

In addition to the aforementioned, demographic and work environment data were captured. This included employment status (currently working, part- or full-time), state of residence, practice setting, job rank (eg, entry-level versus advanced or specialty technician), gender, age, and measures of organizational and profession commitment used previously on an entirely different sample of U.S. pharmacy technicians.[1] This measure, rather than attempting to gauge an amount of the time in the future the respondent plans to stay with the organization and profession, proposes contexts on an ordinal continuum as to whether the respondent is firmly rooted, could be easily provoked to make an employment change, or feels entrenched for the long haul.

2.3. Data analysis

The data were prepared for analysis on SPSS, Version 21.0[30] following export from Qualtrics. Frequency distributions were tabulated for all relevant questions. Survey scales were subjected to a principal components analysis with oblique rotation, item analysis, and internal consistency reliability analysis to evidence construct validity, internal consistency reliability, and appropriateness of each item prior to their use in inferential statistics. Correlation analysis (Pearson's r) was undertaken to determine relationships between continuous variables, particularly self-efficacy variables with years of experience, attitude toward the activities, and level of involvement in those activities. This included an examination of relationships between level of involvement, preference for involvement, and self-efficacies. Independent t tests and one-way analyses of variance (ANOVAs, F test), were conducted to determine any relationships between the demographic/practice setting variables with self-efficacy and with performance ability.

3. Results

3.1. Participant characteristics

Out of 5000 surveys distributed, responses were obtained from 612 participants (12.2% response rate). Respondent employment status and other characteristics are provided in Table 1. Of the 612 respondents, 494 were currently working as a pharmacy technician and not enrolled as a PharmD student. The ensuing analyses and discussion is restricted only to those individuals. Nearly ¾ of those were working full-time, and over ¾ were female. Responses were received from all 8 states sampled and generally in line with the population of those states, respectively. For example, the population of Florida is approximately twice that of New Jersey, both of which exceed all other states.[31] Louisiana's population is a bit higher than Oregon's; however, the response rate from Louisiana was somewhat lower. As such, the response rates from each state might have differed only slightly. "Other" respondents came from various states, usually bordering one of the sampled states. Nearly 2/3 of respondents had earned some sort of higher tier or specialty technician designation. The majority of respondents came from community pharmacy, with 16.4% from the hospital setting. Respondents had been working as a technician for 8.15 years and had been with the current employer for 5.64 years. Most respondents reported at least modest commitment toward their employer. They also reported high levels of commitment to the profession, although more than ¼ of respondents indicated either looking to leave or stating that it might not take much to get them to change their career.

3.2. Community pharmacy technician self-efficacies

Table 2 provides the list of tasks/activities investigated for community pharmacy technicians (all community pharmacy settings combined), the respondents' level of involvement, their attitude about those tasks/activities, and their level of self-efficacy in performing them. Participants reported high levels of involvement around the entire task for prescription acquisition and initial filling, which incidentally loaded together on the principal components analysis. Likewise, their attitudes toward performing these activities and their self-efficacies for doing so were very high. There were a number of activities wherein respondents indicated being less involved but still having a positive, to very positive attitude regarding their conduct and reported a relatively high level of self-efficacy. Examples of such activities include compounding prescriptions, maintaining equipment, supervising other technicians, checking the work of other technicians, receiving prescriptions from prescribers, and maintaining files of habit-forming drugs. Activities that respondents reported positive attitudes but with somewhat lower self-efficacy included communicating lifestyle changes to patients, discussing effectiveness of treatment plans for returning patients, collaborating with other health professionals to monitor drug therapy effectiveness, providing information to providers and patients on medication issues, transferring prescriptions, and administering immunizations. Overall, respondents' attitudes toward most of the activities were above the scale midpoint 2.50, with notable exceptions for administering immunizations and entering prescription data remotely from home. These were activities in which the participants were less involved, along with transferring prescriptions to another pharmacy, accepting verbal prescription orders, and assuming responsibility

Table 1
Descriptive characteristics of study respondents.

Characteristic	n (%) or mean
Employment status	
Currently working as a pharmacy technician	494 (80.7%)
Enrolled in a pharmacy school, but also employed as a technician	23 (3.8%)
Employed in some capacity other than a pharmacy technician	55 (9.0%)
Unemployed (seeking employment)	22 (3.6%)
Unemployed (not seeking employment)	14 (2.3%)
Retired	4 (0.7%)
Work hours	
Full-time	336 (71.5%)
Part-time	134 (28.5%)
State of residence	
Florida	159 (33.8%)
Louisiana	27 (5.7%)
Maine	18 (3.8%)
Nebraska	43 (9.1%)
New Jersey	85 (18.1%)
North Dakota	10 (2.1%)
Oregon	60 (12.8%)
Utah	48 (10.2%)
Other	20 (4.3%)
Position	
Entry-level technician	158 (33.6%)
Advanced tier technician (as per my employer, eg, "Tech II")	123 (26.2%)
Highest tier technician (as per my employer, eg, "Tech III")	110 (23.4%)
Specialty technician	79 (16.8%)
Gender	
Female	171 (79.9%)
Male	43 (20.1%)
Work Setting	
Community pharmacy large organization (eg, chain, discount, mass merchandiser, grocery store pharmacy)	256 (54.5%)
Community pharmacy small organization (eg, independently owned, 5 or fewer stores under same ownership)	62 (13.2%)
Hospital or other inpatient facility	77 (16.4%)
Nursing home/long-term care	19 (4.0%)
Home health care	5 (1.1%)
Mail order pharmacy	10 (2.1%)
Other	41 (8.7%)
Employer Commitment	
I would have left or am looking to leave at the first opportunity	15 (2.5%)
I do not feel much commitment, and keep my options open	25 (4.1%)
I feel modest commitment and do no plan significant changes unless something unexpected happens	101 (16.5%)
I feel strong commitment to the organization and am planning my career/work future with them for the long haul	100 (16.3%)
Profession Commitment	
I am looking or plan to leave this career, altogether	28 (11.6%)
I do not have other plans currently, but it might not take much For me to change careers	42 (17.4%)
In spite of challenges or shortcomings, I feel good about this line of work and hope to make a career of it for quite some time	70 (29.0%)
I feel completely committed and am definitely in this career for my entire work life	101 (41.9%)
Number of years worked as a pharmacy technician	8.15 ± 8.07
Number of years worked for current employer	5.64 ± 6.01

