

2025 OSPA ANNUAL CONVENTION

🎉 DRAW-DOWN FUNDRAISER! 🎉

Only 100 Tickets Will Be Sold!

💵 PRIZES TOTALING $2,100 💵

Here's how it works:

- Buy a ticket for a suggested donation of $50
- 100 tickets enter… final two split the final prize or go for it all!
- The LAST 6 tickets standing WIN CASH!

🏆 Prize Payouts 🏆

- 6th Ticket Remaining → $150
- 5th Ticket Remaining → $150
- 4th Ticket Remaining → $250
- 3rd Ticket Remaining → $250
- 2nd Ticket Remaining → $300
- LAST Ticket Standing → $1,000 GRAND PRIZE!

Proceeds will benefit the Oregon Pharmacist Fund PAC and the Pharmacy Foundation of Oregon


McKESSON


PhRMA
RESEARCH • PROGRESS • HOPE


HDA
Healthcare Distribution Alliance
HEALTH DELIVERED


CardinalHealth


pharmacists mutual
TOMORROW. IMAGINE THAT.


dexcom
CONTINUOUS GLUCOSE MONITORING


Boehringer
Ingelheim


moderna


PioneerRx


RedSail
TECHNOLOGIES


Liberty
SOFTWARE


GSK


MERCK


St. Charles
HEALTH SYSTEM


NAVY TALENT ACQUISITION GROUP
Portland
PORTLAND, OREGON


BAVARIAN NORDIC


Walmart
Pharmacy


U.S. Department of Justice
Drug Enforcement Administration


Pacific
University
Oregon


1868
Oregon State University
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SCHOOL of PHARMACY
THE OREGON BOARD OF PHARMACY


Oregon
Health
Authority


Hi-SCHOOL
pharmacy


OREGON
FAMILIES FOR VACCINES

Oregon State University
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OFFICE OF CONTINUING PHARMACY EDUCATION

OSPA Annual Convention
September 27-28, 2025

A **credit code** will be provided during each activity. This code will be requested during the online evaluation process. This form is to record each **credit code**. ***Be sure to record each code correctly, incorrect codes will NOT be accepted.***

Date & Time	Activity Title	ACPE UAN	Credit Code
9/27/2025 8:00 – 9:00 am	**Gender Affirming Hormone Therapy for Adults**	0036-9999-25-116-L01-P 0036-9999-25-116-L01-T	
9/27/2025 9:00 – 10:00 am	**PrEP in HIV Prevention: Current Evidence and Best Practices**	0036-9999-25-117-L02-P 0036-9999-25-118-L02-T	
9/27/2025 10:30 – 11:30 am	**Pharmacy Law and Policy: Federal and State Updates** *(Law CE)*	0036-9999-25-119-L03-P 0036-9999-25-119-L03-T	
9/27/2025 1:00 – 2:00 pm	**Oregon Board of Pharmacy Law Update** *(Law CE)*	0036-9999-25-120-L03-P 0036-9999-25-120-L03-T	
9/27/2025 2:00 – 3:00 pm	**2025 OTC Challenge**	0036-9999-25-121-L01-P 0036-9999-25-121-L01-T	
9/27/2025 3:30 - 4:30 pm	**Integrating Harm Reduction into Medical Spaces** *(Cultural Competence CE)*	0036-9999-25-122-L99-P 0036-9999-25-122-L99-T	
9/27/2025 4:30 - 5:30 pm	**New Drug Update 2025**	0036-9999-25-123-L01-P 0036-9999-25-123-L01-T	
9/28/2025 8:00 – 9:00 am	**Enabling Clinical Program Growth in Community Pharmacy: Workflow and Mindset Shifts**	0036-9999-25-124-L04-P 0036-9999-25-124-L04-T	
9/28/2025 9:00 – 10:00 am	**The Power of Our Voices: Advocacy for the Modern Era**	0036-9999-25-125-L04-P 0036-9999-25-125-L04-T	
9/28/2025 10:00 – 11:00 am	**Lethal Means Safety: A Pharmacy-Based Approach to Suicide Prevention** *(Patient Safety CE)*	0036-9999-25-126-L05-P 0036-9999-25-126-L05-T	
9/28/2025 11:00 – 12:00 pm	**Looking Out for Drug-Induced Disease in Older Adults** *(Patient Safety CE)*	0036-9999-25-127-L05-P 0036-9999-25-127-L05-T	

Important notes:

- Credits must be redeemed within **14 days** of the activity.
- Upon submission, credits will upload to CPE Monitor within 48 hours.
- The **Credit Code** is a verification of attendance. Do not share the code with anybody who did not attend the activity or seek out a credit code for any activity you did not attend.

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Instructions for Redeeming Credit:

1. Write down the Credit Code provided in a safe place.
2. On your computer or phone, go to https://pharmacy.oregonstate.edu/ce, locate OSPA Lane County Mid-Winter CE Seminar, and follow the link; or scan the QR code to go directly to registration.
3. On the announcement page, click "Register" and follow the prompts.
4. Enter the Credit Code to access the activity evaluation.
5. Complete the activity evaluation.
6. Complete steps 4 and 5 for each activity you attended.
7. Complete the overall Program Evaluation.
8. **SUBMIT CREDITS.** After completing all requirements, **you must submit CE credits**. If you do not complete this final step, your credits will not upload to CPE monitor.
9. **CONFIRM CREDITS.** Within 3 days, confirm your credits have uploaded to your CPE Monitor.

Please note: *Once you register for this seminar, please DO NOT register again. Use the link in your confirmation email or click the link on the registration page to have your personal access link resent.*

Cultural Competence in Oregon

To meet re-licensure requirements, pharmacists must upload cultural competence continuing education information to their Oregon Board of Pharmacy Online License Services account.

1. Login to CPE Monitor at http://mycpemonitor.net and download your CPE Monitor Statement for the cultural competence activity you wish to provide to the Oregon Board of Pharmacy
2. Login to https://orbop.mylicense.com/egov/Login.aspx or register for a new account (instructions found at https://www.oregon.gov/pharmacy/Documents/eGovPersonsLoginInstructions.pdf)
3. Once logged in, click on “Update License Info” in the menu
4. Navigate to “Attach Documents” and upload your CPE Monitor Statement

This program has been planned and implemented in accordance with the policies of the Accreditation Council on Pharmacy Education (ACPE) through the joint sponsorship of Oregon State University College of Pharmacy and Oregon State Pharmacy Association (OSPA). Oregon State University College of Pharmacy is accredited by the Accreditation Council on Pharmacy Education as a provider of continuing pharmacy education.

The Statement of Credit shall be issued only after successful completion of the program. Successful completion is defined as: 1) Attending, in its entirety, the CPE activity or activities; 2) Completion of the online activity evaluation and post-test located at: http://pharmacy.oregonstate.edu/ce within 14 days of program attendance. Statements of Credit will be uploaded to each participant’s NABP e-profile within 48 hours of program completion. It is the participant’s responsibility to complete the online components within 14 days of program attendance to ensure awarding of credit. Credit will not be provided after 60 days.

2025 OSPA Annual Survey

Please complete this short, online survey to provide guidance to the OSPA Board of Directors.

Which one legislative concern should OSPA prioritize for the long legislative session in 2027?

A. Test to Treat
B. DEA license for pharmacist
C. Pharmacist Provider status
D. CAT Tax
E. PBM reform
F. Other: List

What is the primary reason you are an OSPA member?

A. Education
B. Legislative Efforts
C. Networking
D. Other: List

What is your practice setting?

A. Retail Chain Pharmacy
B. Retail Independent Pharmacy
C. Ambulatory Care
D. Managed Care
E. Hospital
F. Compounding
G. PBM
H. Academia
I. Nuclear Pharmacy
J. Other: List



OREGON STATE PHARMACY ASSOCIATION
19363 Willamette Drive #260 • West Linn, Oregon 97068
(503) 582-9055 • www.oregonpharmacy.org • info@oregonpharmacy.org

ANTITRUST COMPLIANCE POLICIES AND PROCEDURES

It shall be the policy of the Association to be in strict compliance with all Federal and State Antitrust laws, rules, and regulations. Therefore:

I. These policies and procedures apply to all membership, board, committee, and other meetings sponsored by the Association, and to all meetings attended by representatives of the Association.

II. Discussions of prices or price levels is prohibited. In addition, no discussion is permitted of any elements of a company's operations which might influence price such as:
   a. Cost of operations, supplies, labor or services;
   b. Allowance for discounts;
   c. Terms of sale including credit arrangements; and,
   d. Profit margins and mark ups, provided this limitation shall not extend to discussions of methods of operations, maintenance, and similar matters in which cost of efficiency is merely incidental.

III. It is a violation of Antitrust laws to agree not to compete, therefore, discussions of division of territories or customers or limitations on the nature of business carried on or products sold are not permitted.

IV. Boycotts in any form are unlawful. Discussion relating to boycotts is prohibited, including discussions about blacklisting or unfavorable reports about particular companies including their financial situation.

V. It is the Association's policy that all meetings attended by representatives of the Association where discussion can border on an area of antitrust sensitivity, that the Association's representative request that the discussion be stopped and ask that the request be made a part of the minutes of the meeting being attended. If others continue such discussion, the Association's representative should excuse himself from the meeting and request that the minutes show that he or she left the meeting at that point and why he left. Any such instances should be reported immediately to the President and staff of the Association.

VI. It is the Association's policy that a copy of these Antitrust Compliance Policies and Procedures be given to each officer, director, committee member, official representative of member companies and Association employees annually and membership of the Association.

The Oregon Pharmacists Fund (OPF)

The Oregon Pharmacists Fund (OPF) helps elect legislators and statewide officials who will act in pharmacists' best interests. The OPF does this by providing financial support to political campaigns. This is a PAC (Political Action Committee) which can help represent the interests of all Oregon Pharmacists and the needs of our patients.

When you support the Oregon Pharmacists Fund you:

- help elect a more pharmacy-friendly legislature
- receive updates on important legal and regulatory issues
- receive invitations to meet with key policy makers

The best way to make sure a good bill passes, or to stop a bad bill, is to elect the right people.

Take advantage of the Oregon Political Tax Credit! Donate to the Oregon Pharmacists Fund, and subtract up to $100 per couple or $50 per individual from your Oregon income tax bill. It is a TAX CREDIT. You can make a PAC donation once every year. This credit is only available to individuals with adjusted gross income of $100,000 or less and for joint filers $200,000 or less.

The Oregon Pharmacists Fund was created by the Statewide Pharmacy Coalition, Oregon State Pharmacy Association and the Oregon Society of Health-System Pharmacists. Each organization supports the fund as the primary political action vehicle for Oregon's pharmacists**. A PAC committee that considers all practice settings governs disbursements to campaigns.**

Oregon Pharmacists Fund PAC donations may be made by mailing a check or credit card information with the following form to Oregon Pharmacists Fund – ***P.O. Box 512, Independence, OR 97351***

----------CUT AND MAIL ----------

Please accept my political action committee donation to the Oregon Pharmacists Fund.
Please use only one form per contributor, if multiple contributors please provide form for each.
Please print information clearly!

