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## LESSONS FOR LEGISLATORS: A GUIDE TO ALLOWING PHARMACIST-PRESCRIBED BIRTH CONTROL

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### INTRODUCTION

As legislators on both sides of the aisle have looked for ways to address high healthcare costs and poor access to healthcare providers, they have discovered what the medical community has known for years: pharmacists are a largely untapped resource. Pharmacists have traditionally been blocked from providing some primary care duties that are well within their expertise due to state licensing restrictions. Yet, in recent years, pharmacists' scopes of practice have gradually expanded across the country—to varying degrees depending on the state—to include prescribing medications and managing patient medication regimens.<sup>1</sup>

1. Ashley Chiara, "The expanding role of pharmacists: a positive shift for health care," *Commonwealth Medicine*, March 26, 2019. <https://commed.umassmed.edu/blog/2019/03/26/expanding-role-pharmacists-positive-shift-health-care#:~:text=Having%20the%20ability%20to%20coordinate,in%20managing%20chronic%20health%20conditions>.

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One scope of practice reform measure in particular that has caught on in recent years is pharmacist-prescribed hormonal birth control. Allowing pharmacists to prescribe birth control is proving successful in increasing access, preventing unintended pregnancy and reducing public healthcare costs.<sup>2</sup> However, the details of each state's pharmacy access model, and how they are implemented, affects their ability to achieve broader access and lower costs. Currently, 16 states allow pharmacists to prescribe birth control; of these,

2. See, e.g., Lorinda Anderson et al., "Pharmacist Provision of Hormonal Contraception in the Oregon Medicaid Population," *Obstetrics and Gynecology* 133:6 (June 2019), pp. 1231-1237. <https://pubmed.ncbi.nlm.nih.gov/31135739/>; Maria I. Rodriguez et al., "Association of Pharmacist Prescription of Hormonal Contraception With Unintended Pregnancies and Medicaid Costs," *Obstetrics and Gynecology* 133:6 (June 2019), pp. 1238-1246. [https://journals.lww.com/greenjournal/Fulltext/2019/06000/Association\\_of\\_Pharmacist\\_Prescription\\_of\\_Hormonal.23.aspx](https://journals.lww.com/greenjournal/Fulltext/2019/06000/Association_of_Pharmacist_Prescription_of_Hormonal.23.aspx); Maria I. Rodriguez et al., "Association of Pharmacist Prescription With Dispensed Duration of Hormonal Contraception," *JAMA Network Open* 3:5 (May 20, 2020). <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766072>.

12 states have successfully passed legislation allowing it, but with differing experiences and bill details.

Now that several states have implemented this model, it is time to examine what works, what can be improved and how to achieve the desired outcome of better access. This paper will identify and discuss all the major components of a pharmacy access model for birth control—insurance/provider status, patient restrictions and type of practice model—as well as highlight the details of models in states that allow pharmacist-prescribing of birth control. Finally, it will provide the key takeaways for creating a pharmacy access model that optimally improves access.

## PHARMACISTS, PROVIDER STATUS AND INSURANCE REIMBURSEMENT

One of the primary components of the pharmacy access model is whether or not pharmacists are recognized as medical providers for insurance reimbursement purposes. Without provider status, pharmacists must require patients to pay for the consultation out of pocket, which discourages pharmacists from providing this service and patients from taking advantage of it.

Allowing pharmacists to prescribe birth control can increase access to contraception, but doing so requires that pharmacists be given full provider and prescriber status. At the state level, provider status is complex; while pharmacists are legally recognized as healthcare providers in 38 states, this status is not often found in every state regulation regarding providers and insurance. For example, states may list pharmacists as providers in the Medicaid code, but not elsewhere for private insurers.<sup>3</sup> Further, most states do not grant express reimbursement privileges, which is the main benefit from provider status. Essentially, while pharmacists can provide some services for patients, they cannot seek reimbursement through insurance programs for those services the way physicians and other advanced healthcare professionals can. Full provider status means that pharmacists are considered providers by law, ideally for both public and private insurance programs, so that they can bill for services. Otherwise, pharmacist participation is likely to suffer—without reimbursement for services provided, pharmacists have little incentive to provide additional services such as prescribing birth control.