for disaster preparedness. Activities involvement with high standard deviations included repackaging non-sterile products, maintaining equipment, and assisting with prescription assistance program for patients; this would be indicative of consistency in either high or very low levels of involvement for these activities. Those with lower standard deviations included administering immunizations, entering data remotely from home, assessing prescription for completeness, and identifying problems with a prescription, indicative of those tasks being performed at either a consistently low or consistently high level among the respondents. With respect to self-efficacies, overall, on 36 items (tasks/activities), with a potential range of self-efficacy scores of 36–360 (10-point scale), the lowest response total was 84 and the highest was 360, with an overall mean of 251.95 ± 19.99, well above the scale's midpoint of 198. Female respondents from community practice reported an overall self-efficacy of 258.71 ± 24.71, versus that of 247.62 for males ($t = 2.74$, $p < 0.05$). Those working full-time reported an overall self-efficacy of 261.33 ± 47, versus 240.24 for those working part-time ($t = 2.92$, $p < 0.05$). Respondents with a rank of Technician II and III reported self-efficacies of 268.51 ± 22.37 and 270.12 ± 28.21, respectively, versus a mean self-efficacy of 239.14 ± 21.84 for those with a Technician I rank ($F = 5.02$, $p < 0.01$).

3.3. Hospital pharmacy technician self-efficacies

Table 3 provides the list of tasks/activities investigated for hospital pharmacy technicians, the respondents' level of involvement, their attitude about those tasks/activities, and their level of self-efficacy in performing them. The level of involvement in the various tasks/activities for hospital pharmacy technicians was more disparate between the tasks than was the case for community pharmacy technicians. Participants reported high levels of involvement around replenishing dose carts, ensuring proper storage of medication, assisting with medication distribution, and maintaining automated dispensing technology. They reported low levels of involvement in many of the activities, including oversight of medical assistance programs, preparation of clinical monitoring information, administering immunizations, providing information to patients, and collaborating with other health professionals to evaluate the effectiveness of medication therapy. In spite of low levels of current involvement, respondents reported rather positive attitudes about the performance of most of the tasks, in general, with exceptions being preparation of clinical monitoring information, updating medication administration records, assisting with transitions of care, and administering immunizations. Activities with relatively positive attitudes wherein respondents were only moderately involved included purchasing and inventory management, controlled substances systems management, supervising, and checking the work of other technicians. On the other hand, attitude toward assistance with medication distribution was only modest, in spite of a relatively high level of involvement in that activity. Activities involvement with higher standard deviations included maintaining files of habit-forming drugs, evaluating labels and packaging of drugs, checking the work of other technicians, assuming responsibility for quality assurance activities, and following up on medication distribution problems. Those with lower standard deviations included entering prescription orders, oversight of medication assistance programs, preparation of clinical monitoring information, assisting with hiring other technicians, and running medication utilization reports, all of which saw respondents involved rather consistently at a low level. With respect to self-efficacies, overall, on 36 items (tasks/activities), with a potential range of self-efficacy scores of 36–360 (10-point scale), the lowest response total was 71 and the highest was 360, with an overall mean of 242.22 ± 24.56, still above the scale's midpoint of 198. Males reported an overall self-efficacy of 249.35 ± 36.82 versus that of 239.82 ± 25.11 for females ($t = 2.11$, $p < 0.05$). Respondents with a rank of Technician II and Technician III reported self-efficacies of 259.12 ± 29.19 and 257.38 ± 28.94, respectively, versus those with a rank of Technician I reporting a mean self-efficacy of 233.76 ($F = 4.81$, $p < 0.01$).

Table 2
Hospital pharmacy technician involvement in, attitude toward, and self-efficacy for performing various tasks.[a]