Name _____ Occupation _____ Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Employer Name* _____
Employer Address* _____
City* _____ State* _____ Zip* _____
Amount of Donation: $_____

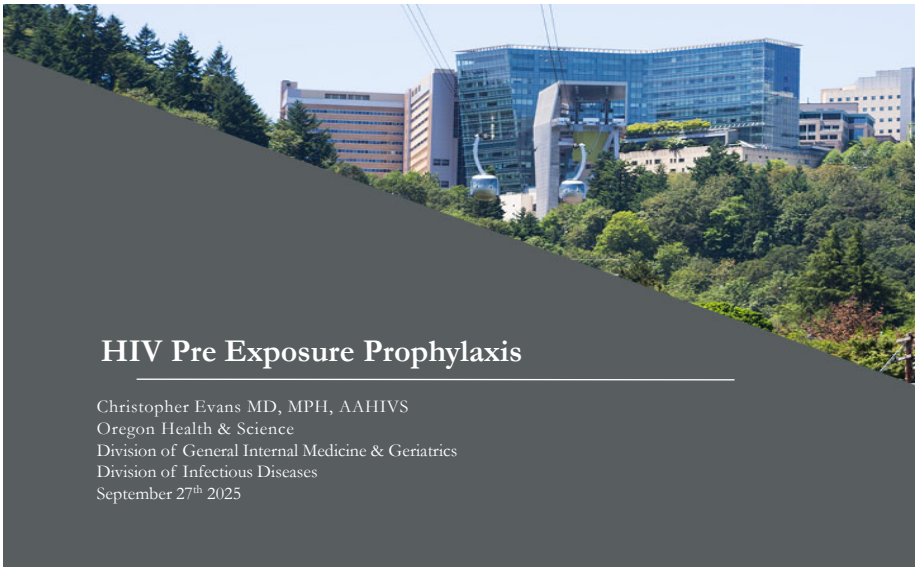
Employer/Occupation information is a mandatory requirement for state filing.

Payment method: ❒ check (payable to Oregon Pharmacists Fund) -or- ❒ credit card

Charge $_____ to: ❒ VISA ❒ MC ❒ American Express ❒ Discover
Account # _____ Expire (Month/Year) _____
Billing Address _____
City _____ State _____ Zip _____
Signature _____

Please return form to:
Oregon Pharmacists Fund
P.O. Box 512
Independence, OR 97351
Questions? Call 800.293.0510

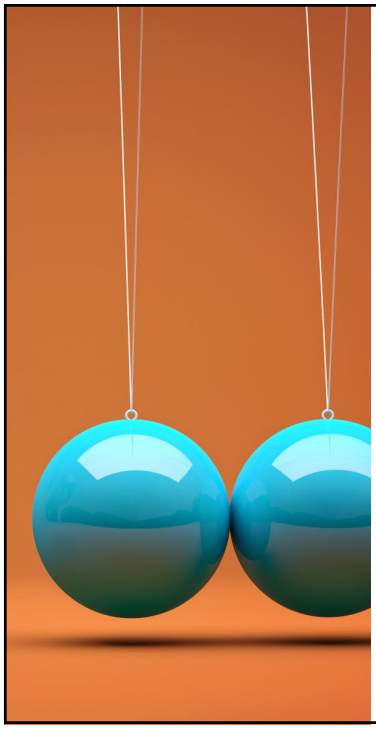
Due to a changing federal landscape the Hormone Therapy for Adults presentation slides are not for distribution.



HIV Pre Exposure Prophylaxis

Christopher Evans MD, MPH, AAHIVS
Oregon Health & Science
Division of General Internal Medicine & Geriatrics
Division of Infectious Diseases
September 27th 2025

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Disclosures

Dr. Christopher Evans has received a research grant from ViiV Healthcare.

Any relevant financial relationships have been mitigated.

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Learning Objectives: PrEP in Pharmacy Practice

1. **Describe** the clinical indications for prescribing Pre-Exposure Prophylaxis (PrEP).
2. **Evaluate** the evidence for PrEP's efficacy in reducing HIV transmission.
3. **Apply** updated prescribing and monitoring guidelines
4. **Recognize** potential side effects of PrEP and **develop** effective strategies for patient counseling and adherence support.
5. **Integrate** PrEP delivery into clinical practice

3

Pretest Questions

Which is the preferred HIV screening test before starting a patient on oral PrEP?
a) HIV-1/2 antigen-antibody (4th generation) test.
b) HIV-1 antibody rapid test only.
c) HIV RNA PCR.

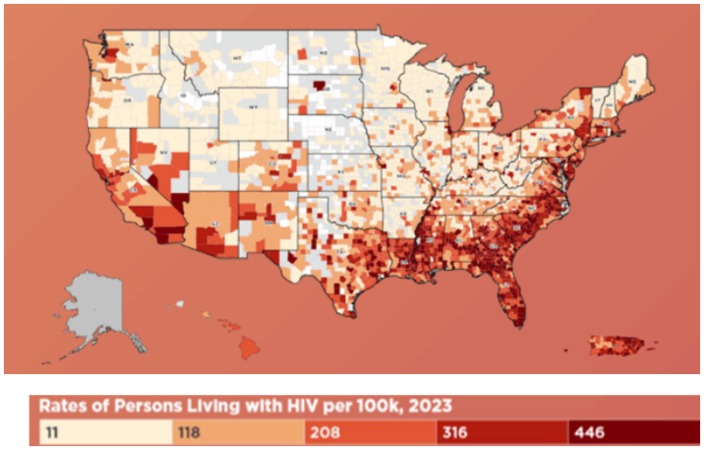
Which hepatitis B finding would require additional clinical consideration before starting PrEP?
a) Positive hepatitis B surface antigen.
b) Negative hepatitis B core antibody.
c) Positive hepatitis B surface antibody.

Which is the most effective approach to support PrEP adherence for people on oral PrEP?
a) Provide a year's supply of PrEP (90 days with 3 refills).
b) Provide counseling, reminders, and follow-up visits to address barriers to daily use.
c) Recommend event-based dosing for cisgender women at risk for HIV

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HIV Prevalence

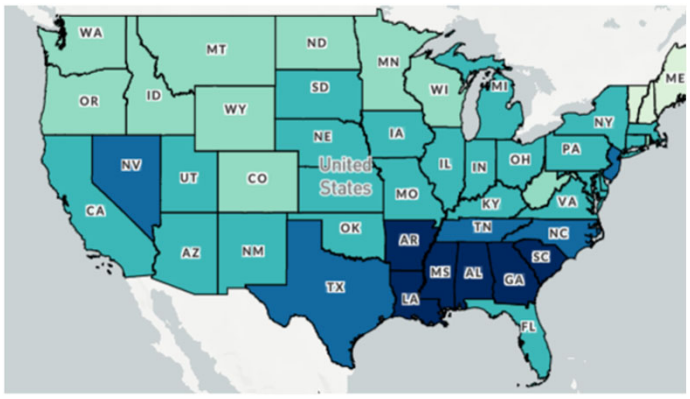
1.1 Million People Living with HIV – U.S., 2023



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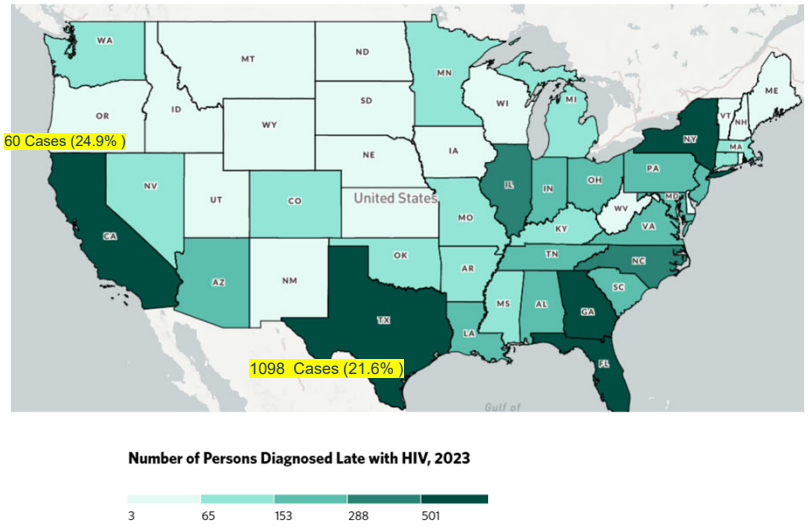
HIV Incidence in the USA

39,182 New HIV Diagnoses – U.S., 2023



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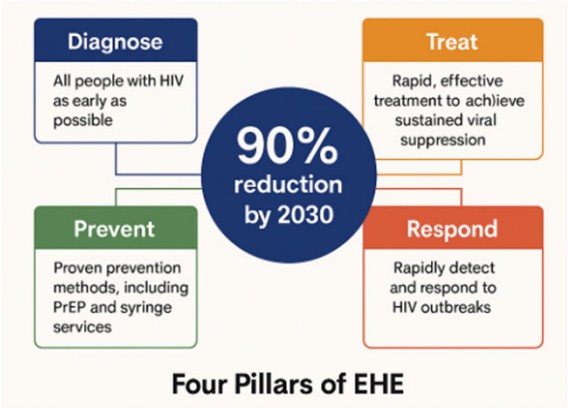
Late HIV Diagnosis – U.S., 2023



AIDSvu.org

7

Ending the HIV Epidemic (EHE)

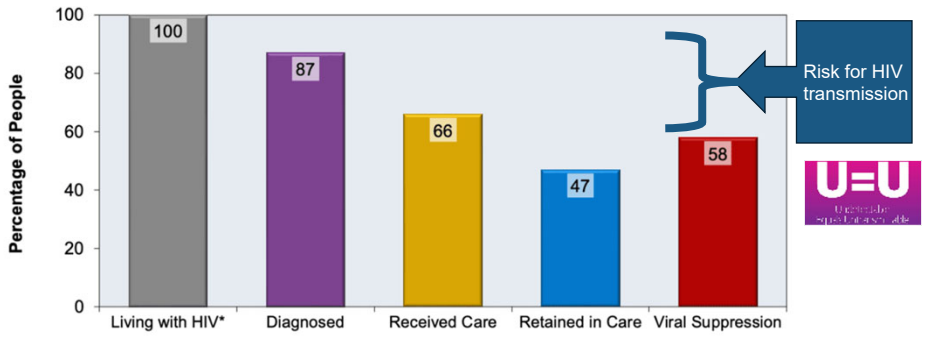


- **EHE (2019) to reduce new HIV infections.**
  - Reduce HIV infections by 75% by 2025
  - Reduce HIV infections by 90% by 2030.

https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/key-strategies

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HIV Cascade of Care

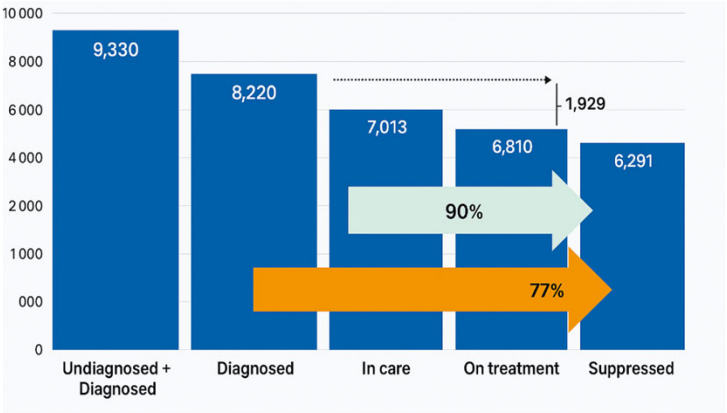


40% of new HIV infections occur in people unaware of their HIV status
Undetectable = Untransmittable (U=U)