States that allow pharmacists to prescribe birth control have handled provider status and insurance reimbursement in a variety of ways. For example, the Council of the District of Columbia included pharmacist authority for birth control prescriptions and insurance reimbursement for their servic-

es—for private insurers, Medicaid and the D.C. Health Alliance—all in the same bill.<sup>4</sup> West Virginia passed pharmacist-prescribing of birth control legislation in 2019, and passed an additional bill in 2020 that requires private insurers to cover pharmacist-provided services if these same services are covered when performed by existing providers.<sup>5</sup>

These variations in coverage are less than ideal, but are likely the result of political pressures. However, from a policy standpoint, requiring all insurers to provide pharmacist service reimbursement is the optimal strategy. This is not a costly measure for states; pharmacists charge less than physicians, meaning that identical services rendered from a pharmacist cost less to the insurer. For pharmacists prescribing birth control, the early cost savings results are promising. Research on the outcomes of Medicaid patients in Oregon seeing pharmacists for birth control prescriptions found that within the first two years of pharmacists prescribing the Oregon Medicaid program saved \$1.6 million due to increased prevention of unintended pregnancy.<sup>6</sup> Further, prior research on pharmacist intervention for certain conditions, like diabetes, has found significant healthcare cost savings associated with increased pharmacist guidance.<sup>7</sup> Table 1 shows how each state that currently allows the pharmacy access model handles medical provider status and insurance reimbursement for pharmacists prescribing.

3. Kristalyn K. Weaver, "More states address pharmacists' provider status recognition," *Pharmacy Today* 21:4 (April 2015), pp. 66-67. [https://www.pharmacytoday.org/article/S1042-0991\(15\)30395-9/fulltext](https://www.pharmacytoday.org/article/S1042-0991(15)30395-9/fulltext).

4. D.C. Act 22-246, Defending Access to Women's Health Care Services Amendment Act of 2018, Council of the District of Columbia, Jan. 31, 2018. [https://lms.dccouncil.us/downloads/LIMS/37359/Signed\\_Act/B22-0106-SignedAct.pdf](https://lms.dccouncil.us/downloads/LIMS/37359/Signed_Act/B22-0106-SignedAct.pdf).

5. H.B. 2583, A bill to amend the Code of West Virginia West Virginia Legislature, 1931, as amended, West Virginia Legislature 2019 Regular Session. [https://www.wvlegislature.gov/Bill\\_Status/bills\\_text.cfm?billdoc=hb2583%20intr.htm&vr=2019&sesstype=RS&i=2583](https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=hb2583%20intr.htm&vr=2019&sesstype=RS&i=2583); Richard Stevens, "Pharmacists Attain Provider Status," West Virginia Pharmacists Association, March 27, 2020. <http://wvpharmacy.org/2020/03/pharmacists-attain-provider-status>.

6. Rodriguez et al. [https://journals.lww.com/greenjournal/Fulltext/2019/06000/Association\\_of\\_Pharmacist\\_Prescription\\_of\\_Hormonal.23.aspx](https://journals.lww.com/greenjournal/Fulltext/2019/06000/Association_of_Pharmacist_Prescription_of_Hormonal.23.aspx).

7. Carole W. Cranor et al., "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program," *Journal of the American Pharmaceutical Association* 43:2, (March/April 2003), pp. 173-184. <https://www.aphafoundation.org/sites/default/files/ckeditor/files/TheAshevilleProject-Diabetes-JAPhA-2003-43-173-84.pdf>.