Task/Activity	Involvement[b]	Attitude[b]	Self-efficacy[c]
Enter prescription orders in computer	1.38 ± 0.85	2.30 ± 0.84	6.17 ± 3.89
Replenish dose carts and floor stock	3.26 ± 1.14	2.86 ± 0.44	9.17 ± 2.32
Maintain automated dispensing technology	3.07 ± 1.20	2.73 ± 0.58	8.60 ± 2.74
Help to maintain pharmacy equipment	2.98 ± 1.14	2.87 ± 0.35	8.30 ± 2.51
Compound sterile products	2.79 ± 1.28	2.80 ± 0.55	8.07 ± 3.06
Compound non-sterile products	2.63 ± 1.16	2.67 ± 0.66	8.07 ± 2.84
Perform packaging/repackaging activities	2.88 ± 1.14	2.52 ± 0.74	8.10 ± 3.03
Purchasing and inventory management	2.40 ± 1.21	2.77 ± 0.57	6.90 ± 3.55
Communicate with wholesale suppliers and vendors	1.74 ± 1.04	2.40 ± 0.77	5.27 ± 2.77
Oversee activities related to medication assistance programs	1.36 ± 0.73	2.10 ± 0.76	3.67 ± 3.18
Controlled substances system management	2.56 ± 1.22	2.77 ± 0.50	7.50 ± 3.16
Billing and other accounting functions	2.00 ± 1.29	2.48 ± 0.79	5.10 ± 3.39
Engage in continuous professional development	2.84 ± 1.07	2.57 ± 0.63	7.38 ± 2.84
Check the work of other technicians (check-tech-check)	1.98 ± 1.26	2.53 ± 0.73	7.60 ± 3.24
Supervise other technicians	1.79 ± 1.03	2.41 ± 0.83	7.10 ± 3.59
Encourage professional development of other technicians	2.14 ± 1.08	2.52 ± 0.74	7.27 ± 3.11
Assist with hiring other technicians	1.62 ± 0.91	2.37 ± 0.81	6.87 ± 3.36
Determine future staffing needs	1.67 ± 1.02	2.28 ± 0.92	6.13 ± 3.62
Reconcile errors or other issues with medication administration records	1.95 ± 1.13	2.43 ± 0.77	5.53 ± 3.71
Update medication administration record or patient's profile	1.69 ± 1.05	2.20 ± 0.93	4.47 ± 3.40
Preparation of clinical monitoring information for pharmacist review	1.31 ± 0.72	1.97 ± 0.93	3.67 ± 3.37
Assist with or facilitate patient transitions of care	1.55 ± 1.00	2.20 ± 0.85	4.73 ± 3.78
Run medication utilization reports	2.05 ± 0.92	2.33 ± 0.84	5.83 ± 3.86
Assist with distribution of medications throughout facility	3.05 ± 1.20	2.70 ± 0.65	7.80 ± 3.41
Follow-up on medication distribution issues or problems	2.63 ± 1.27	2.63 ± 0.72	7.40 ± 3.56
Communicate with nurses and other professionals regarding patient therapy	2.07 ± 1.17	2.37 ± 0.81	5.50 ± 3.70
Ensure proper storage of medications	3.30 ± 0.96	2.77 ± 0.57	8.87 ± 2.27
Participate in protocol or guideline adherence monitoring activities	2.27 ± 1.25	2.23 ± 0.86	5.47 ± 3.56
Communication medication storage issues with nurses	2.81 ± 1.22	2.57 ± 0.68	8.00 ± 2.78
Assume responsibility for quality assurance activities	2.28 ± 1.28	2.23 ± 0.86	6.24 ± 3.44
Participate in disaster preparedness activities	2.16 ± 1.19	2.33 ± 0.80	6.37 ± 3.31
Provide information to patients on drug interactions, side effects, and medication storage	1.48 ± 0.92	2.38 ± 0.86	4.90 ± 3.63
Collaborate with other health professionals to plan, monitor, review and evaluate the effectiveness of medication therapy	1.64 ± 0.98	2.24 ± 0.87	4.79 ± 3.44
Maintain files of narcotics and habit-forming drugs in accordance with legal requirements	2.02 ± 1.28	2.48 ± 0.83	6.21 ± 3.45
Evaluate labels, packaging and advertising of drug products	2.24 ± 1.25	2.25 ± 0.84	6.52 ± 3.58
Administer immunizations	1.10 ± 0.37	1.87 ± 0.90	3.41 ± 3.08

[a] Possible respondents (N) = 77. Actual number of respondents ranged from 68 to 75 on various questions.
[b] 4-point scale anchored from less (1) to more (4) involved or more positive.
[c] 10-point scale.

4. Discussion

To the authors' best knowledge, this is the first study to closely examine the self-efficacy beliefs of pharmacy technicians. The salience of self-efficacy beliefs has been underscored in pharmacists, for example, by their ability to communicate effectively with patients, particularly those of varied backgrounds[32] and other vulnerable populations like those at-risk of or currently engaging in substance abuse.[33] In fact, pharmacist self-efficacy was paramount in determining their readiness for embracing new practice roles, such as ameliorating the deleterious outcomes of illicit drug dependence.[34] Lack of self-efficacy has been cited as a major impediment to implementation of pharmaceutical care[35] and suggested to be a critical factor in the training of pharmacists for designing interventions.[36] The salience of self-efficacy in care delivery is also well reported outside of pharmacy.[37,38]

The continued transition of pharmacy to a more patient-centered philosophy of practice hinges upon the readiness and competence of pharmacists and their support personnel. Technicians play key roles in pharmacy care all throughout the world,[21] and initial evidence would suggest they are vital in helping to ensure patient safety, all the while promoting efficiency in pharmacy operations.[39] Logically, then, an evaluation of technicians' self-efficacy and preparedness to engage in current and emerging roles is critical.