University of Washington Curriculum. https://i-base.info/u-equals-u-qa/

9

HIV Cascade of Care in Oregon, 2022

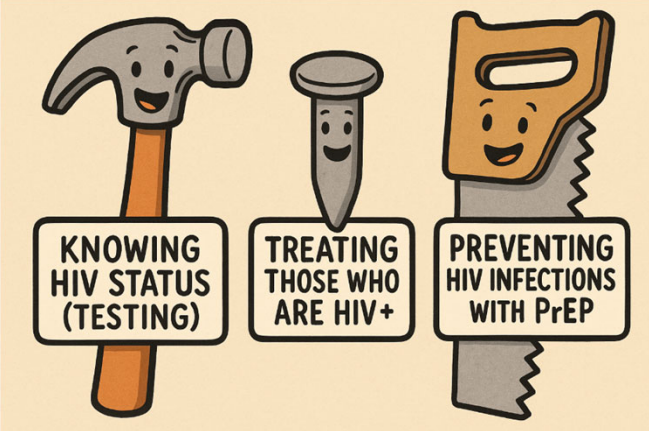


HIV Viral Load Suppression in 93% of reported results

Slide Credit Menza. OHA

10

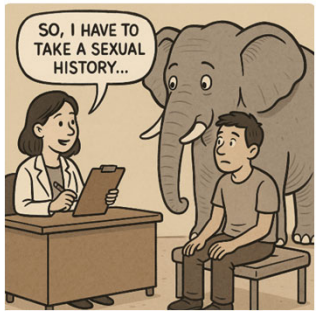
Stopping HIV: The tools we have today



11

Sexual History: The Conversation We Skip





Condom Use: 0–10 scale encourages more honest,
Nuanced discussion

12

Community, Networks, and Partners: HIV Risk Factors

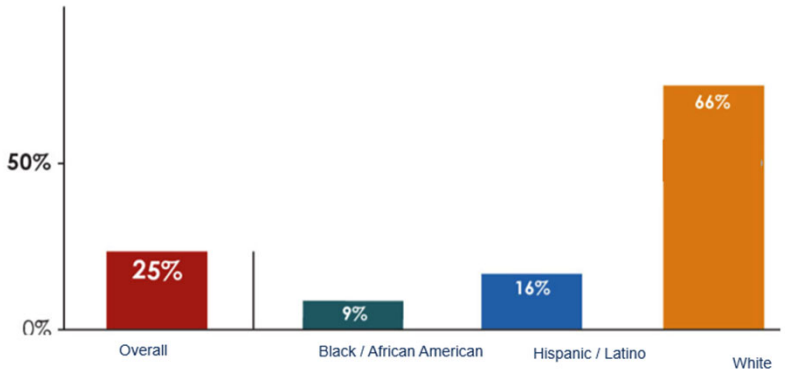
1. **Community Viral Load**
   - Higher HIV prevalence in a community increases individual risk
2. **Networks**
   - Social and sexual networks influence HIV exposure
3. **Partner Characteristics**
   - Partners' HIV status and risk behaviors are key factors



HIV risk depends less on partner number, more on partner behavior

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Disparities in PrEP Uptake Across Communities



CDC

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Importance of routine HIV Screenings



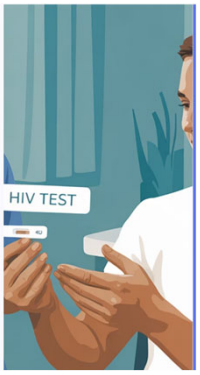
CDC Recommendations

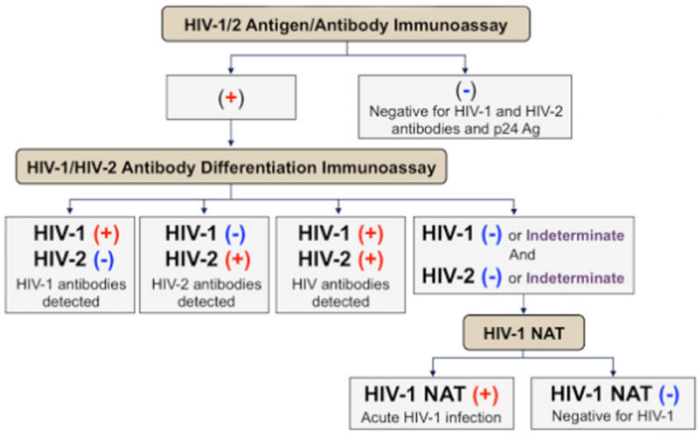
- To screen everyone ages 13–64
- 1 in 8 people HIV+ are unaware of status
- Undiagnosed HIV is driving new infections
- High-risk groups, more frequent testing
- Testing recommended in pregnancy

CDC. AIDSVU.org

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HIV Testing Algorithm



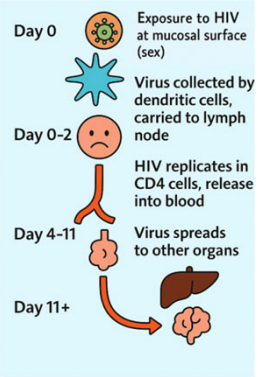


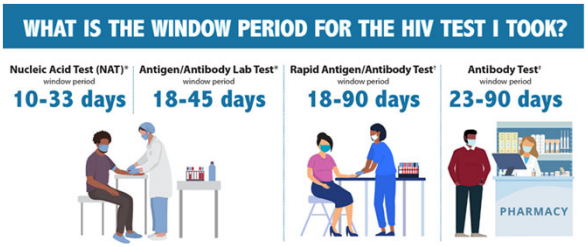
UW HIV curriculum

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Timeline of Detectable HIV Markers





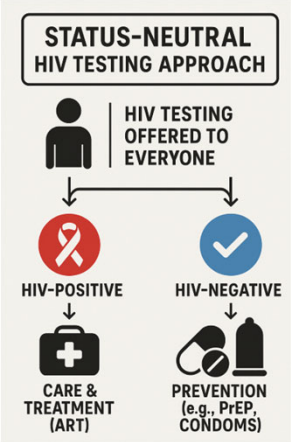
- No written consent required; patient must be informed
- HIV RNA detectable within 5–10 days
- HIV-1 p24 antigen detectable by ~15 days

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Status Neutral Approach

Status-Neutral Approach

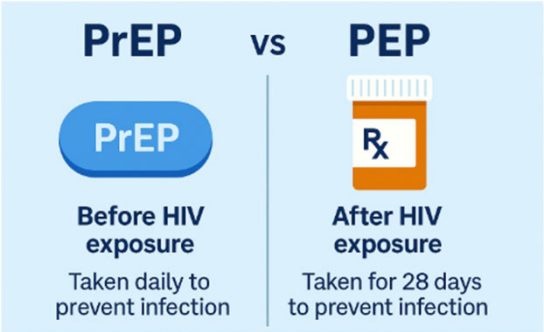
- Offer HIV testing universally, regardless of risk
- Link people with HIV to care and treatment
- Link HIV-negative people to prevention (e.g., PrEP)



Status Neutral normalizes HIV testing and can reduce stigma,

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PrEP vs. Post-Exposure



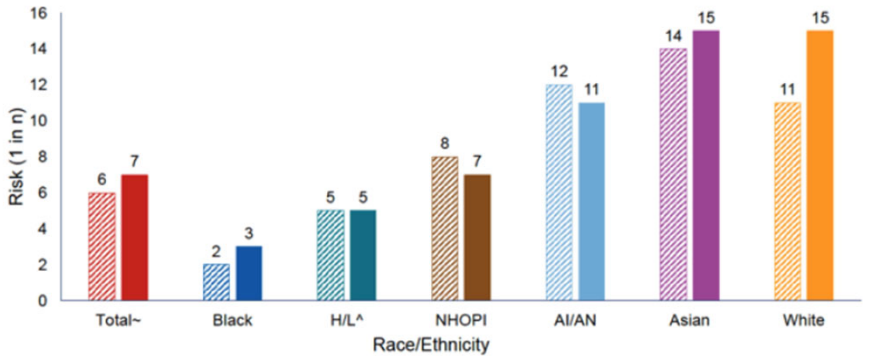
US Preventive Services Task Force | Evidence Report
June 11, 2019
Preexposure Prophylaxis for the Prevention of HIV Infection
Evidence Report and Systematic Review for the US Preventive Services Task Force
Roger Chou, MD[1,2]; Christopher Evans, MD, MPH[2]; Adam Hoverman, DO[3]; et al

PEP (within 72 hrs)
TDF/FTC 300/200 mg once QD
+
RAL 400 mg twice daily or
DTG 50 mg daily

CDC. PrEP Basics (https://www.cdc.gov/hiv/risk/prep/index.html)

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Lifetime HIV Risk among MSM 2010–2014 vs. 2017–2021 (Race/Ethnicity)

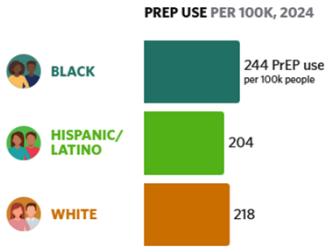


- AI/AN = American Indian/Alaska Native
- HL = Hispanic/Latino
- NHOPI = Native Hawaiian/Other Pacific Islander

Hess et al. *Lifetime risk of a diagnosis of HIV infection in the United States. Ann Epidemiol.* 2017;27(4):238–243 Singh et al.. CROI 2024 March 3-6 Denver.

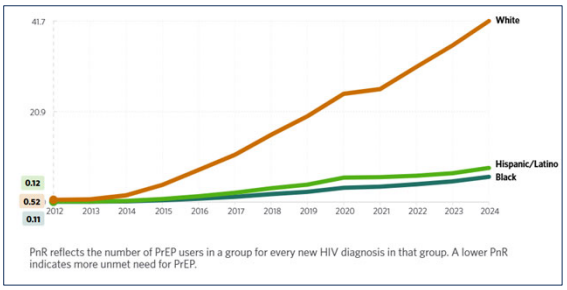
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Racial & Ethnic PrEP Disparities in HIV,USA– 2023





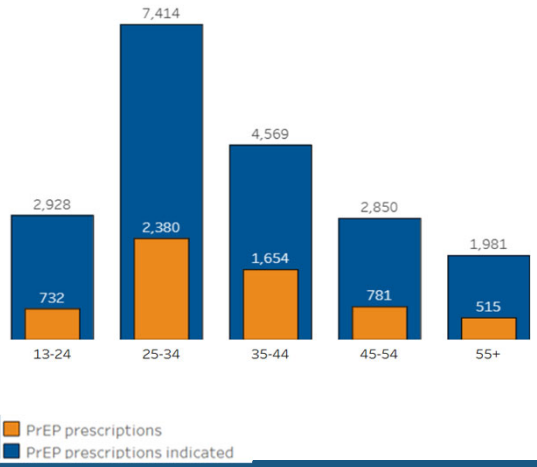
PrEP-to-Need Ratio (PNR) Trends by Race/Ethnicity, 2012–2024

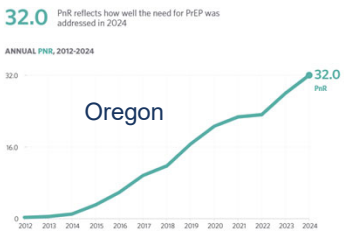


- PrEP-to-Need Ratio (PNR) compares
- PrEP uptake to new HIV diagnoses
- Higher PNR ratios mean better prevention coverage.