**TABLE I: INSURANCE REIMBURSEMENT STATUS BY STATE**

State	Insurance Reimbursement	Insurers Required to Comply
California	Yes	All
Colorado	Yes	Currently, reimbursement only required for pharmacist services provided in designated health professional shortage areas (HPSAs).
Hawaii	Yes	All
Idaho	No	None
Maryland	Yes	Medicaid
Michigan	Data forthcoming	Data forthcoming
Minnesota	Data forthcoming	Data forthcoming
Montana	Data Forthcoming	Data Forthcoming
New Hampshire	No	None
New Mexico	No	None
Oregon	Yes	All
Tennessee	No	None
Utah	No	None
Virginia	Yes; private.	Private
Washington	Yes	All except Medicaid Fee-for-service
Washington, D.C.	Yes	All
West Virginia	Yes	Private

Source: Data used to create this table is from “Pharmacist Prescribing of Hormonal Contraceptives,” Power to Decide, last accessed Sept. 15, 2020. <https://powertodecide.org/sites/default/files/2020-06/Pharmacist%20Prescribing.pdf>.<sup>8</sup>

### NON-EVIDENCE-BASED PATIENT RESTRICTIONS

Restrictions on which patients can see pharmacists for birth control prescriptions are another major component of a pharmacy access model. Pharmacists prescribing birth control are required to assess patients for contraindications to hormonal birth control, and if the patient has contraindications, deny a prescription and refer them to their primary physician. The essence of a pharmacist consultation for a birth control prescription is the same as a physician visit; however, some states impose additional restrictions on pharmacist-prescribed birth control that are not imposed on physicians. The two most common restrictions found in current pharmacy access models are age requirements and evidence of regular physician visits. These are medically unnecessary restrictions that hamper the very access that pharmacist-prescribed birth control is intended to provide.

#### Age

While the U.S. teen pregnancy rate is at a historic low, it is still the highest teen pregnancy rate among developed coun-

8. Note: Of the states marked “Data forthcoming,” Michigan and Montana pharmacies recently began taking advantage of CPAs that allow pharmacists to furnish hormonal contraception. Minnesota passed a law in May 2020 allowing the pharmacy access model, but the protocol has not yet been developed. The details on provider status and insurance reimbursement are still developing for these three states and were not available at time of publication.

tries.<sup>9</sup> Research has shown that contraceptive access affects these rates: first, the decline in U.S. teen pregnancy from 2007-2012 is largely attributed to better contraceptive access, and second, the higher rates of teen pregnancy for minorities coupled with minorities’ relative lack of access to birth control suggests that access is a primary factor in unwanted teen pregnancy.<sup>10</sup> Yet, of the states allowing pharmacists to initiate birth control prescriptions, several limit this practice to patients that are 18 or older. However, there is no medical basis for this age restriction; among all the contraindications to hormonal birth control identified in the U.S. medical eligibility criteria for contraceptive use from the Centers for Disease Control and Prevention (CDC), the only concern for adolescent use is a potential decrease in bone mineral density.<sup>11</sup> Otherwise, it has long been established that many contraindications become more likely with increasing age.<sup>12</sup>

### Evidence of Physician Visits

Some states also require that patients provide evidence of regular physician visits in order to take advantage of pharmacist-prescribed birth control. Typically, if a patient has not seen a primary care physician within a certain number of years, per the state’s law, she cannot get a birth control prescription from a pharmacist. Additionally, if she does receive a birth control prescription from a pharmacist, she must periodically provide evidence of a physician visit to continue receiving this service. While this is likely meant to encourage regular check-ups with physicians, it’s unclear how the intervals mandated in some states are directly applicable to hormonal birth control prescriptions. For example, the American College of Obstetricians and Gynecologists only recommends Pap tests every three years beginning at age 21, so encouraging three-year intervals is unnecessary for patients under 21, and many over 30 (who are often recommended to test every five years).<sup>13</sup> Whereas, the standard for pelvic exams is annual visits—though this guideline has

9. “Adolescent Pregnancy and Its Outcomes Across Countries,” Guttmacher Institute, August 2015. <https://www.guttmacher.org/sites/default/files/pdfs/pubs/FB-Adolescent-Pregnancy-Outcomes-Across-Countries.pdf>.

10. See, e.g., Laura Lindberg et al., “Understanding the Decline in Adolescent Fertility in the United States, 2007-2012,” *Journal of Adolescent Health* 59:5 (November 2016), pp. 577-583. <https://pubmed.ncbi.nlm.nih.gov/27595471/>; Kathryn Kost et al., “Pregnancies, Births and Abortions Among Adolescents and Young Women in the United States, 2013: National and State Trends by Age, Race and Ethnicity,” Guttmacher Institute, September 2017. <https://www.guttmacher.org/report/us-adolescent-pregnancy-trends-2013>.