When evaluating technicians' roles, respondents from this study in community pharmacy reported relatively high levels of involvement, self-efficacy in, and positive attitudes toward a large number of tasks, many of which revolved around prescription receipt and dispensing processes. Still, there were a number of activities for which they reported positive attitudes and self-efficacies but were only marginally or moderately involved. These are activities for the most part that are legal for practice, with some exceptions in certain states. Technicians would like to be involved in supervisory activities and with participating not only in their own professional development, but in assisting their peers with doing so, and this can be taken as a sign of maturation of the profession.[40,41]

For hospital pharmacy technicians, level of involvement in activities was more diffuse, which might owe to technicians in that setting being more specialized and the tasks involved around medication preparation and dissemination being more compartmentalized. Still, it would appear as though opportunities exist for furthering their involvement in a variety of areas, particularly where attitudes and self-efficacy are high. Of course, some of these areas require more experience and arguably some degree of clinical judgment, depending upon how that task is configured, and there might be a number of barriers and rationale why hospitals would not want to deploy certain technicians, particularly more junior ones, in activities requiring at least some level of clinical

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Table 3
Community pharmacy technician involvement in, attitude toward, and self-efficacy for performing various tasks.[a]

Task/Activity	Involvement[b]	Attitude[b]	Self-efficacy[c]
Collect or communicate patient information	3.57 ± 0.83	2.91 ± 0.29	8.95 ± 1.81
Assess prescription for completeness, accuracy, authenticity, and legality	3.63 ± 0.72	2.95 ± 0.26	8.95 ± 1.58
Input prescriptions into computer	3.44 ± 0.98	2.84 ± 0.46	8.73 ± 2.20
Provide prescription to patient	3.41 ± 1.02	2.72 ± 0.60	8.93 ± 2.35
Triage patient needs for referral to pharmacist	3.10 ± 1.14	2.68 ± 0.63	8.20 ± 2.77
Identify any problems with prescription (eg, dosage, patient instructions, missing information, medication name, other)	3.33 ± 0.88	2.89 ± 0.36	8.71 ± 1.72
Discuss over-the-counter medication options with patients	2.21 ± 1.13	2.38 ± 0.72	6.55 ± 3.11
Repackage or reconstitute non-sterile products	2.62 ± 1.30	2.56 ± 0.72	7.61 ± 3.35
Compound prescriptions	1.76 ± 1.03	2.30 ± 0.82	5.76 ± 3.74
Inventory management	3.04 ± 1.09	2.73 ± 0.54	8.31 ± 2.45
Manage medications currently in stock, including organization, storage, and stock rotation	3.38 ± 0.97	2.78 ± 0.52	8.87 ± 2.17
Maintain automated dispensing technology and other equipment	2.37 ± 1.26	2.38 ± 0.82	6.52 ± 3.52
Communicate with insurance companies regarding patient eligibility and other issues	3.09 ± 1.15	2.71 ± 0.55	7.86 ± 2.97
Explain use of medical equipment, appliances, or other devices to the patient	1.91 ± 1.00	2.34 ± 0.74	5.84 ± 3.19
Communicate lifestyle changes to patients	1.70 ± 1.06	2.23 ± 0.84	5.04 ± 3.61
Engage in your own continuous professional development	3.07 ± 0.98	2.70 ± 0.58	8.18 ± 2.48
Supervise other technicians	2.24 ± 1.27	2.34 ± 0.83	6.91 ± 3.33
Discuss effectiveness of treatment plan for returning patients	1.72 ± 1.12	2.23 ± 0.88	4.96 ± 3.77
Accounting and record-keeping	2.55 ± 1.22	2.50 ± 0.73	7.14 ± 3.20
Disposal of expired or adulterated medications	2.90 ± 1.12	2.71 ± 0.60	8.16 ± 2.56
Assist with prescription assistance programs	2.23 ± 1.28	2.33 ± 0.79	6.28 ± 3.67
Assume responsibility for quality assurance activities	2.44 ± 1.26	2.50 ± 0.73	6.70 ± 3.27
Assume responsibility for disaster preparedness	1.79 ± 1.13	2.20 ± 0.83	5.57 ± 3.54
Receive prescriptions from medical doctors or other prescribers	2.29 ± 1.35	2.48 ± 0.78	6.79 ± 3.55
Check patients' medication histories	3.07 ± 1.05	2.67 ± 0.59	8.05 ± 2.68
Ensure proper dosage and drug compatibility before dispensing	2.71 ± 1.24	2.63 ± 0.69	7.07 ± 3.33
Label liquid medicines, ointments, powders, and other medicines before dispensing	3.48 ± 0.96	2.81 ± 0.51	8.80 ± 2.21
Provide information to providers and patients on drug interactions, side effects, and medication storage	2.08 ± 1.22	2.47 ± 0.79	6.07 ± 3.50
Collaborate with other health professionals to plan, monitor, review and evaluate the effectiveness of medication therapy	1.61 ± 1.03	2.23 ± 0.87	4.91 ± 3.71
Maintain prescription files of narcotics and habit-forming drugs in accordance with legal requirements	2.76 ± 1.22	2.66 ± 0.65	7.79 ± 2.90
Evaluate labels, packaging, and advertising of drug products	2.28 ± 1.24	2.24 ± 0.79	6.23 ± 3.53
Administer immunizations	1.17 ± 0.65	2.03 ± 0.95	3.91 ± 3.69
Accept verbal prescription orders from a physician or other prescriber	1.45 ± 0.92	2.23 ± 0.90	5.32 ± 3.83
Transfer a prescription from on pharmacy to another	1.63 ± 1.09	2.23 ± 0.90	5.66 ± 3.86
Check the work of other technicians (check-tech-check)	2.51 ± 1.23	2.50 ± 0.73	7.51 ± 3.17
Enter prescription data remotely from home	1.23 ± 0.70	1.91 ± 0.93	5.10 ± 4.06

[a] Possible respondents (N) = 312. Actual number of respondents ranged from 290 to 302 on various questions.
[b] 4-point scale anchored from less (1) to more (4) involved or more positive.
[c] 10-point scale.

knowledge. Technicians' involvement in some activities, such as communication with nurses, is almost unavoidable or inherent to the job; thus, the fact that self-efficacies are only low to moderate for these activities should provide insight for employing institutions, vocational training programs, and even credentialing (eg, certification) organizations for future educational and development endeavors.