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Gaps for PrEP use by Age in OR

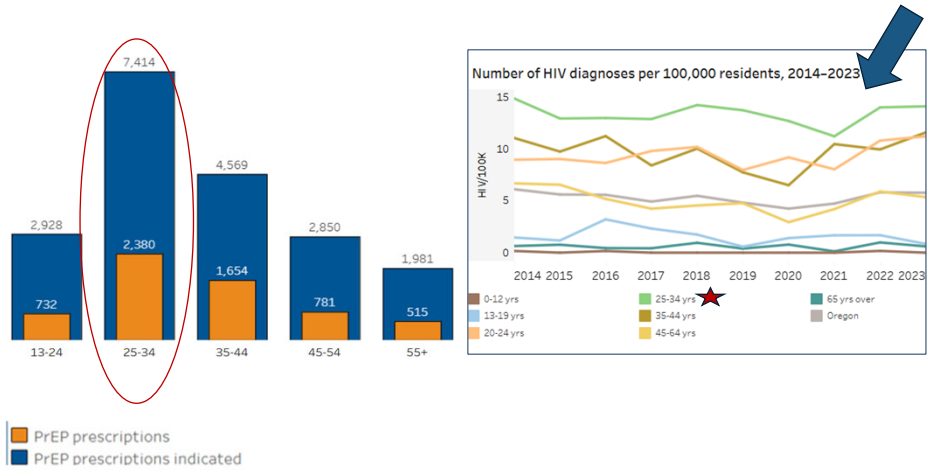






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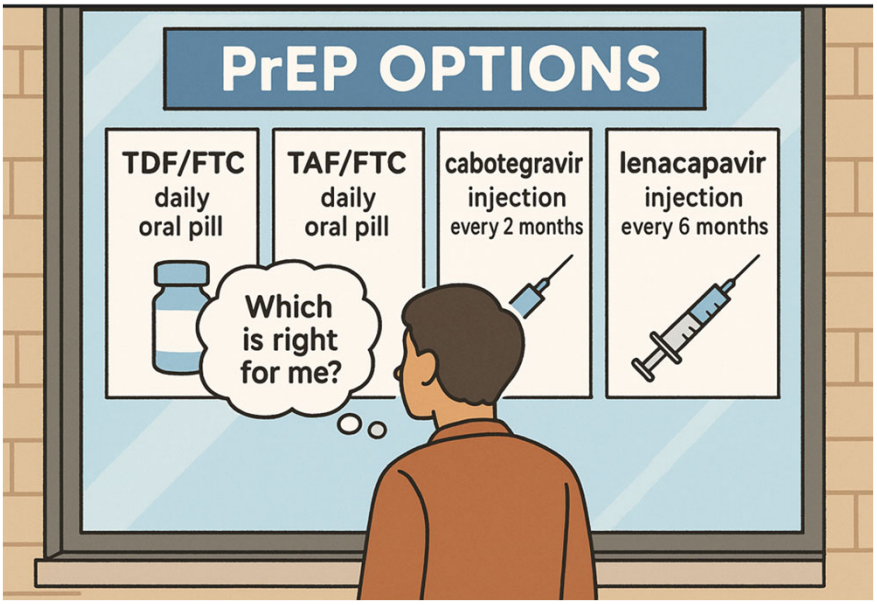
Gaps for PrEP use by Age in OR



Slide Credit Menza. OHA data. .Aidsvu.org

23

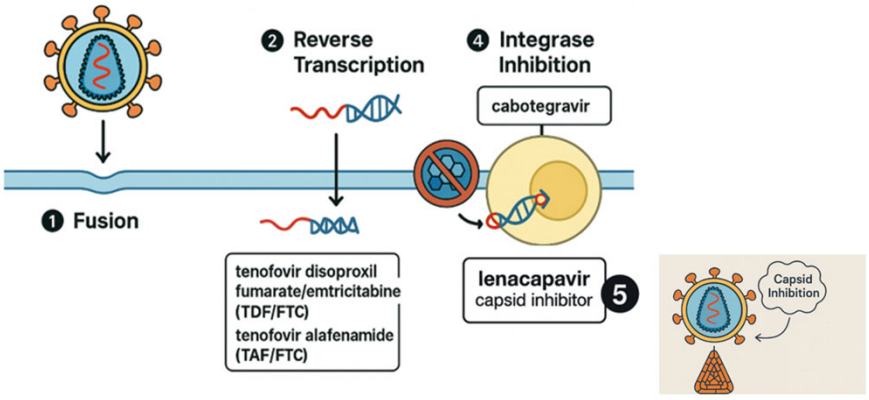
23



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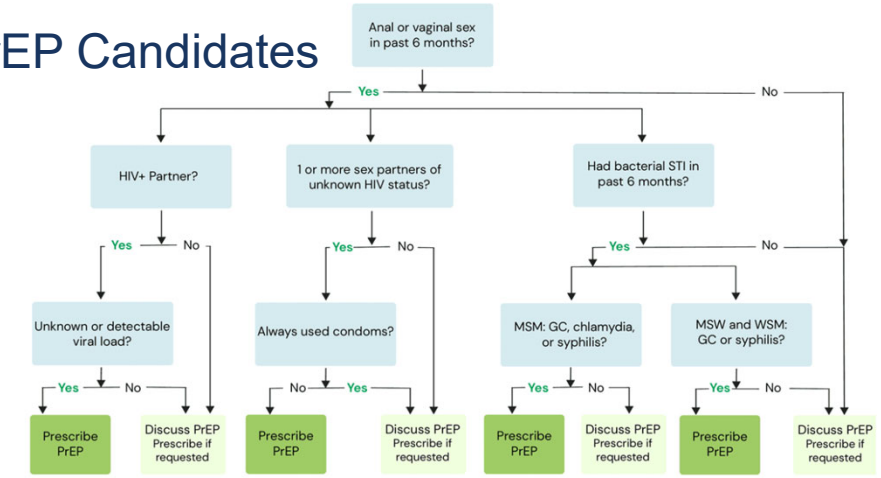
HIV Replication: PrEP Medications How They Work



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PrEP Candidates



Risk Factor	Population
HIV+ partner with unknown or detectable viral load*	All
Multiple partners of unknown status	All
Inconsistent condom use	All
Recent STI (GC, chlamydia, syphilis)	All

Risk Factor	Population
GC, chlamydia, or syphilis in past 6 months	MSM
GC or syphilis in past 6 months	MSW / WSM
Injection drug use	People who inject drugs

https://www.hivprep.uw.edu/ * U= U

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Major Trials (oral PrEP)

Study	Population	Comparison	Effectiveness
iPrEx	MSM & TGW	TDF/FTC vs Placebo	✔ 44% reduction overall, 92% if adherent
Partners PrEP	Serodifferent heterosexual couples	TDF/FTC vs TDF vs Placebo	✔ 75% reduction across all groups
VOICE	Cisgender women	5 arms (oral & vaginal TDF vs Placebo)	❌ Not effective overall, poor adherence
Bangkok Study	PWID	TDF vs Placebo	✔ 49% reduction overall, 74% if adherent

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Summary of PrEP studies

Trial	Population	Intervention	Efficacy (HIV Reduction)
iPrEX (N=2499)	MSM (US, S. America, Africa, Thailand)	Daily oral TDF/FTC	44% (95% CI 15–63)
Partners PrEP (N=4747)	Serodiscordant couples (Africa)	Daily oral TDF; TDF/FTC	Women: 71%; Men: 63% Women: 66%; Men: 84%
TDF2 (N=1219)	Heterosexual men & women (Botswana)	Daily oral TDF/FTC	62%* (underpowered)
Bangkok TFV (N=2413)	IDU (Bangkok)	Daily oral TDF	49% (95% CI 9.6–72.2)
FEM-PrEP (N=2120)	High-risk women (Africa)	Daily oral TDF/FTC	Stopped early (adherence)
VOICE (N=5029)	High-risk women (Africa)	Daily oral TDF; TDF/FTC; 1% TFV gel	No efficacy – adherence Gel & TDF arms stopped early

Adherence Measure	VOICE	FEM-PrEP
Self-report	91%	95%
Returned pill counts	92%	88%
Plasma TFV detection	**29%**	**24%**

Marrazzo et al. NEJM 2015; Van Damme et al. NEJM 2012

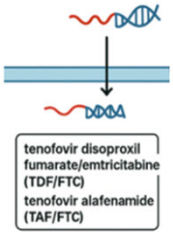
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Tenofovir DF–emtricitabine: TDF/FTC(Oral)

Product	Truvada® – Adults & adolescents ≥35 kg
Formulation & Dosing	TDF 300 mg + FTC 200 mg (fixed-dose) 1 tablet once daily (with or without food) On-demand 2-1-1 (not FDA-approved*)
Renal Impairment	Avoid use if CrCl <60 mL/min
Key Studies	1. Effective in MSM (iPrEx Trial) 2. Heterosex serodifferent (Partners PrEP) 3. Heterosexual men & women (TDF2) 4. Risk IVDU (Bangkok Study)

Mechanism: Inhibits reverse transcriptase (RNA → DNA)



UW PrEP Curriculum. * CDC supports off-label' use for select MSM

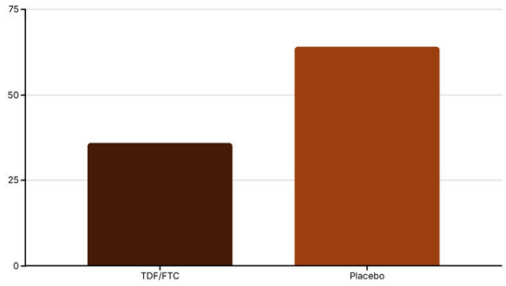
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iPrEx Trial – TDF/FTC PrEP

- Multinational, randomized, double-blind, placebo-controlled
- **MSM & TGW** at high risk for HIV

4,970	2,499	2,470
Total Participants	**Placebo Group**	**TDF/FTC Group**
HIV-negative adults at high risk for HIV acquisition		

Primary Results: New HIV Infections



44%
Overall Risk Reduction
95% CI: 15–63%; $p<0.001$

92%
pts with detectable drug levels,

Key Point
Daily TDF/FTC → significantly lowers HIV incidence, esp. with good adherence

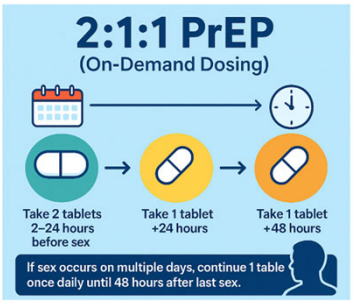
Grant RM, Lama JR, Anderson PL, et al. N Engl J Med. 2010;363:2587-99. UW PrEP Curriculum

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PrEP on Demand event-driven or 2-1-1

Before Sex
- Take 2 pills of = 2 to 24 hours before sex

After Sex
- Take 1 pill 24 hours after the first dose
- Take 1 pill 48 hours after the first dose
- Total 4 pills



Key Finding:
- IPERGAY - Efficacy 86%
- Only studied in MSM

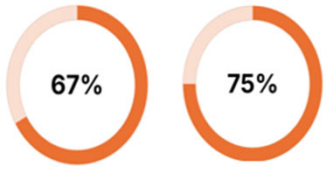
Molina et al December 3, 2015. N Engl J Med 2015;373:2237-2246

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PrEP in Heterosexual HIV-Serodifferent Couples

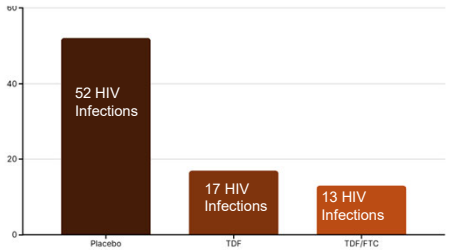
- Randomized, double-blind, placebo-controlled trial (Kenya & Uganda)
- **4,747 serodifferent couples**
  - HIV+ partner not on ART
- Arms**: Placebo vs TDF vs TDF/FTC**

Free condoms, training & counseling, referrals for male circumcision and PEP per national policies



TDF: **risk reduction**

TDF/FTC: **risk reduction**



Key Finding:
- Daily oral TDF or TDF/FTC reduced HIV transmission in serodifferent heterosexual couples.

Baeten JM, Donnell D, Ndase P, et al. N Engl J Med. 2012;367:399-410.

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Bangkok TDF: HIV PrEP for People Who Inject Drugs

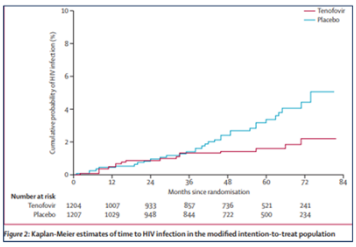


- Randomized, double-blind, placebo-controlled (Thailand)
- Participants: **2,413 HIV-negative adults**
- 20–60 yrs with recent IVDU
- Daily oral TDF vs. placebo

0.35
HIV Incidence (TDF)
Per 100 person-years with TDF treatment

0.68
HIV Incidence (Placebo)
Per 100 person-years with placebo

49%
Risk Reduction
95% CI: 9.6–72.2; p=0.01



Key Finding
- Oral TDF significantly reduced HIV risk among persons who inject drugs.