11. “Classifications for Combined Hormonal Contraceptives,” Centers for Disease Control and Prevention, last accessed Sept. 15, 2020. <https://www.cdc.gov/reproductive-health/contraception/mmwr/mec/appendixd.html>.

12. Matthew Peterson, “Seminar 1: Contraception/Sexual Differentiation,” University of Utah: Human Reproduction: Clinical, Pathologic and Pharmacologic Correlations, 1997. [https://library.med.utah.edu/kw/human\\_reprod/seminars/seminar1A4.html](https://library.med.utah.edu/kw/human_reprod/seminars/seminar1A4.html).

13. “Cervical Cancer Screening,” The American College of Obstetricians and Gynecologists, last accessed Sept. 15, 2020. <https://www.acog.org/patient-resources/faqs/special-procedures/cervical-cancer-screening#:~:text=Women%20aged%2021%E2%80%9329%20years,test%20alone%20every%203%20years.>

come under fire as too stringent in recent years.<sup>14</sup> However, pelvic exams are not used to initiate birth control pill prescriptions because they are not medically necessary for that initiation.<sup>15</sup> Finally, research shows that women still obtain screenings in areas where they can get birth control pills over the counter at a similar rate to women who have to visit a doctor for birth control.<sup>16</sup> In light of these factors, physician visit restrictions are not strongly justified. Table 2 below provides a breakdown of age and physician visit requirements for pharmacist-prescribed birth control by state.

**TABLE 2: AGE AND PHYSICIAN VISIT REQUIREMENTS BY STATE**

State	Age Requirement	Required Evidence of Physician Visit
California	No	N/A
Colorado	18+	Every 3 years
Hawaii	No	N/A
Idaho	No	N/A
Maryland	No	N/A
Michigan	Data forthcoming	Data forthcoming
Minnesota	18+ or under 18 if evidence of prior prescription	Every 3 years
Montana	Data forthcoming	Data forthcoming
New Hampshire	No	N/A
New Mexico	No	N/A
Oregon	18+ (until 2020, when the age restriction was phased out)	Every 3 years
Tennessee	18+ (under 18 if emancipated minor)	N/A
Utah	18+	Every 2 years
Virginia	18+	N/A
Washington	18+	N/A
Washington, D.C.	No	N/A
West Virginia	18+	Each year

Source: Data used to create this table is from “Pharmacist Prescribing of Hormonal Contraceptives.” <https://powertodecide.org/sites/default/files/2020-06/Pharmacist%20Prescribing.pdf>.<sup>17</sup>

14. “Do you need to see your gynecologist every year?” *Harvard Women’s Health Watch*, February 2013. <https://www.health.harvard.edu/womens-health/do-you-need-to-see-your-gynecologist-every-year>.

15. “Pelvic Exam or Physical Exams to Prescribe Oral Contraceptive Medications,” American Academy of Family Physicians, last accessed Sept. 15, 2020. <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/cw-oral-contraceptives.html>.

16. Kristine Hopkins et al., “Reproductive health preventive screening among clinic vs. over-the-counter oral contraceptive users,” *Contraception* 86:4 (October 2012), pp. 376-382. [https://www.contraceptionjournal.org/article/S0010-7824\(12\)00105-9/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(12)00105-9/fulltext).

17. Note: Michigan and Minnesota pharmacies recently began taking advantage of CPAs that allow pharmacists to furnish hormonal contraception. The details on age restrictions and evidence of physician visits are still developing and data was not available at time of publication.