These findings coincide with calls for re-examining and further leveraging the maturing of technician education and professionalization, including the potential for work redesign so that pharmacy could reach its full potential.[42,43] It also reinforces the need for use of sound pedagogy when educating technicians on emerging roles such as providing immunizations to ensure that trainees are not only provided basic concepts, but are also instilled with the confidence that they can contribute effectively to the goals of the pharmacy organization, regardless of practice setting. These findings also support the most recent calls for standardizing education requirements for technicians, advocating for their certification, and more careful planning by employers to promote efficiency in pharmacy operations while at the same time helping technician practice to become a career choice rather than just a job.[2]

There were differences in self-efficacies reported among various groups. Females in community practice reported higher self-efficacy, while the opposite was true in hospital practice. This could possibly be owing to females having reported greater caring behaviors when dealing directly with patients,[44] but the study design here precludes definitive conclusions in that regard. Respondents working full-time in community pharmacy reported higher self-efficacy than part-time workers in community, but not hospital settings. Again, greater experience in a more customer- or patient-oriented practice could be implicated in this finding, and this has ramifications for job training and evaluation of part-timers. Those with higher “rank” or designations (eg, Tech II or Tech III) reported much higher self-efficacies than entry-level technicians in both settings. This might suggest that employers' job promotion efforts have been successful, and might provide evidence for even more ubiquitous career-laddering mechanisms for technicians.[45]

The relationship between technician commitment and self-efficacy merits some attention. While there was little association with employer commitment, there was a significant relationship self-efficacy and career commitment, at least among respondents in community practice. A similar link between self-efficacy, career commitment, and work engagement has been reported for nurses.[46] It also has been reported that nurses demonstrated greater resilience after untoward job events when they possess higher levels of job self-efficacy.[46] Additionally, nursing assistants with higher self-efficacy were able to overcome difficulties in practice and were even able to reshape their practice

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environments.[47] This finding likewise further evidences the need for leaders and educators to bolster self-efficacy among pharmacy technicians during early training and perhaps reinforcement of such throughout their careers during development and even re-certification or re-validation initiatives.

4.1. Study limitations

This study has several limitations that warrant caution when interpreting the results. The response rate, even while favorable when compared to similar survey research endeavors,[48] is low enough so that any number of response biases could be manifest. This could include responses more likely acquired from those more highly engaged in the profession and from those very unsatisfied with their working conditions. With survey research of this sort, the prospect of respondents providing socially desirable responses cannot be precluded. Also, some caution and consideration is merited when examining the range and mean of responses around "attitude" toward certain activities. For some specialized activities, such as providing immunizations and assistance with monitoring drug therapy, the respondent would likely be either involved or not at all involved in such activities. As such, their attitude could be based upon a relative lack of knowledge for such an activity. The responses came predominately from 8 states in the U.S. randomly sampled and from which the scopes of practice might vary to some degree, but none of which are known in recent history for any groundbreaking scope of practice changes for technicians.

5. Conclusion

This study evaluated the self-efficacies of pharmacy technicians in community and hospital practice across a broad range of current and evolving job tasks/activities. Self-efficacies were generally high, especially for the tasks centered around medication order/prescription receipt, preparation, and dissemination. There are a number of activities for which technicians reported very positive attitudes and at least modest self-efficacy, which might be instructive for their greater involvement in these areas. At the same time, there were areas reported wherein technicians can be afforded more education and training. Association of self-efficacies with other work-related facets such as commitment, further evidence the potential benefit of career planning, laddering, and professional development for these important members of the workforce.

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Expanded pharmacy technician roles: Accepting verbal prescriptions and communicating prescription transfers

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Scope of practice

ABSTRACT

As the role of the clinical pharmacist continues to develop and advance, it is critical to ensure pharmacists can operate in a practice environment and workflow that supports the full deployment of their clinical skills. When pharmacy technician roles are optimized, patient safety can be enhanced and pharmacists may dedicate more time to advanced clinical services. Currently, 17 states allow technicians to accept verbal prescriptions called in by a prescriber or prescriber's agent, or transfer a prescription order from one pharmacy to another. States that allow these activities generally put few legal limitations on them, and instead defer to the professional judgment of the supervising pharmacist whether to delegate these tasks or not. These activities were more likely to be seen in states that require technicians to be registered and certified, and in states that have accountability mechanisms (e.g., discipline authority) in place for technicians. There is little evidence to suggest these tasks cannot be performed safely and accurately by appropriately trained technicians, and the track record of success with these tasks spans four decades in some states. Pharmacists can adopt strong practice policies and procedures to mitigate the risk of harm from verbal orders, such as instituting read-back/spell-back techniques, or requiring the indication for each phoned-in medication, among other strategies. Pharmacists may also exercise discretion in deciding to whom to delegate these tasks. As the legal environment becomes more permissive, we foresee investment in more robust education and training of technicians to cover these activities. Thus, with the adoption of robust practice policies and procedures, delegation of verbal orders and prescription transfers can be safe and effective, remove undue stress on pharmacists, and potentially free up pharmacist time for higher-order clinical care.