Choopanya K, Martin M, Suntharasamai P, et al. Lancet. 2013;381:2083-90.

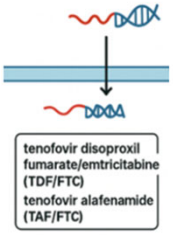
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Tenofovir Alafenamide–Emtricitabine (Oral)

Product	Descovy® – Adults & adolescents ≥35 kg
Formulation & Dosing	TAF 25 mg + FTC 200 mg (fixed-dose) 1 tablet once daily (with or without food)
Not Recommended For	• Women at risk from vaginal sex • On-demand (2-1-1) dosing • People who inject drugs
Renal Impairment & Key Study	Not recommended if CrCl <30 mL/min
Key Studies	DISCOVER Trial: TAF/FTC non-inferior to TDF/FTC in MSM & transgender women

Mechanism: Inhibits reverse transcriptase (RNA → DNA)

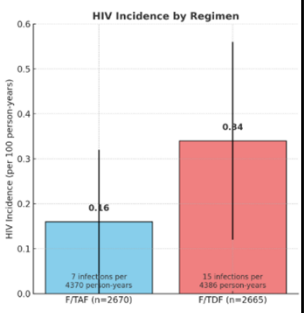


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DISCOVER Trial

- **Design**:
  - Phase 3, randomized, double-blind, active-controlled.
- >5,300 MSM and TGW who have sex with men in North America and Europe.
- **FTC/TAF (Descovy) vs. FTC/TDF**
- **Findings**:
  - HIV Incidence:
    - 7 HIV + (FTC/TAF)
    - 15 HIV + (FTC/TDF)
      - (IRR 0.47 not statistically sig)

HIV Incidence By Regimen

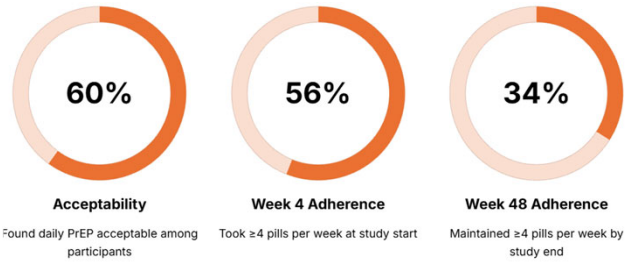


Key Finding:
- FTC/TAF non-inferior to FTC/TDF in MSM/TGW.
- Safer for renal & bone.
- Risks Weight gain & lipids
- Not approved for receptive vaginal sex.

Mayer et la. Lancet. 2020 Jul 25;396(10246):239-254. doi: 10.1016/S0140-6736(20)31065-5.

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ATN 110: HIV PrEP for Young MSM



Acceptability	**60% found daily TDF/FTC acceptable**
Adherence	**56% adequate at week 4 → dropped to 34% by week 48**
Behavior	**High sexual activity, frequent STIs, stable throughout**
Efficacy	**4 HIV seroconversions (3.29/100 person-years)**

Key Finding: While PrEP was acceptable, adherence declined sharply

Hosek SG, Rudy B, Landovitz R, et al. J Acquir Immune Defic Syndr. 2017;74:21-9. [PMID: 27632233

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Time to Protection with PrEP (TDF/FTC)



Day 1
Begin PrEP regimen

2

Day 7
Protective levels for rectal tissue

Day 21
Maximum protection for all tissue types
Vaginal tissue

- **Anal sex (receptive):** Maximum protection in ~7 days of daily PrEP use
- **Vaginal sex & IVD:** Maximum protection in ~21 days of daily PrEP use

Seifert, CID, 2015; www.cdc.gov/hiv/basics/prep.html

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Labs for Baseline oral PrEP

Test	TDF/FTC	TAF/FTC
HIV Ag/Ab	Baseline + every 3 months	Baseline + every 3 months
Kidney function (Cr/eGFR)	Baseline + q6–12mo Avoid if eGFR <60 mL/min	Baseline + q6–12mo Avoid if eGFR <30 mL/min
Hepatitis B serologies	Baseline	Baseline
Hepatitis C antibody	Baseline	Baseline
STI screening (GC/CT, syphilis, swabs)	Baseline + q3–6mo	Baseline + q3–6mo
Lipids	Not required	Baseline
Pregnancy test (if applicable)	Baseline ± as indicated	Baseline ± as indicated

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Interpreting Hepatitis B Serology

Pattern	Interpretation	PrEP Guidance
HBsAg –, Anti-HBs – Anti-HBc –	Susceptible (no infection, no immunity)	💉 Vaccinate before or during PrEP
HBsAg – Anti-HBs + Anti-HBc –	Immune (vaccine)	✅ Safe (oral or injectable)
HBsAg – Anti-HBs + Anti-HBc +	Immune (past infection)	✅ Safe (oral or injectable)
HBsAg + Anti-HBc +	Chronic infection	⚠️ Oral PrEP treats HBV but flare risk if stopped
HBsAg – Anti-HBs – Anti-HBc +	Isolated anti-HBc (uncertain)	🔎 Check HBV DNA ✅ Can use PrEP with monitoring

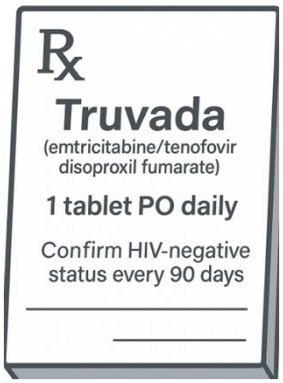
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Rx. Oral PrEP (TAF/FTC or TDF/FTC)

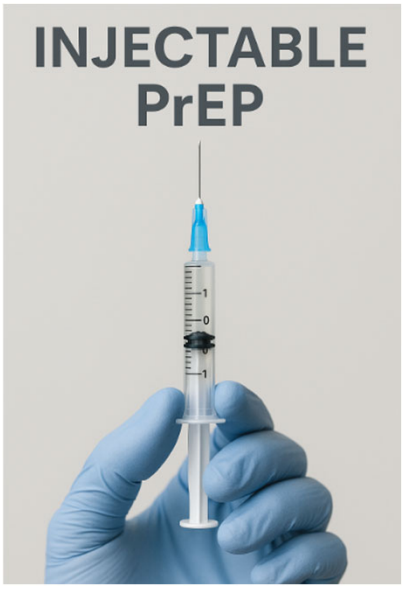
- TDF/FTC : Take 1 tablet daily
- TAF/FTC: Take 1 tablet daily

- Confirm HIV status every 90 days
- Assess adherence
- Provide risk-reduction counseling



http://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf

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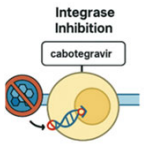


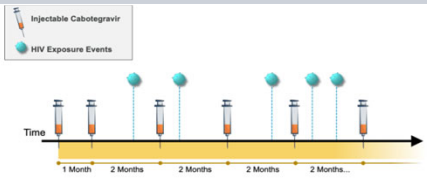
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Cabotegravir LA Injectable

Products	
Indication	Apretude® • PrEP (Adults & adolescents ≥35 kg
Initiation	**Oral Optional lead-in:** • Oral cabotegravir 30 mg QD × ≥28 days **Injectable Phase:** • Injection 1: 600 mg IM (gluteal) • Injection 2: 600 mg IM (gluteal) given ~1 month later
Maintain	• 600 mg IM (gluteal) every 2 months • No oral overlap needed after initiation **Gluteal injection** • 2-inch needle (BMI of ≥30)

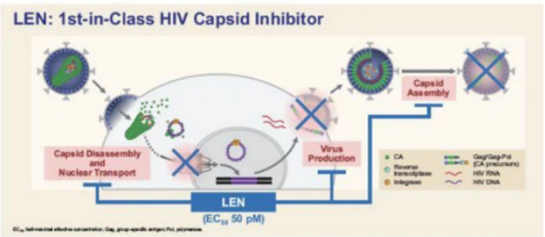




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Lenacapavir-SQ (LA)

Category	Details
Products	Yeztugo® • PrEP-Sex (Adults & adolescents ≥35kg Sunlenca® HIV treatment
Initiation (2 days)	• Day 1: Oral 600 mg (2 × 300 mg) + SQ 927 mg (2 × 463.5 mg) • Day 2: Oral 600 mg (2 × 300 mg)
Maintain	• SQ 927 mg every 26 weeks • Rapid LEN plasma levels after oral + first injection → therapeutic by Day 2





https://www.hsppharma.com/info/gilead-lenacapavir-treats-patients-with-multi-59781417.html. https://www.yeztugohcp.com/dosing-administration

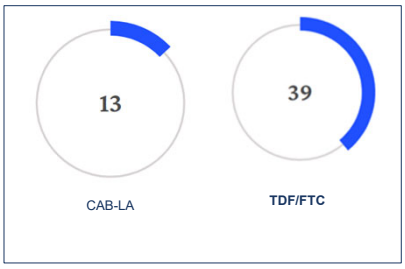
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HPTN 083 – Cabotegravir vs. TDF/FTC for HIV PrEP in MSM

- Randomized, double-blind,
- Noninferiority trial
- Participants: 3,992 MSM
- **Intervention:**
  - CAB-LA N =2,282
  - TDF/FTC N =2,284

Results: HIV infections:

- 13 (CAB) vs 39 (TDF/FTC)
- Incidence: 0.41 vs 1.22/100 py



Key Finding:

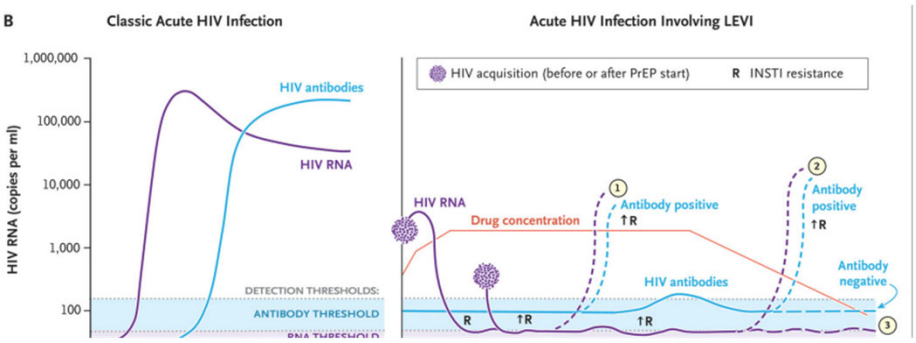
- **HPTN 083 (MSM & TGW):**
  - CAB-LA significantly reduced HIV incidence vs daily oral TDF/FTC
- **HPTN 084 (Cisgender Women):**
  - 34 new HIV infections in **TDF/FTC** group (1.79/100 person-years) vs.
  - 4 new HIV infections in **CAB-LA** group (0.21/100 py)
- CAB-LA demonstrated **superiority** over daily oral FTC/TDF in both trials

Landovitz et al. 2021 Aug 12;385(7):595-608. Moretlwe, et al Lancet. 2022 May 7;399(10337):1779-1789

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False negative HIV test on LA CAB LA Early Viral Syndrome(LEVI)



Delayed HIV seroconversion in people on LA-CAB

https://www.natap.org/2023/CROI/croi_27.htm

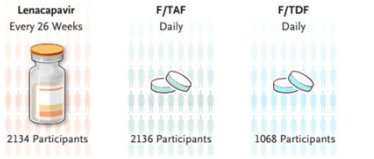
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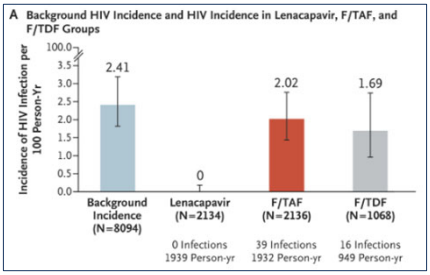
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Lenacapavir. Purpose 1