## SPECTRUM OF GRANTED AUTONOMY

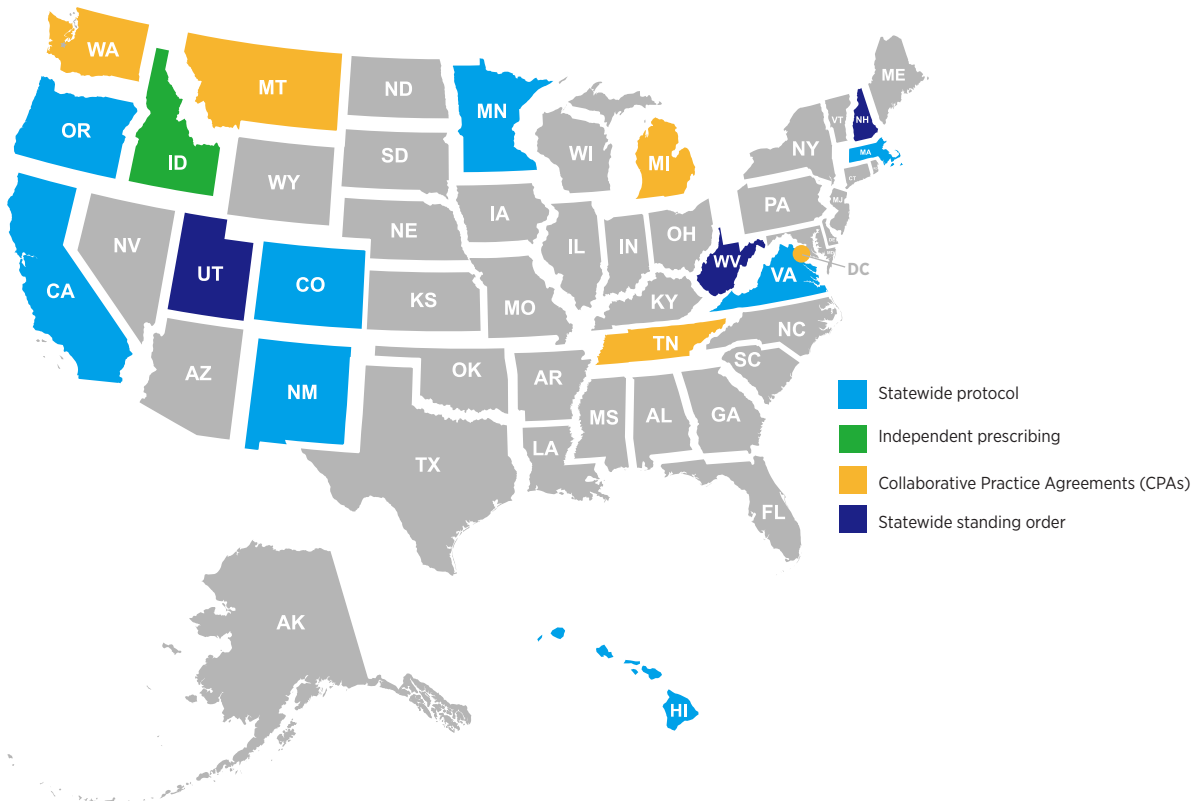
The final major component of a pharmacy access model concerns the type of practice model used to enable pharmacists to prescribe birth control. While specific regulations for pharmacist scope of practice vary, states generally fall into one of four categories for how they issue pharmacist prescribing authority. Alex J. Adams and Kristalyn K. Weaver developed a spectrum—from most restrictive to least—of these pharmacist-prescribing authority models, using legislative and regulatory data from the National Alliance of State Pharmacy Associations (NASPA).<sup>18</sup> The four models are detailed below:

- **Patient-specific collaborative practice agreement (CPA):** A pharmacist has authority from a physician to work with a specific patient on his medication regimen, which can include prescribing, adjusting prescriptions and monitoring.
- **Population-specific CPA:** A pharmacist has authority to work with a defined population of patients. For example, patients over a certain age and without specific conditions, can be treated for influenza by a pharmacist.
- **Statewide protocol (and statewide standing orders):** Under a state authority, such as a state medical board or health department, all pharmacists can prescribe specific medications or treat for certain conditions (sometimes only if additional training requirements are met).
- **Category-specific prescribing:** Pharmacists are able to prescribe certain categories of medications by following existing prescription guidelines from medical associations or professional bodies (i.e., the state does not control which specific medications can be prescribed; instead, regularly updated industry guidelines determine this.)