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1. Background

As the role of the clinical pharmacist continues to develop and advance, it is critical to ensure pharmacists can operate in a practice environment and workflow that supports the full deployment of their clinical skills. As it stands, pharmacists report high levels of job stress and professional dissatisfaction.[1] In a national survey, pharmacists reported the top stress events they face are “having so much work to do that everything cannot be done well” and “not being staffed with an adequate number of technicians.”[1]

Implicit in these responses is the critical role that appropriately trained pharmacy technicians can play in reducing workload and stresses faced by pharmacists. When technician roles are optimized, patient safety can be enhanced and pharmacists may dedicate more time to advanced clinical services. When technician roles are unnecessarily restricted, there is poor division of labor amongst the pharmacy team and pharmacists spend a substantial fraction of time devoted to non-clinical activities.[2,3] The legally permitted roles and responsibilities of pharmacy technicians varies greatly country to country and across state lines in the Untied States (U.S.).[4] In some respects, the U.S. lags behind other developed nations in the full deployment of the technician workforce. In Denmark, for example, “pharmaconomists” perform the final medication check, answer medication queries, and screen for allergies, among other tasks.[5]

A commonly reported reason for the lack of full deployment of the pharmacy technician workforce is the great variability in their education and training.[6,7] Less reported is the reciprocal: the variability in legally permissible roles and responsibilities of technicians may suppress investment in more robust education and

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training. For example, why would a technician or employer invest time and money in a skill that is legally prohibited from performing in practice? Similarly, why would a technician training program integrate the teaching of such a skill into its curriculum? This chicken-or-egg scenario leads to robust debates about what the appropriate order of operations should be in terms of expanding technician roles. We personally believe the legal framework for pharmacist delegation should be more permissive than precautionary, and the onus should be on the supervising pharmacist to determine what tasks are appropriate to delegate and to whom. Such a permissive framework can spur investment in education and training that is valued by the individual or the employer.[8]

In that respect, an area in which some have suggested pharmacy technicians could play an increased role relates to a commonly rated pharmacist stressor: being interrupted by phone calls while performing other job duties.[9] Forty percent of chain pharmacists rated this as a high stress event.[1] Phone calls – like other sources of interruptions and distractions – can divert attention from other activities. Nursing literature has estimated that every interruption can increase the chance of medication error by 12.7%.[10–12] Two common sources of phone calls that interrupt pharmacy workflow are: 1) verbal prescriptions called in by a prescriber or prescriber's agent; and 2) requests to transfer a prescription order from one pharmacy to another. The National Association of Boards of Pharmacy (NABP) Model State Pharmacy Act and Model Rules recommends allowing certified technicians – but not technician trainees – to transfer prescriptions.[13] The Model Act expressly recommends prohibiting technician trainees from receiving new oral prescriptions, but it is silent on this task for certified technicians, implying assent.[13]

Allowing technicians to receive and handle these phone calls may serve to reduce interruptions on pharmacists, potentially increasing time for other clinical activities or reducing errors that stem from distractions. Verbal orders such as receiving prescriptions or transferring prescriptions, however, have the potential to be misunderstood or misheard, creating an error cascade that is difficult for the pharmacist to catch during drug utilization review. If handled by individuals who are less familiar with medications than pharmacists or interns, verbal orders *may* have the potential to introduce new errors into the dispensing process.

The purpose of this manuscript is to describe the potential role for technicians in receiving verbal prescriptions and performing prescription transfers, describe the legal and practice safeguards that may be placed on these activities, and review the existing evidence of the safety of technicians performing these roles. This information will be used as a framework to make recommendations regarding future applications of these tasks.

2. Overview of verbal prescriptions and transferred prescriptions

Verbal communication is one means by which a licensed prescriber may transmit a valid prescription drug order to a pharmacy. Alternatively the prescriber may issue an original signed and written prescription, electronically route it, or fax it to the pharmacy. For a verbal prescription drug order, the prescriber or prescriber's agent must communicate all the information required of a valid prescription drug order except for the signature of the prescriber. Verbal prescriptions may be synchronous or asynchronous (e.g., left as a voicemail). The pharmacist receiving the verbal prescription must promptly reduce it to writing and may process the prescription as any other. Federal law prohibits verbal prescriptions for Schedule II substances, except in rare emergency situations.[14] Unless a state's law is more stringent, federal law permits a verbal prescription as a valid means of ordering a Schedule III through V controlled substance or any non-controlled medication. Extralegal forces are also in play. For example, the Joint Commission accreditation standards prohibit the use of verbal orders for chemotherapy.[15] Various groups recommend reserving the use of verbal orders to only true emergency situations.[16] Still, many verbal orders are called in for prescriber or patient convenience, though their use has certainly declined with the increased rates of electronic prescribing. For example, one study found a decrease in verbal orders from 22% to 10% of total orders in the 21 months following implementation of an electronic order entry system.[17]

A prescription may be transferred from one pharmacy to another up to the maximum refills permitted by the issuing prescriber. There are many reasons why a patient may want to transfer a prescription to a different pharmacy, including convenience. Federal law limits the transferring of a controlled substance to a single, one-time transfer.[12] The transferring pharmacist and the receiving pharmacist must record and document certain pieces on information, and the transferring pharmacist must void the original prescription either on the hard copy or in the electronic record so as not to inadvertently dispense more prescriptions than authorized by the prescriber. Functionally, the act of receiving a transferred prescription is very similar to receiving a new verbal prescription.