Cis Women – Sub-Saharan Africa

- **Phase 3 RCT**
- **N=5,338, HIV–negative**
  - Randomization 2:2:1
    - LEN (SC q26w), F/TAF QD,
    - F/TDF QD (active control)
- **HIV Infections (per 100 PY)**
  - **LEN: 0 (**95% CI, 0.00–0.19)
  - **F/TAF: 39 (**95% CI, 1.44–2.76)
  - **F/TDF: 16** 95% CI, 0.96–2.74)
  - Background incidence: 2.41





Key Finding:
- LEN provided 100% protection against HIV
- No difference between F/TAF & FTC/TDF (? adherence)

Bekker et al. N Engl J Med 2024;391:1179-1192

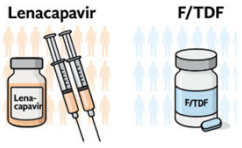
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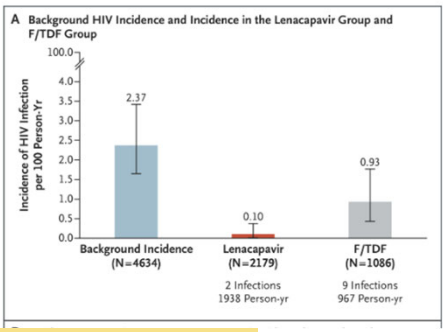
Lenacapavir. Purpose 2

Cis men, TGW/men, non-binary (global)

Phase 3 RCT
N = 3,265 (HIV negative)
- Randomization **2:1**
- **Arms:** LEN q26w (SQ) vs. F/TDF daily

HIV Infections (per 100 PY)
- **LEN:** 2 / 2,183
  - **0.10** (95% CI, 0.01–0.37)
- **F/TDF:** 9 / 1,088
  - **0.93** (95% CI, 0.43–1.77)
- Oral PrEP limited by adherence





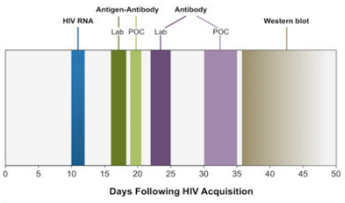
Key Finding: LEN 96% relative risk reduction against HIV

C. F. Kelly et al. N Engl J Med 2025;392:1261-1276. November 27, 2024

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Labs for Baseline Injectable PrEP

Test	CAB-LA	LEN-SC
HIV Ag/Ab ± HIV RNA	Baseline + before every injection (q2mo)	Baseline + before every injection (q6mo)
Kidney function (Cr/eGFR)	Not required	Not required
Hepatitis B serologies	Baseline	Baseline
Hepatitis C antibody	Baseline	Baseline
STI screening (GC/CT, syphilis, swabs)	Baseline + q3–6mo	Baseline + q3–6mo
Lipids	Not required	Not required
Pregnancy test (if applicable)	Baseline ± as indicated	Baseline ± as indicated



UW National HIV curriculum

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Missed Doses LEN & CAB

Lenacapavir

Missed Day # 2 pill:
Take ASAP (not with Day 1)

- **Injection ≤2 wks late:** Continue schedule as planned
- **Injection >2 wks late:**
  - Use 300 mg pill weekly until restart (for ≤6 months)
- **>28 wks since last injection:**
  - Restart full initiation

Cabotegravir

- **Missed 2nd dose**
  - ≤2 months late → Give ASAP, continue q2mo
  - 2 months late → Restart initiation doses
- **Missed 3rd+ dose**
  - ≤3 months late → Give ASAP, continue q2mo
  - 3 months late → Restart initiation doses

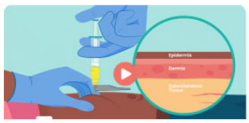
Product Package inserts,

50

Injection Site Reactions – Injectables

Cabotegravir LA) –

- Very common (38–82% in trials)
- Pain, redness, swelling
- Typically mild–moderate, short-lived
- Occasional systemic effects: fever, fatigue, headache
- Rare but possible: depression, liver issues



Lenacapavir SC

- Very common (≥65% in trials)
- Nodules/lumps, pain, swelling, redness, itching
- Most mild–moderate; <1% severe
- Nodules may persist but improve with time

Expect in first week

- ❄️ Ice: apply before & after injection
- 💊 Medication: numbing cream or oral analgesics

https://www.askgileadmedical.com/docs/yeztugo/yeztugo-injection-site-reactions

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Lenacapavir: Key Drug Interactions

Metabolism

- Substrate of **P-gp, UGT1A1, CYP3A**
- **Caution / Monitor With**
  - **DOACs** → ↑ bleeding risk
  - **Corticosteroids** (oral, inhaled, systemic:
    - LEN inhibits CYP3A4 → ↑ steroid
      - Risk: **Cushing's / adrenal suppression**
      - **Consider beclomethasone**
- **PDE5 inhibitors**
  - Sildenafil → start 25 mg q48h; monitor
  - Tadalafil → start 5 mg; max 10 mg q72h;
- **Boosters** (cobi or DRV/cobi
  - (HIV treatment NOT PrEP) → ↑ LEN
- **Inducers** (rifampin) → ↓ LEN exposure



https://www.askgileadmedical com https://www.hivguidelines.org. DRV – Darunavir Cobi – cobicistat

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The Future: Antibodies & PrEP

The NEW ENGLAND JOURNAL of MEDICINE

CURRENT ISSUE SPECIALTIES TOPICS

ORIGINAL ARTICLE

Two Randomized Trials of Neutralizing Antibodies to Prevent HIV-1 Acquisition

Authors: Lawrence Corey, M.D., Peter B. Gilbert, Ph.D., Michal Juraska, Ph.D., David C. Montefiori, Ph.D., Lynn Morris, Ph.D., Shelly T. Karuna, M.D., Srilatha Edupuganti, M.D., +38, for the HVTN 704/HPTN 085 and HVTN 703/HPTN 081 Study Teams* Author Info & Affiliations

Published March 17, 2021 | N Engl J Med 2021;384:1003-1014 | DOI: 10.1056/NEJMoa2031738 | VOL. 384 NO. 11

- At-risk cisgender men & transgender persons (Americas/Europe) and at-risk women (sub-Saharan Africa)
- Randomized to VRC01 (10 or 30 mg/kg) or placebo, every 8 weeks
- **Outcome:** No overall HIV prevention benefit

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Islatravir (MK-8591) & MK8527.

1st -in-Class HIV Nucleoside RT Translocation Inhibitor (NRTTI)

September 20, 2022 11:00 AM EDT R&D **Islatravir**

In wake of safety scare, Merck scraps monthly PrEP plans for lead HIV drug — while marching ahead with revised clinical plans



Merk discontinues Islatravir
- Discontinued once-monthly oral **islatravir** for PrEP
- Trials saw decreases in **total lymphocytes** and **CD4 counts**

Newer Agent
- **MK-8527 (NRTTI) – once per month**
- Two large Phase III trials, EXPrESSIVE-10 and EXPrESSIVE-11

https://www.aidsmap.com/news/sep-2022/merck-restarts-islatravir-hiv-treatment-studies-abandons-monthly-prep.
https://www.prepwatch.org/products/mk-8527

54

The Future: Patches & Injectables

TAF/ELV Insert



Microneedle Array Patches



ULA CAB



- Studies looking at ultra-long yearly Lenacapavir for PrEP.
- Studies looking at rectal tenofovir douche is in Phase 1 testing.

IAS Raphael J. Landovitz, MD, MSc. AIDS map L. Highleyman. Weld. J Infect Dis 2024 Apr 12;229(4):1131-1140

55

55

Summary of PrEP Choices

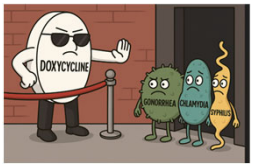
💊 Oral (TDF/FTC)	💊 Oral (TAF/FTC)	💉 CAB LA	💉 LEN SC
🛡️ 99% effective (with adherence)	🛡️ Effective for MSM & TGW (sex with men)	🛡️ Superior to TDF/FTC (adherence)	🛡️ Superior to TDF/FTC (adherence)
• All Sexual Exposures • IVDU	• Specific Sexual Exposures ⚠️ Not vaginal ⚠️ Not IVDU	• All Sexual exposures ⚠️ Not IVDU	• All Sexual exposures ⚠️ Not IVDU
• Daily pill or • Event-dose 2-1-1 (MSM)	Daily Pill	IM every 2 months	SC every 6 months
Self administration	Self administration	Medical/Office administration	Medical/Office administration

MSM . Men who have male partners. TGW. Transgender Women

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STI Prevention –DoxyPEP

Remember other Prevention



Timing & Dosage
- Take 200 mg doxycycline within 72 hours (ideally <24h) after condomless sex
- Max 200 mg every 24 hours

Eligibility Criteria
- Assigned male at birth
- Living with HIV or on PrEP
- ≥1 STI in past 12 months
- Condomless sex w ≥1 male partner in past year

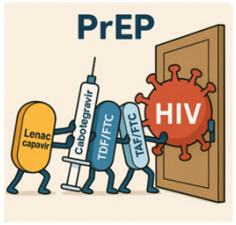
Prescription Instructions
- Take 2 tablets after sex (within 24–72 hrs)
- Rx. Limit to 1 dose/24 hrs; # 60
- Discuss side effects

Infection	Risk Reduction (PrEP)	Risk Reduction (PLWH)
Gonorrhea	55% (CI: 35–68%), $p<0.0001$	57% (CI: 29–74%), $p=0.001$
Chlamydia	88% (CI: 75–95%), $p<0.0001$	74% (CI: 43–88%), $p=0.0007$
Syphilis	87% (CI: 41–97%), $p=0.0084$	77% (CI: 71–96%), $p=0.095$

Leutkemyer et al. N Engl J Med. 2023 Apr 6; 388(14): 1296–1306, Stewart et al. **December 20, 2023 N Engl J Med 2023;389:2331-2340**

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Summary on PrEP



1. PrEP prevents HIV if used consistently
2. Options: daily oral (TDF/FTC, TAF/FTC), CAB q2mo, LEN q6mo
3. Some PrEP has specific risk approvals
4. TDF/FTC can be taken on demand
5. Oral PrEP → HIV labs q3mo
6. CAB → HIV test q2mo
7. LEN → HIV test q6mo
8. STI screening + vaccines (Hep A/B, Mpox, HPV)
9. Consider DoxyPEP for MSM, TGW
10. Adherence support needed for oral PrEP
11. Injectables help with pill fatigue/adherence
12. Address barriers: stigma, awareness, access



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Pretest Questions

Which is the preferred HIV screening test before starting a patient on oral PrEP?

a) HIV-1/2 antigen-antibody (4th generation) test.
b) HIV-1 antibody rapid test only.
c) HIV RNA PCR.

Which hepatitis B finding would require additional clinical consideration before starting PrEP?

a) Positive hepatitis B surface antigen.
b) Negative hepatitis B core antibody.
c) Positive hepatitis B surface antibody.

Which is the most effective approach to support PrEP adherence for people on oral PrEP?

a) Provide a year's supply of PrEP (90 days with 3 refills).
b) Provide counseling, reminders, and follow-up visits to address barriers to daily use.
c) Recommend event-based dosing for cisgender women at risk for HIV

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Questions ?