None of the above practice models are inherently bad—each one may be useful or effective depending on the scenario. For example, a patient-specific CPA could be useful for a pharmacist and a physician who work together in caring for a hospitalized patient with chronic conditions. Similarly, if a pharmacist and a physician work in close proximity—at a hospital, for example—and treat the same population, then a population-specific CPA between them would be reasonable enough to obtain so that the pharmacist could independently administer vaccinations or treat common illnesses in patients under physician supervision per the CPA. Both of these models are more effective for integrated teams in

18. Alex J. Adams and Kristalyn K. Weaver, “The Continuum of Pharmacist Prescriptive Authority,” *Annals of Pharmacotherapy* 50:9 (June 2016), pp. 778-784. <https://journals.sagepub.com/doi/abs/10.1177/1060028016653608>.

**FIGURE I: PRACTICE MODEL BY STATE**



Source: Data used to create this figure taken from: Sally Rafie and Sharon Landau, “Opening New Doors to Birth Control: State Efforts to Expand Access to Contraception in Community Pharmacies,” Birth Control Pharmacist, Dec. 21, 2019. <https://birth-controlpharmacist.com/2019/12/21/report>; S.F. No. 13 Chapter 115, 91st Minnesota Legislature, <https://www.revisor.mn.gov/laws/2020/0/Session+Law/Chapter/115>; “Pharmacist Prescribing of Hormonal Contraceptives.” <https://powertodecide.org/sites/default/files/2020-06/Pharmacist%20Prescribing.pdf>.

medical practices like hospitals, where these professionals are working side by side.

However, CPAs create higher barriers for many pharmacists, and are less effective in achieving better access to medications. Statewide protocols and standing orders grant broader access to healthcare services by allowing all licensed pharmacists in a state to prescribe certain medications and manage appropriate conditions. Limiting prescribing authorities to only those pharmacists who go through the process of securing a CPA—which can be financially burdensome and time-consuming—is inequitable; all pharmacists in a particular state have met the same requirements to obtain their licenses, so CPAs aren’t filtering out pharmacists who aren’t capable of prescribing. Instead, they can arbitrarily limit access to care.

Finally, category-specific prescribing grants the broadest autonomy to pharmacists. Idaho, for example, allowed pharmacists to prescribe fluoride supplements if they followed American Dental Association protocol for doing so; this model lets the industry set the standards, rather than having the

state continually reassess what is medically appropriate.<sup>19</sup> It is worth noting that Idaho has greatly expanded pharmacist prescribing authority beyond this in the last few years, and now allows pharmacists to prescribe medications that meet four broad criteria—except for those expressly prohibited by the Board of Pharmacy.<sup>20</sup> Figure 1 above shows which type of practice model is used to enable pharmacist to prescribe birth control.

**OPPOSITION TO THE PHARMACY ACCESS MODEL**

Some state legislators have experienced opposition to pharmacy access model proposals. This opposition usually comes from special interest groups who have the incentive to prevent pharmacists from providing an increased number of

19. Ibid.

20. James Broughel et al., “Reforming the Practice of Pharmacy: Observations from Idaho,” Mercatus Center at George Mason University, April 2020, <https://www.mercatus.org/system/files/broughel-pharmacy-idaho-mercatus-research-v1.pdf>.



health services. Fortunately, the two major concerns of the opposition are largely unfounded.

### Hormonal birth control is not safe enough for pharmacists to prescribe it

This concern is repeatedly proven false.<sup>21</sup> First, pharmacists are medication experts, so identifying contraindications to medications is already within their skillset. Pharmacists are capable of checking for contraindications for birth control, and in over a dozen states, they already do.<sup>22</sup> Additionally, in a pilot study to measure the satisfaction of patients seeing a pharmacist for birth control, it was found that virtually all patients surveyed were happy with seeing a pharmacist and would continue to do so.<sup>23</sup>

Further, the relative risk of hormonal birth control is low enough that many leading medical associations in the United States, including the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians and the American Medical Association support over-the-counter birth control access.<sup>24</sup> This is due to its safety and the data showing that women can accurately self-screen for contraindications for hormonal birth control.<sup>25</sup> If it is safe enough for over-the-counter access—which is what the majority of countries allow—then it’s safe enough for pharmacists to be the facilitating prescriber.<sup>26</sup>