3. U.S. state law environmental scan

Currently, 17 U.S. states allow technicians to receive verbal prescriptions in community or institutional settings, and/or transfer prescriptions orders in community or institutional settings (Table 1).[18] Ten states allow technicians to perform both of these tasks, five states allow only the receipt of verbal prescriptions, and two states allow only the transferring of prescription orders between pharmacies.[18]

States that allow the receipt of verbal prescriptions and/or transferring of prescription orders were compared to states that do not allow these tasks on certain variables. States that allow these tasks are more likely than states that do not allow these tasks to require either licensure or registration of technicians (88.2% vs. 83.3%, respectively), and are more likely to require that technicians obtain national certification (47.1% vs. 38.9%, respectively). Similarly, states that allow these tasks are more likely than states that do not allow these tasks to have the ability to hold technicians accountable, such as restricting, suspending, or revoking their license (47.1% vs. 33.3%, respectively). Lastly, states that allow these tasks were more likely than states that do not allow these tasks to have all three of these variables present (registration/licensure, certification, accountability capability). Specifically, 47.1% states have all three of these variables allow technicians to take verbal prescriptions and/or transfer prescriptions, compared to 33.3% of the states that do not.[18] The presence of these variables may instill more confidence in the technician workforce that make the delegation of a wider variety of practice activities acceptable, and thus may represent the critical building blocks of expanded technician roles.

We reviewed the state statutes and regulations that permit verbal prescriptions in the aforementioned states. States generally were not too prescriptive in terms of adding legal limitations to when and how this task may be carried out. A few states limited this task to only certified technicians, not trainees. Louisiana was the only state that required the supervising pharmacist to review and initial an oral prescription prior to moving forward with prescription processing; all remaining states allowed the technician to begin data entry, with the pharmacist's review occurring at the traditional drug utilization review step.[19] Wisconsin's law was the most circumscribed in that it permits the acceptance of an oral prescription only if the conversation is recorded, and the

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Table 1
Review of state laws.

State	Allow technicians to accept verbal prescriptions	Allow technicians to transfer prescriptions
Arizona		X
Illinois	X	
Iowa	X	
Louisiana	X	X
Massachusetts	X	X
Michigan	X	X
Missouri	X	X
New Hampshire	X	
North Carolina	X	X
North Dakota	X	X
Puerto Rico	X	X
Rhode Island	X	X
South Carolina	X	X
Tennessee	X	X
Utah	X	
Wisconsin	X	
Wyoming		X

pharmacist "listens to and verifies that transcription prior to dispensing" which likely significantly limits use.[20]

With respect to transferring prescription orders, states also tended to be permissive in statutes and regulations and leave the restrictions to the judgment of the supervising pharmacist. The most common limitation found in law was carving out controlled substances from the prescriptions that technicians could legally transfer between stores. A few states allowed a technician to transfer a prescription as long as the recipient on the other end of the phone was a pharmacist. Arizona had the most narrowly focused law, allowing technicians to perform only an *electronic* transfer between pharmacies owned by the same company and using a common or shared database.[21] Thus, Arizona technicians are not permitted to verbally communicate a transfer between competitor pharmacies.

4. Existing evidence base with respect to patient safety

In a systematic review on verbal orders, Wakefield et al. found this topic has not been studied in depth and the extant literature is generally anecdotal.[22] Paradoxically, Wakefield et al. noted the lone study connecting verbal orders to safety found verbal orders actually decreased the risk of error compared to handwritten orders by a factor of four![22,23] We found the paucity of available data to be true in the context of technician acceptance of verbal prescriptions and transferring prescription orders. The identified literature on pharmacy technicians accepting verbal prescriptions was limited to a single study by Friesner and Scott which documents uptake and not commenting on safety or effectiveness; no articles were identified on technicians transferring prescription orders.

Friesner and Scott conducted a survey of technicians registered to practice in North Dakota, a state that allows technicians to accept verbal prescriptions.[24] Surveys were mailed to all 456 technicians in the state, and 192 (42.1%) responded in full. Respondents were queried on the extent to which they performed certain tasks, one of which was "taking new prescriptions over the telephone." Overall, 63% of technician respondents reported taking new verbal prescriptions. Technicians working in community independent pharmacies were much more likely to perform this task that those in inpatient hospitals or large chain community pharmacies. In addition, technicians working in towns with less than 2000 people were much more likely to perform this task than those working in towns with larger populations. This study was limited in that it did not assess the frequency with which technicians performed this task, and it did not provide any information on the safety – or perceived safety – of technicians perform this task.[24]

Two case studies were identified related to verbal orders were identified. In Iowa, a pharmacy technician used the verbal prescription route to create forged prescriptions for hydrocodone/acetaminophen.[25] In Missouri, a technician misheard a prescription for metolazone 2.5 mg daily as methotrexate 2.5 mg daily, a case in which the patient involved died.[26] The prescription was one of eleven that were called into the pharmacy at one time. A state court delivered a $2 million award against the pharmacy in a negligence suit.[26]