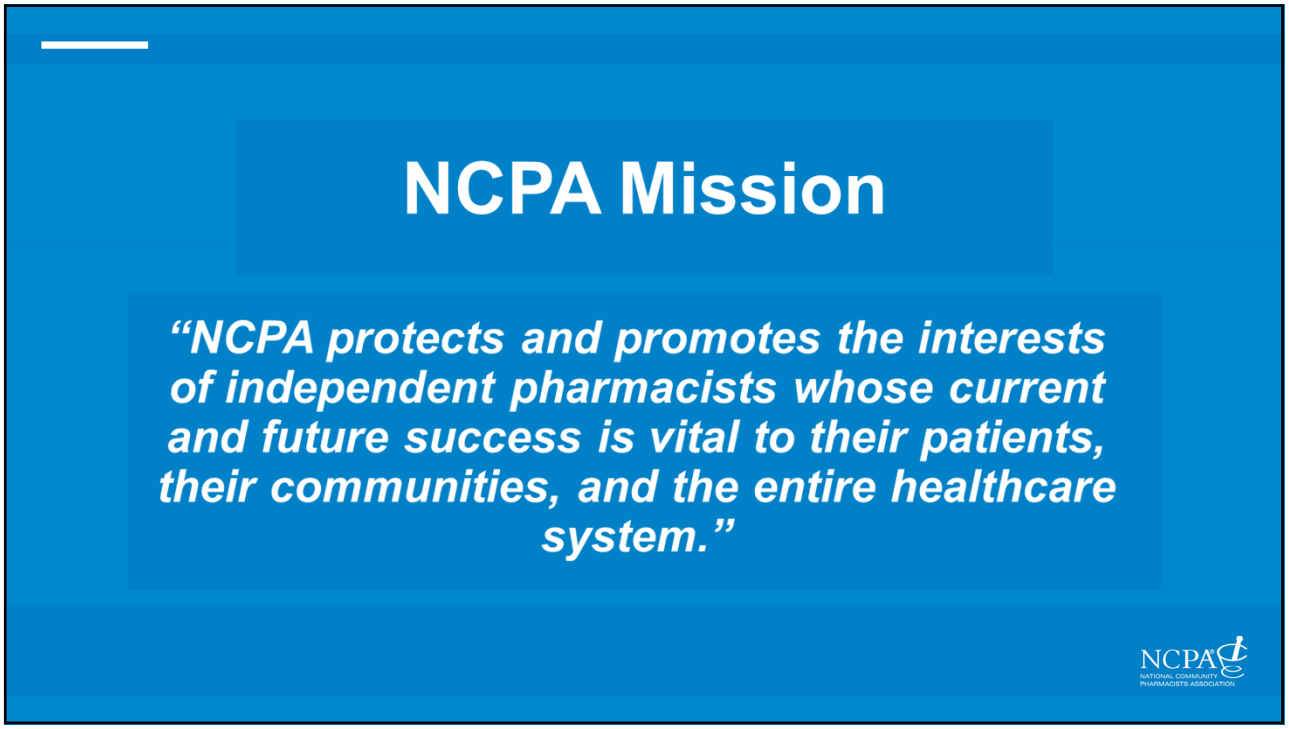


Contact: evanch@ohsu.edu

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The *voice* of the community pharmacist.
NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

1


NCPA Mission
"NCPA protects and promotes the interests of independent pharmacists whose current and future success is vital to their patients, their communities, and the entire healthcare system."
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NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

2

Pharmacy Policy and Law Update



Oregon State Pharmacy Association Annual Convention

September 27, 2025

3

Speakers



Steve Postal, JD

Senior Director, Policy & Regulatory Affairs, NCPA

Editorial Director, ASPL



Jeff Harrell, PharmD

President, NCPA

CEO, Cascadia Pharmacy Group

4

Learning Objectives

- Identify key federal regulatory developments that directly impact the pharmacy profession, including changes to Medicare Part D and the Medicare Drug Price Negotiation Program
- Analyze the potential effects of proposed federal legislation on pharmacy practice, patient care, and the broader healthcare system, with focus on emerging trends such as pharmacy benefits managers (PBMs), and pharmacy reimbursement

5

Learning Objectives

- Examine developments in key legal cases that impact the pharmacy profession
- Evaluate the role of pharmacists in advocating for or responding to federal legislative changes, including strategies for engaging with policymakers and ensuring new federal regulations and legislation align with the goals of patient safety, access to care, and professional standards

6

Pre-Test Question #1

Which of the following is a likely financial impact of the Medicare Drug Price Negotiation on pharmacies?

A) Payment delays
B) Weekly cash flow shortfalls
C) Annual revenue losses
D) All of the above

7

Pre-Test Question #2

If passed, how much in taxpayer savings would PBM reform save, according to the CBO?

A) $1 billion
B) $2 billion
C) $3 billion
D) $4 billion
E) Over $5 billion

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Pre-Test Question #3

Which of the following is the limited liability company created by NCPA to investigate and, when appropriate, litigate or arbitrate on behalf of community pharmacies to recover coerced price concessions?

A) NCPA LLC
B) FAIR LLC
C) TRUST LLC
D) STARK LLC

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Pre-Test Question #4

What can pharmacists and pharmacy technicians do to become more involved in advocacy?

A) Keep updated by visiting NCPA's and CMS' websites
B) Visit NCPA's Legislative Action Center to support PBM reform
C) Come to NCPA's annual convention
D) All of the above

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Inflation Reduction Act

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Inflation Reduction Act

2023
- Vaccines – Part D, Medicaid, CHIP
- Insulin – Part D and MA

2024

For Part D:
- Coinsurance for catastrophic coverage eliminated
- Premium increases capped

2025

For Part D:
- Annual out-of-pocket cap
- Optional "smoothing" of patient cost-sharing

We are Here

2026
- **Medicare Part D Drug Price Negotiation Program (MDPNP)**

12

Medicare Drug Price Negotiation

Secretary of HHS will negotiate pricing for:

- 2026: 10 drugs based on Part D spending
- 2027: 15 more drugs based on Part D spending
- 2028: 15 drugs more based on combined Part D and Part B spending
- 2029 and beyond: 20 more drugs based on combined Part D and Part B spending



Maximum fair prices (MFPs) were publicly released in 1) August 2024 and 2) January 2025

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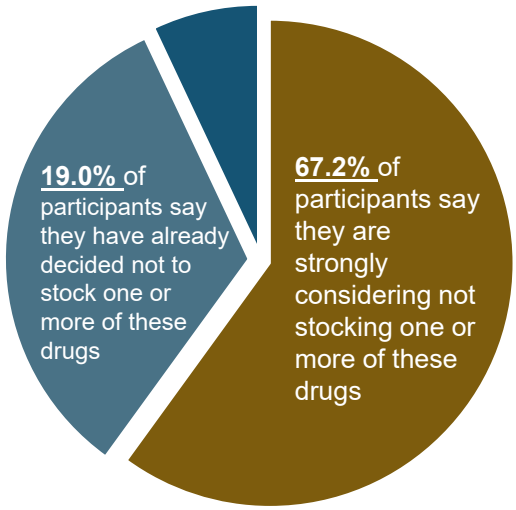
14

Unpacking the Financial Impacts of Medicare Drug Price Negotiation

- **Payment delays:** Pharmacies will face prescription payment settlement delays of at least seven additional days for negotiated drugs, exceeding current Medicare Part D prompt pay requirements.
- **Weekly cash flow shortfalls:** Each pharmacy stands to lose nearly $11,000 in weekly cash flow due to delayed payments.
- **Annual revenue losses:** Pharmacies could forfeit an average of $43,000 in annual revenue — roughly equivalent to a pharmacy technician's yearly salary.

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NCPA Found that 86.2% of pharmacies have either decided not to stock drugs covered by the MDPN program or are considering not stocking them.

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NCPA Comments Submitted

- Letter to Dr. Oz re: ongoing concerns with Medicare Drug Price Negotiation Program (MDPNP) (September 2025)
- Comments to CMS on Draft Guidance on the MDPNP (June 2025)
- Comments to CMS deregulation RFI (June 2025)
- Welcome letter to Dr. Oz (May 2025)
- Comments to CMS on MDPNP program draft forms (May 2025)
  - MTF DM Dispensing Entity and Third-Party Support Entity Enrollment Form
  - MTF DM Primary Manufacturer MFP Effectuation Plan Form
  - Complaint and Dispute Intake Form

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NCPA Comments Submitted

- Joint NCPA/APhA/ASCP/NASPA/ASHP letter calling on CMS to freeze the MDPNP (Feb 2025)
- Comments to CMS on Medicare Part D and MA advance notice (Feb 2025)
- Comments to CMS on Medicare Part D proposed rule (Jan 2025)
- Comments to Domestic Policy Council regarding concerns with the MDPNP (Jan 2025)
- Comments to CMS on its draft pharmacy agreements of the MDPNP (Jan 2025)
- Letter to DOGE regarding recommendations for PBM reform and reforms to the MDPNP (Dec 2024)

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NCPA Comments Submitted

- Comments to CMS on MDPNP draft forms (Dec 2024)
  - MTF DM Dispensing Entity and Third-Party Support Entity Enrollment Form
  - MTF DM Primary Manufacturer MFP Effectuation Plan Form
  - Complaint and Dispute Intake Form
- Comments to CMS' calendar year 2025 physician fee schedule (Sept 2024)
- Comments to CMS' draft guidance on the MDPNP (July 2024)

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NCPA Asks for IRA/MFP Implementation

CMS Must Address Part D Plan Sponsor/PBM Payments to Pharmacies for MFP Drugs to Ensure Beneficiary Access to MFP Drugs

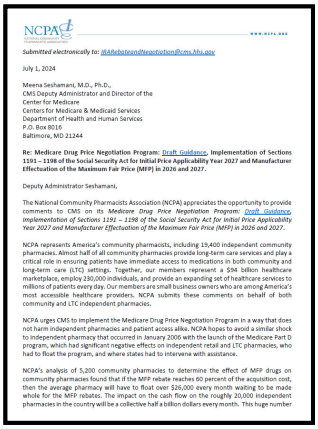
CMS did not adequately address

CMS must clarify that the **manufacturer should pay the pharmacy a rebate amount of the difference between Wholesale Acquisition Cost (WAC) and MFP**.

WAC minus MFP is the standard default refund amount , however, manufacturers can choose another amount

NCPA stresses that **pharmacies need to be paid timely**, within 14 days of adjudicating the claim.

The 14-day window does not begin until manufacturer receives MTF DM data. CMS states MFP refund payment will be in excess of 14 days from time of claim submission.



NCPA

July 1, 2024

Meena Seshamani, M.D., Ph.D.,
CMS Deputy Administrator and Director of the
Center for Medicare
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244

Re: Medicare Drug Price Negotiation Program: Draft Guidance, Implementation of Sections 1191 – 1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price (MFP) in 2026 and 2027.

Deputy Administrator Seshamani,

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NCPA urges CMS to implement the Medicare Drug Price Negotiation Program in a way that does not harm independent pharmacies and patient access alike. NCPA hopes to avoid a similar shock to independent pharmacy that occurred in January 2006 with the launch of the Medicare Part D program, which had significant negative effects on independent retail and LTC pharmacies, who had to float the program, and where states had to intervene with assistance.

NCPA's analysis of 5,200 community pharmacies to determine the effect of MFP drugs on community pharmacies found that if the MFP rebate reaches 60 percent of the acquisition cost, then the average pharmacy will have to float over $26,000 every month waiting to be made whole for the MFP rebates. The impact on the cash flow on the roughly 20,000 independent pharmacies in the country will be a collective half a billion dollars every month. This huge number

20

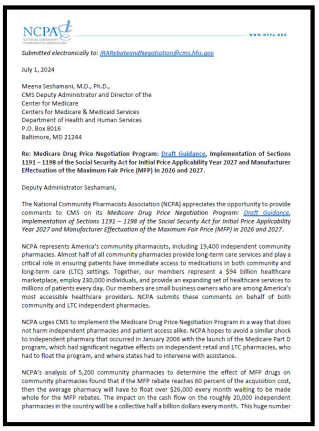
NCPA Asks for IRA/MFP Implementation

CMS must mandate that the **Medicare Transaction Facilitator (MTF) generate an Electronic Remittance Advice (ERA), or 835, to the pharmacy** for purposes of reconciling manufacturer retrospective MFP refunds.