### Patients will no longer schedule regular physician visits

There is no evidence to suggest this is the case. Pharmacists are required to refer patients to physicians if they have contraindications to a hormonal birth control prescription, and are often required to tell the patient about the importance

of regular exams, so the interaction between a pharmacist and a patient could encourage regular physician visits. This argument has been used against pharmacist-administered vaccines, too, even though there is no evidence of decreased health visits due to pharmacists providing vaccinations.<sup>27</sup> Instead, pharmacists offer additional interactions with a trusted medical professional—which can, and does, enhance patient health.<sup>28</sup>

## POLICY RECOMMENDATIONS

States that allow pharmacists to prescribe contraception have done so in a number of ways. Some pass legislation explicitly allowing for pharmacists to prescribe hormonal birth control; some pass broader reforms allowing pharmacists to prescribe a broader range of products such as tobacco cessation products, travel medications and birth control. Others do not require legislation to allow pharmacists to prescribe birth control, and instead take advantage of CPAs already allowed by state regulation.

The details of each state’s pharmacy access model, as well as how it is enacted, matter for the model’s relative success. The following recommendations will allow broader success and increased patient access to hormonal birth control.

### Recognize Pharmacists as Medical Providers

Recognizing pharmacists as medical providers by law means that pharmacists can bill insurance for birth control consultations, which will make it much more likely that a pharmacist will become a birth control prescriber. Otherwise, there is little incentive to provide this service, which means the pharmacy access model will have little effect in increasing the number of available providers in the state. Additionally, this move is likely to reduce healthcare costs that the patient—and, in turn, the insurer—incurs. This was the case in Oregon; once pharmacists were able to prescribe birth control to Medicaid patients, Medicaid costs for unintended pregnancies decreased.<sup>29</sup> Some states have made this change in the same bills that enable pharmacists to prescribe birth control, and some have passed subsequent legislation on insurance coverage. West Virginia, for example, passed two separate bills; the first allowed pharmacists to prescribe, and

21. Courtney M. Joslin, “FAQ: Is It Safe for Pharmacists to Prescribe Birth Control,” R Street Institute, July 29, 2019, <https://www.rstreet.org/2019/07/29/faq-is-it-safe-for-pharmacists-to-prescribe-birth-control>.

22. “Pharmacist Prescribing of Hormonal Contraceptives,” <https://powertodecide.org/sites/default/files/2020-06/Pharmacist%20Prescribing.pdf>.

23. Jacqueline S. Gardner et al., “Pharmacist prescribing of hormonal contraceptives: results of the Direct Access study,” *Journal of the American Pharmacists Association* 48:2 (March–April 2008), pp. 212–221. <https://pubmed.ncbi.nlm.nih.gov/18359734>.

24. See, e.g., “Over-the-Counter Access to Hormonal Contraception: Committee Opinion Number 788,” The American College of Obstetricians and Gynecologists, October 2019. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception>; Gerald E. Harmon, “Report of the Board of Trustees: Over-the-Counter Contraceptive Drug Access (Resolution 110-A-17),” American Medical Association, 2018 <http://ocsotc.org/wp-content/uploads/2018/06/2018-AMA-OCs-OTC-resolution-110-A-17.pdf>; “Over-the-Counter Oral Contraceptives,” American Academy of Family Physicians, 2019. <https://www.aafp.org/about/policies/all/otc-oral-contraceptives.html>.

25. See, e.g., Joslin. <https://www.rstreet.org/2019/07/29/faq-is-it-safe-for-pharmacists-to-prescribe-birth-control>; Daniel Grossman et al., “Accuracy of self-screening for contraindications to combined oral contraceptive use,” *Obstetrics and Gynecology* 112:3 (September 2008), pp. 572–578. <https://pubmed.ncbi.nlm.nih.gov/18757654>.

26. “Global Oral Contraception Availability,” OCs OTC Working Group, last accessed Sept. 21, 2020. <http://ocsotc.org/world-map>.

