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Pharmacist Uptake of Autonomous Hormonal Contraceptive Prescribing

By Chelsea Boyd

The policymaking process for authorizing pharmacists to autonomously prescribe HC should not end with enacting a bill. We must continue to evaluate the impact and outcomes over time to refine policies and ensure that as many consumers as possible have access to these convenient, often-preferred forms of contraception.

Introduction

In a recent survey of women ages 18 to 49, 69 percent said that avoiding pregnancy in the next month was "very important" to them.[1] Given this prioritization, it is not surprising that 82 percent reported using some form of contraceptive during the preceding 12 months.[2] Having access to contraceptives to prevent pregnancy is associated with many broader benefits, including lower rates of pregnancy-related illness and death, better infant health, lower healthcare costs, higher educational attainment, and increased labor force participation.[3]

A range of contraceptive methods is available to prevent pregnancy, each with its own set of advantages and disadvantages.[4] Short-acting, hormonal forms of contraception, which include oral pills, vaginal rings, injections, and skin patches, are among the most frequently used.[5] These types of contraceptives are more than 90 percent effective at preventing pregnancy under real-world use conditions, and most are self-administered (excluding injections).[6]

Despite statistics showing high utilization of hormonal contraception (HC), approximately one-third of women report difficulty obtaining a prescription for these medications.[7] Reported challenges include a lack of appointment availability, inconvenient clinic locations, and pelvic exam or Pap smear requirements.[8] These barriers are problematic, as they can discourage individuals from initiating or continuing HC. Indeed, such barriers may help explain survey findings indicating that 54 percent of reproductive-age women at risk of unintended pregnancy chose their current birth control method specifically because it did not require a prescription.[9]

Of note, this same survey found that 41 percent of those not using contraceptives would begin using HC if they could secure a prescription from their pharmacist.[10] This is an important finding because properly implemented pharmacist-prescribed HC can decrease healthcare costs, reduce logistical access challenges, and improve medication adherence.[11] With these benefits in mind, many states have passed

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The sources included in this paper were verified and active at the time of publication.

legislation that expands pharmacists' scope of practice to include autonomously prescribing HC, but this legislation has come with its own set of challenges related to implementation time and effort, leading to suboptimal rates of pharmacist and consumer uptake.[12]

As more states pass legislation authorizing pharmacists to prescribe HC autonomously, it is important that lawmakers understand the real-world impact of these policies and their implementation challenges so they can proactively design legislation to minimize them. This paper explores these factors and offers targeted recommendations to improve the development, implementation, and revision of pharmacist-prescribing policies with the goal that such legislation will improve patient access to the degree the bills intend.

The Path to Pharmacist Prescribing of HC

In 2016, Oregon and California became the first states to authorize pharmacists to autonomously prescribe HC. As of September 2025, that number has grown to include 37 states and the District of Columbia.[13]

Multiple national and state-based surveys of practicing community pharmacists and pharmacy students demonstrate their interest in prescribing HC.[14] Consumer surveys mirror this interest, with one national survey finding that 63 percent of women at risk of unintended pregnancy were interested in pharmacist-prescribed HC services.[15] This interest suggests that pharmacist-prescribed HC services would be widely utilized once legislation is passed, but data suggests that real-world uptake is falling short, highlighting the importance of understanding how implementation factors shape access.[16]

The Many Steps Between Authorization and Access

Enacting pharmacist-prescribed HC legislation is the first of many steps that must occur before a patient can obtain a new HC prescription at their local pharmacy. In most cases, after legislation is enacted, the state's Board of Pharmacy (and often other healthcare boards) must issue documentation to guide implementation.[17]

States implement pharmacist prescribing authority by establishing statewide protocols or by issuing standing orders and changes to the scope of practice that allow prescriptive authority when certain parameters are met.[18] Once this regulatory groundwork is in place, actual implementation shifts to pharmacy-level decision makers (i.e., independent pharmacy owners, chain pharmacy executives) who must then approve offering HC prescribing services.[19] If leaders decide to offer the service, individual pharmacists must meet any specified training requirements, and the service must be integrated into pharmacy workflows.[20] Perhaps most importantly, once implemented, the public must be made aware of the offering and choose to utilize it.

Complications and barriers contribute to the well-documented gap between public and pharmacist interest in pharmacist-prescribed HC and the availability of services. This highlights the fact that policy success depends as much on execution as on intent.

Each of these steps has potential complications and barriers that can delay or block the path to easier HC access. Collectively, they contribute to the well-documented gap between public and pharmacist interest in pharmacist-prescribed HC and the availability of services.[21] This highlights the fact that policy success depends as much on execution as on intent.