Perhaps the most interesting finding of our attempted review of evidence was what was not found. Despite 17 states allowing these activities, some for up to four decades, and apparently high uptake of this activity in practice – 63% of technicians in the Friesner and Scott study – we did not find any published studies documenting that these activities lead to widespread safety issues. Of the two cases identified, cases similar to that in Iowa are rendered moot with the reclassification of hydrocodone as a Schedule II substance which can now only be called in emergency situations; while a technician could use the verbal route to forge other controlled substances, this is not exclusive to technicians and can and does unfortunately occur with pharmacists as well. Improvements in state prescription drug monitoring programs can mitigate the risk of this scenario occurring. The Iowa technician had her registration revoked, received a fine, and the board order further suggests that a criminal complaint was filed.[25]

The case identified in Missouri is tragic and highlights the consequences that can occur in pharmacy practice.[26] The mix-up of metolazone and methotrexate is serious. Methotrexate is, however, typically dosed weekly whereas metolazone is typically dosed daily. That such an error could or should have been caught by the pharmacist in the drug utilization review stage may cause some to question the extent to which this error is attributable to the technician receiving the verbal order or the pharmacist who reviewed it for clinical appropriateness.

5. Implications for safety: the role of policies and procedures

Wakefield et al. reviewed common sources of error in the verbal order process.[22] Errors could occur on the communicator's end (e.g., misspeaking, confusing patient data, using unapproved communication), or on the receiver's end (e.g., misunderstood sound-alike medications, transcription error, failure to seek clarification, etc.).[22] Certainly familiarity with common medications, doses, and uses can mitigate some of the risk on the receiver's end. Pharmacy technicians are increasingly gaining experience with this. For example, studies have recently demonstrated technicians perform accurately at medication reconciliation, often outperforming other health professionals including nurses at this activity.[27–30] There is undoubtedly transferability of skill set from taking an accurate medication history and accepting a verbal prescription as the former necessitates probing to identify current and past medication names, strength, dosage form, allergies, and other related pieces of information. Practices that have leveraged technicians in medication history roles may be able to use similar training components for these new tasks.

In addition, there are practice policies and procedures that may be adopted to mitigate the potential for harm. Entities such as the Institute for Safe Medication Practice (ISMP) recommend using a prescription pad that prompts the receiver to ask for key pieces of information.[31–33] Pharmacies may also institute a read-back

technique in which the receiver reads back the order to ensure it was heard accurately, which can include a spelling back of the medication name itself. ISMP goes so far as saying that the read-back technique should be a standard of practice in every setting regardless of who is receiving the verbal order.[16] The receiver may also consider documenting the indication for the medication; this could prevent a metolazone vs. methotrexate mix-up by providing the pharmacist one additional piece of information at the drug utilization review stage that may help ward off errors.[32] Pharmacies may also prohibit the use of new or unapproved abbreviations, and confirm doses by reading back the individual digits (e.g., "60 mg: six, zero milligrams").[33]

One issue that remains is the ability of technicians to seek clarification as appropriate in an instance in which the medication that is being called in is not for an appropriate dose, or in the event of a contradiction, among other patient safety issues. Given that most verbal prescriptions are now called in by an agent of the prescriber, clinical conflict resolution is unlikely to occur in real time. If the pharmacist has the right information to catch these issues at the drug utilization review stage, resolution is likely to occur within the same general time duration as if a probing question was asked up front by the pharmacist receiving the verbal order.

6. Conclusion and future direction

Currently 17 states allow technicians to accept verbal prescriptions and/or transfer prescription orders between pharmacies. States that allow these activities generally put few legal limitations on them, and instead defer to the professional judgment of the supervising pharmacist whether to delegate these tasks or not. These activities were more likely to be seen in states that require technicians to be registered and certified, and in states that have accountability mechanisms in place for technicians. Thus, these factors may be seen as critical first steps to enabling advanced pharmacy technician roles. Limiting certain expanded duties to certified technicians is consistent with the NABP Model Act.

As noted previously, the rate of verbal prescriptions has declined, and we envision this will continue as the rate of electronic prescribing continues to grow. Still, these interruptions will continue and creating opportunities to delegate these tasks to technicians will continue to represent an opportunity moving forward. While limited evidence is currently published on these tasks, there is little to suggest appropriately trained technicians cannot perform them safely and accurately, and the track record of success with these tasks spans four decades in some states. The law is, of course, just the minimum standard. Pharmacists are often required to go above and beyond what the law allows in order to provide optimal patient care, and pharmacists can adopt strong practice policies and procedures to mitigate the risk of harm from verbal orders. Such risk reduction strategies include instituting read-back, spell-back techniques, or requiring the indication for each phoned-in medication, among other risk reduction strategies. Pharmacists may also exercise discretion in deciding to whom to delegate these tasks. Pharmacists may be more comfortable with senior technicians who have more experience with medication names, or technicians who have previously conducted medication histories. In addition, extra-legal factors such as Joint Commission accreditation standards also provide checks and balances on the process.

As the legal environment becomes more permissive, we foresee investment in more robust education and training of technicians both in the mechanics of receiving a verbal prescription (e.g., simulated lab with environmental noise) and the understanding of common medication names and doses. Overall, with the adoption of robust practice policies and procedures, delegation of verbal orders and prescription transfers can be safe and effective, remove undue stress on pharmacists, and potentially free up pharmacist time for higher-order clinical care.

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Disclaimer

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