27. Allison Kite, “Bill would allow Kansas pharmacists to administer more vaccines to children,” Kansas Health Institute, March 8, 2016. <https://www.khi.org/news/article/bill-would-allow-pharmacists-to-administer-more-vaccines-to-children#:~:text=HB%202646%20would%20allow%20properly,rather%20than%20a%20doctor's%20office.&text=According%20to%20the%20Kansas%20Pharmacists,to%20increase%20access%20to%20vaccines>.

28. Terry Spears, “Community Pharmacists Play Key Role in Improving Medication Safety,” *Pharmacy Times*, Nov. 23, 2010. [https://www.pharmacytimes.com/publications/issue/2010/November2010/CommunityPharmacists\\_MedSafety](https://www.pharmacytimes.com/publications/issue/2010/November2010/CommunityPharmacists_MedSafety).

29. Rodriguez et al. [https://journals.lww.com/greenjournal/Fulltext/2019/06000/Association\\_of\\_Pharmacist\\_Prescription\\_of\\_Hormonal.23.aspx](https://journals.lww.com/greenjournal/Fulltext/2019/06000/Association_of_Pharmacist_Prescription_of_Hormonal.23.aspx).

the second recognized pharmacists as providers for insurance purposes.<sup>30</sup>

### Exclude Medically Unnecessary Restrictions on Pharmacist-prescribed Birth Control

Requiring that patients be 18 or older, as well as requiring that they show evidence of a physician visit within certain timeframes, decreases the number of patients eligible to see pharmacists for contraception. These restrictions have no medical bases; bone mineral density is the primary concern for hormonal birth control use in patients under 18, but this is minimal and must be put into perspective relative to other risks.<sup>31</sup> Additionally, medical professionals maintain that birth control prescriptions are not tied to pelvic exam or Pap testing results, so requiring that patients provide evidence of a physician visit is unnecessarily tethered to a birth control prescription.<sup>32</sup>

### Allow Implementation Through Statewide Standing Orders or Protocols

Requiring that pharmacists obtain CPAs with physicians imposes costly and time-consuming barriers that disincentivize pharmacists to become birth control prescribers. Statewide standing orders or statewide protocols are more equitable mechanisms for enabling pharmacists to prescribe birth control across the board.

### Recognize That Common Objections are Contrary to the Evidence

Hormonal birth control is safe enough that leading medical organizations advocate for complete over-the-counter status.<sup>33</sup> Thus, pharmacists, who are highly skilled medication experts, are capable of examining patients for contraindications to birth control. Further, there is no evidence that allowing pharmacists to prescribe means that patients will stop seeing their physician. Rather, pharmacists are often required to refer patients to their regular provider and communicate prescription information to that provider; in this

way, pharmacists are an added touchpoint with a medical professional, which can enhance patient health.<sup>34</sup>

## CONCLUSION

The pharmacy access model has grown in popularity, and as it has, more legislators have thought through how the implementation of a pharmacy access model affects its uptake by both pharmacists and patients. Creating a pharmacy access model without unnecessary restrictions, as well as with the proper incentives for pharmacists, leads to increased access to contraception for many who struggle to obtain regular birth control prescriptions from a doctor. This innovation is a two-fold win for healthcare professionals and patients, as long as the right conditions are created.

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30. "Pharmacist Prescribing of Hormonal Contraceptives." <https://powertodecide.org/sites/default/files/2020-06/Pharmacist%20Prescribing.pdf>.

31. "Classifications for Combined Hormonal Contraceptives." <https://www.cdc.gov/reproductivehealth/contraception/mmwr/mec/appendixd.html>.

32. "Pelvic Exam or Physical Exams to Prescribe Oral Contraceptive Medications." <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/all-clinical-recommendations/cw-oral-contraceptives.html>.

33. See, e.g., "Over-the-Counter Access to Hormonal Contraception: Committee Opinion Number 788." <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/10/over-the-counter-access-to-hormonal-contraception>; Harmon. <http://ocsotc.org/wp-content/uploads/2018/06/2018-AMA-OCs-OTC-resolution-110-A-17.pdf>; "Over-the-Counter Oral Contraceptives." <https://www.aafp.org/about/policies/all/otc-oral-contraceptives.html>.

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