Real-World Uptake in Early-Adopter States

Although a growing number of states have enacted legislation expanding pharmacists' scope of practice to include HC prescribing, studies assessing real-world outcomes

are somewhat limited and based on early data. This gap is understandable, given that many states have only recently issued the regulatory guidance needed to provide this service. Existing implementation studies have primarily focused on states at the forefront of this trend: Oregon, California, Utah, Hawai'i, and New Mexico.[22]

Oregon

A number of studies have evaluated the effects of Oregon's 2016 policy allowing pharmacists to prescribe HC.[23] Within the first several months of the policy's implementation, nearly half of the state's pharmacists had enrolled in the required training to prescribe HC.[24] Three years later, 46 percent of pharmacists were estimated to have prescribed HC, which is a higher percentage than in other states with similar policies.[25] In addition, two studies analyzed the state's Medicaid claims for HC and found that two years after pharmacists were given the authority to prescribe, 10 percent of newly written oral and transdermal patch contraceptive prescriptions were written by pharmacists.[26] Despite these findings, broader Medicaid prescription data that included refills and renewals as well as new prescriptions indicated that pharmacists wrote only 0.3 percent of oral HC prescriptions and 0.6 percent of transdermal patch HC prescriptions.[27] Still, an analysis of Oregon Medicaid enrollees estimated that pharmacist-prescribed HC services prevented 51 unintended pregnancies and saved the state $1.6 million in the first two years of implementation.[28] These findings suggest that even though the state's pharmacists may not be writing a large share of HC prescriptions overall, their involvement in this process has resulted in measurable public-health and economic benefits.

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California

Two studies have evaluated California's experience.[29] The first was a "secret shopper" telephone survey conducted from December 2016 to April 2017 that assessed service uptake among retail pharmacies.[30] Of the 457 pharmacies contacted 9 to 12 months after the policy took effect, only 5.1 percent reported offering HC prescribing services.[31] The second, which used similar methods and was conducted from February 2017 to April 2017, found higher—but still lower than ideal—participation, with 11.1 percent of the 1,008 pharmacies contacted reporting that they offered pharmacist-prescribed HC.[32] This study also found that more than two-thirds of pharmacies offering this service charged a consultation fee, which averaged $45.[33] This is an important finding, as these types of consultation fees could discourage individuals from using pharmacists to obtain HC prescriptions. Another noteworthy finding of both studies was that oral pills were the most common type of HC that pharmacists offered, despite other HC options being available.[34] Because pills are the most commonly used type of HC, this finding may be a result of patient preference; however, it is still beneficial to allow pharmacists to prescribe alternative HC options to accommodate a broader range of contraceptive needs.[35]

California regional data suggests that uptake has modestly increased over time. Nevertheless, to meaningfully improve HC access, uptake must continue to increase.

Notably, regional data indicate that uptake has increased modestly over time. A 2020 survey of community pharmacies in San Francisco found that 19 percent offered HC prescriptions, and a 2023 study in the Central Valley region reported 15.2 percent uptake.[36] Nevertheless, to meaningfully improve HC access, uptake must continue to increase.

Other States

Experiences across other early-adopter states underscore both the promise and limitations of pharmacist-prescribed HC, with uptake varying widely and consultation fees being a consistent potential barrier. One year after Utah's standing order went into effect, 28 percent of retail pharmacies were offering HC prescription services, mostly in urban areas and within retail chain stores, and nearly all (98 percent)

charged a consultation fee.[37] In Hawai'i, a 2020 study found that 31 percent of pharmacies provided this service.[38] Nearly all of the pharmacies that did so belonged to retail chains, and rates for prescription services were similar between rural and urban pharmacies.[39] Two-thirds of pharmacies charged patients a consultation fee to prescribe HC, which ranged from $15 to $45.[40] In New Mexico, 19 percent of retail pharmacies offered HC prescribing within a year of implementation, with no significant differences between rural and urban areas.[41] More broadly, an R Street Institute survey conducted in Fall 2022 that excluded most national chain pharmacies found that 34.6 percent of pharmacies contacted had at least one pharmacist on staff who was eligible to prescribe HC.[42] Despite this level of pharmacy uptake, most pharmacists surveyed said they provide this service fewer than three times per month.[43]

Key Policy Takeaways

Importantly, most of this implementation data reflects uptake measured within one year of policy authorization, which might not provide enough time for all interested pharmacies to implement the service. Although enthusiasm may be high during the first year, practical and logistical barriers for pharmacies often delay rollout to consumers.[44] Moreover, some states have enacted additional policies that influence pharmacies' decision to offer HC prescribing. For example, California's original law did not allow pharmacists to bill Medicaid for HC consultations, but a 2017 bill addressed this issue with reimbursement starting in 2021.[45] Taken together, these case studies highlight the need for continued evaluation across longer timeframes to understand how pharmacist-prescribing policies affect real-world access. This is particularly true when policies are modified or augmented by additional legislation, as these changes may change pharmacies' motivations to offer HC prescribing.

Existing evidence from the states underscores the need for continued evaluation over longer time frames to understand how pharmacists' prescription policies impact real-world access.

Barriers to Uptake and Policy Solutions

Despite legislative momentum and interest, existing research evaluating pharmacy uptake of HC prescribing shows that many pharmacies are not electing to offer this service. Implementation studies suggest that this gap stems from a range of structural and policy barriers. The next sections outline targeted policy solutions for the most commonly cited challenges.

Remove Billing Barriers

Targeted Policy Solution

Although many pharmacists are interested in prescribing HC to better serve their communities and support public health, financial realities can affect whether pharmacies ultimately decide to offer this service.[46] A commonly cited challenge among pharmacists and pharmacy leaders is the lack of insurance reimbursement for providing an HC consultation.[47] Federally, pharmacists are not in the same category as other healthcare providers, and thus cannot bill for their consultation time unless the state they are licensed in has classified them as providers.[48] To cover consultation costs, some pharmacies charge patients an out-of-pocket consultation fee, but this cost can discourage use, particularly among low-income individuals, thereby undermining the access-expanding impact of these policies.[49]

To support broader uptake, implementation efforts should address reimbursement structures directly. Implementation studies suggest that pharmacist-prescribing policies may be more effective when they include clear mechanisms for covering consultation services through insurance.[50] Additionally, billing systems must be simple and efficient because pharmacies typically lack dedicated medical billing teams to navigate complex systems.[51] State pharmacy boards and Medicaid offices are typically responsible for creating billing infrastructure for these services, making early and sustained coordination with these entities essential for success.[52]

Engage with Stakeholders and Policy Champions

Targeted Policy Solution

It is vitally important that states considering introducing or modifying existing pharmacist-prescribed HC legislation engage stakeholders in their efforts. Consulting with those responsible for implementation can help ensure that policies address real-world needs. Possible stakeholders in this type of legislation include pharmacists, independent pharmacy owners, chain pharmacy leadership, state pharmacist associations, physicians, trade associations, state Medicaid offices, state boards of medicine and pharmacy, schools of pharmacy, patient advocacy groups, and community leaders.[53] Selecting committed and influential people from these groups to champion implementation can also help increase uptake.[54] Additionally, contacting stakeholders from states that have successfully implemented this type of legislation can also help optimize policies and facilitate better uptake.[55]

Implement Policies Quickly

Targeted Policy Solution

As noted previously, there is a significant gap between the time legislators enact pharmacist-prescribing policies and the time regulatory bodies issue their statewide protocols, standing orders, or guidance for providing the service. One study reported that gaps of more than three to six months between these events hinder momentum for further implementation actions.[56] As such, minimizing the length of this gap is critical for maintaining momentum and enthusiasm among stakeholders and boosting pharmacist motivation to offer the services.[57] Policymakers should therefore invest in implementation and allocate resources to build the systems needed to facilitate pharmacist prescribing and billing.[58]

Build Consumer Awareness and Drive Demand

Targeted Policy Solution

One additional factor that can discourage the uptake of HC prescribing at pharmacies is insufficient demand for the service.[59] States can improve community awareness and increase demand by partnering with the same coalition of stakeholders who helped pass the legislation. They should also explore ways to engage directly with consumers and providers, such as funding public service announcement campaigns or direct engagement with pharmacists by the board of pharmacy. In Oregon, for example, investment in implementation and awareness may have contributed to higher rates of pharmacist participation compared to states that did less outreach.[60]

Conclusion

Pharmacist-prescribed HC services show great promise as a way of improving access to these medications. Approximately 500,000 women of reproductive age reside in U.S. counties with fewer than one provider prescribing HC per 1,000 women.[61] If all pharmacists in the country were authorized to prescribe contraception, it would reduce the number of women in that category by 85 percent.[62] To accomplish this, the policymaking process should not end with enacting a bill. We must continue to evaluate the impact and outcomes of authorizing pharmacists to autonomously prescribe HC over time to refine policies and ensure that as many consumers as possible have access to these convenient, often-preferred forms of contraception.[63] Although 37 states and the District of Columbia have taken the much-needed first step of authorizing pharmacists to prescribe HC, they must continue to invest in implementation efforts to drive greater uptake.

About the Author

Chelsea Boyd is a research fellow at the R Street Institute.

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