CMS will mandate ERA

CMS must ensure **that payment for MFP drugs be reasonable and relevant.**

"CMS is not establishing requirements for dispensing fees for selected drugs at this time but will monitor complaints and audits related to this issue. CMS encourages plan sponsors to work with pharmacies to ensure adequate and fair compensation for dispensing selected drugs."



NCPA

Submitted electronically to: IRARebateandNegotiation@cms.hhs.gov

July 1, 2024

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Tiny Olive Branch

Dispensing Entity Self-Identification of Material Cashflow Concerns: In section 40.4.2.2, CMS added that during enrollment in the MTF DM dispensing entities will be asked to self-identify whether they are dispensing entities that anticipate having material cashflow concerns at the start of the initial price applicability year due to the reliance on retrospective MFP refunds within the 14-day prompt MFP payment window. This information will be provided to Primary Manufacturers to assist in the development of their MFP effectuation plans, as described in section 90.2.1 of this final guidance.



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22

Tiny Olive Branch

Inclusion of Mitigation Processes for Material Cashflow Concerns in MFP Effectuation Plans for 2026 and 2027:

- Manufacturers must have a process in their effectuation plans
- CMS will make list of self-identified dispensing entities (described in more detail in section 40.4.2.2) available to manufacturers in the MTF DM prior to submission of their MFP effectuation plans for 2026 and 2027.



Examples

- Prospective purchasing agreements
- Accelerated MFP refund timelines.

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Dispensing Entities with Cashflow Concerns



"For example, CMS expects dispensing entities of the types that have raised material concerns about cashflow related to the effectuation of MFP—such as **sole proprietor rural and urban pharmacies with high volume of Medicare Part D prescriptions dispensed, pharmacies who predominantly rely on prescription revenue to maintain business operations, long-term care pharmacies**, 340B covered entities with in-house pharmacies, and Indian Health Service, Tribal, and Urban Indian (I/T/U) pharmacies—may self-identify through this process."

-CMS' recent Draft Guidance on the Medicare Drug Price Negotiation Program **[NCPA emphasis]**

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Small Win: Different Dispensing Fees

- From Contract Year (CY) 2026 Part D Pricing Data Submission Guidance (June 2025)
- "In response to industry inquiries, CMS will allow Part D sponsors to define a different dispensing fee for Medicare Drug Price Negotiation program selected drugs at a 30 day supply, 60 day supply, and 90 day supply" for Medicare Part D in CY 2026.
  - This is a mechanism for PBMs and plans to provide multiple dispensing fees for the same drug.
  - Pharmacies can reference this CMS guidance if facing pushback from plans and PBMs who are unwilling to provide different dispensing fees.

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IRA MFP Concerns

Goal is to lower out of pocket costs for patients who use these drugs, however, PBMs ARE NOT REQUIRED to place these drugs on their lowest cost-sharing tiers.

Pharmacies will still be purchasing these drugs at the same prices they do today from their wholesalers.

CMS must require Part D plans and PBMs to pay pharmacies NO LESS than the maximum fair price PLUS a commensurate dispensing fee when providing these drugs to patients, and CMS SHOULD MANDATE THAT PBM'S CANNOT ASSESS DIR FEES ON THE MFP DRUGS.

26

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27

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28

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NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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Bottom line

NCPA: Biden's Drug Program Will Fail if Pharmacies Are Paid Too Little and Too Late

ALEXANDRIA, Va. (Oct. 3, 2024) – The National Community Pharmacists Association today warned that President Biden's plan to negotiate drug prices...

NEWS RELEASES | OCT 03, 2024

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

NCPA: Biden's Drug Program Will Fail if Pharmacies Are Paid Too Little and Too Late

CMS' failure to require timely, sufficient pharmacy reimbursement will lead to closures not seen since the start of Part D and patients will suffer as a result

NCPA · October 3, 2024

ALEXANDRIA, Va. (Oct. 3, 2024) – The National Community Pharmacists Association today warned that President Biden's plan to negotiate drug prices in Medicare will fail and patient access to the first 10 negotiated drugs will be jeopardized beginning in 2026 because the Centers for Medicare & Medicaid Services neglected in its final guidance to prevent pharmacy benefit managers and manufacturers from paying pharmacies too little and too late.

In comments to CMS on the draft guidance, NCPA stressed the need for the agency to ensure that PBMs reimburse community and long-term care pharmacies fairly for maximum fair price (MFP) drugs — at a negotiated price that is no lower than the maximum fair price plus a commensurate professional dispensing fee. NCPA also emphasized that manufacturers must refund pharmacies within 14 days of adjudicating the claim. Otherwise, according to an NCPA analysis, the average pharmacy will have to float over $27,000 every month waiting to be made whole from the manufacturer refunds. Collectively among community and LTC pharmacies, the cash flow

30

Concerns Intensified for LTC Pharmacies

- Increased volume of business in Medicare Part D
- Mandate to fill prescriptions for patients in LTC
- Same terms from wholesalers as retail pharmacies
- For Part A contracts with the facility, the facility must be billed at the higher price, not the new MFP → facility pays more for these drugs
- More at risk for LTC pharmacies

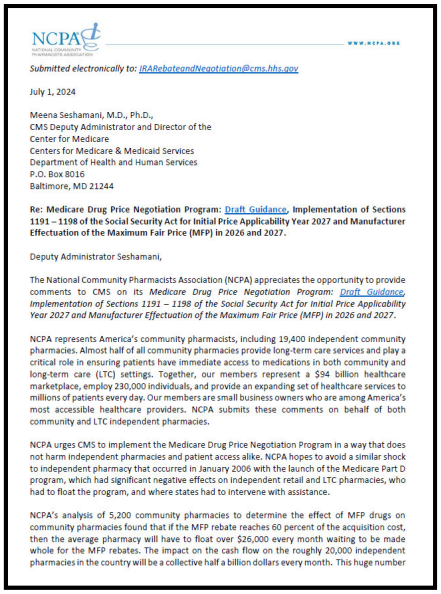
Patients ultimately suffer.

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To Recap…

- Pharmacies are **worried they will have to float program costs** while waiting for reimbursement.
- NCPA urges CMS to **ensure pharmacies are paid at least the MFP for drugs, plus a dispensing fee with no DIR fees.**
- Recommends CMS **shorten data reporting windows** to expedite pharmacy payments.
- NCPA **opposes manufacturers using a benchmark lower than WAC** to calculate pharmacy refunds.



NCPA

Submitted electronically to: IRARebateandNegotiation@cms.hhs.gov

July 1, 2024

Meena Seshamani, M.D., Ph.D.,
CMS Deputy Administrator and Director of the
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32

NCPA/ASCP Feedback to Manufacturers

- Submitted to manufacturers, PhRMA, BIO June 2025
- How to effectuate maximum fair price (MFP) for pharmacies with material cash flow concerns
- Pay the pharmacy the SDRA = WAC - MFP
- Pay pharmacies within 14 days of the Part D plan adjudicating the claim
- Prefund MFP refund payments
- Pay SDRA via MTF-PM
- “Professional fee” and “administrative fee” for pharmacies

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Check Your Contracts re: Dispensing

- Review your contracts
- Consult with your PSAOs
- Any such requirement from PBMs and plans will govern, despite CMS stating that they will not require such dispensing in an updated FAQ and letter.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

June 23, 2025

Medicare Transaction Facilitator: Pharmacies and Other Dispensing Entities Frequently Asked Questions

MEDICARE DRUG PRICE NEGOTIATION PROGRAM

This Frequently Asked Questions (FAQs) document contains information intended to support pharmacies, mail order services, and other dispensing entities (hereafter collectively referred to as "dispensing entities") as they prepare to engage with the new Medicare Transaction Facilitator (MTF). To ensure the implementation of the negotiated maximum fair prices (MFPs) agreed upon by CMS and applicable Manufacturers for drugs selected for negotiation, CMS will establish an MTF system composed of two modules: the MTF Data Module (MTF DM) and the MTF Payment Module (MTF PM). For more information, please see the MTF Fact Sheet. Guidance and other important documents about the Negotiation Program can be found on the CMS website here.

These FAQs will be updated periodically and are organized by topic area. If you do not see the answer to your question within this document, guidance, or additional resources available on the Resources for Pharmacies and Dispensing Entities webpage, please access the MTF Help Desk at https://mtf.helpdesk.cms.gov/home where you will find additional information and can submit your questions for a response.

MTF Enrollment: Dispensing Entities

Q1. How do I initiate the MTF enrollment process?

CMS has distributed invitations to enroll in the MTF via email to a 'first user' for each pharmacy, drawing on data from the National Council on Prescription Drug Programs (NCPDP) database to identify and validate initial dispensing entity users. This first user may be the Authorized Signatory Official (ASO) or the Access Manager (AM), but it must be the contact listed with the NCPDP database. The ASO is an appointed individual of the dispensing entity with authority to legally bind that organization in agreements, represent the organization in an official capacity, and act on behalf of an organization. The AM is an individual from the dispensing entity authorized to act on behalf of the organization to view, modify, submit, and certify the completeness and accuracy of information in the MTF DM on behalf of the organization. If the first user is the AM, however, that user must first invite the ASO to complete enrollment. Please see Q12 for additional information about the various user role types in the MTF DM.

CMS began sending these email invitations over the course of several weeks following the MTF Launch Event on June 5, 2025. If you did not receive an immediate invitation by email, it is no cause for concern. If you are the first user in the NCPDP database, you can also access the MTF to begin enrollment by visiting https://mtf.cms.gov. Please access the MTF Help Desk for any enrollment related questions or concerns at https://mtf.helpdesk.cms.gov/home. MTF enrollment will be open on a rolling basis, meaning you will be able to sign up at any time. However, we strongly encourage you to enroll as soon as practicable and no later than November 15th, 2025, to ensure a smooth transition and avoid potential delays when the first cycle of MFPs goes into effect in January 2026.

Q2. How can a pharmacy update their NCPDP profile and points of contact? What should a pharmacy do if they have listed a resource email box and not an individual in the NCPDP database?

CMS will be using the information in dispensing entity NCPDP profiles to identify where to send MTF DM

Updated July 2025 1

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MTF Resources and Checklist

- CMS webinar to NCPA on MTF
- Intro to the MTF on CMS' dispenser homepage
- FAQ on MTF
- Contact CMS with any questions at MFPMedicareTransactionFacilitator@cms.hhs.gov

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MTF Resources and Checklist

- Before enrollment,
  - Update your NCPDP profile
  - Know role of third-party support entities
- During enrollment
  - Sign a legal agreement, consult counsel
  - **Identify as having "material cashflow concerns"**

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Federal Legislative Updates

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Budget Reconciliation: What Happened?

- Initially included Medicaid Managed Care
- Spread pricing agreement
- Parliamentarian pulled provision because it did not meet reconciliation rules
- Pharmacy pulled together to get mandatory NADAC reporting pulled
  - Must have fair reimbursement coupled with NADAC reporting



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Now What? NCPA's Congressional PBM Reform Priorities

Pass Medicaid managed care reform by (1) requiring spread pricing with a fair dispensing fee AND (2) mandated NADAC reporting which saves over $1 billion

S. 927, Protecting Pharmacies in Medicaid Act

Pass legislation requiring reasonable and relevant contract terms in Medicare Part D

S. 882, PBM Act

H.R. 4317, PBM Reform Act

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LTC Legislation

- HR 5031, the Preserving Patient Access to Long-Term Care Pharmacies Act
- Introduced by Reps. Duyune (R-TX) and Schneider (D-IL)
- Referred to Energy and Commerce, Ways and Means
- Targeted $30 supplemental supply fee on prescription drugs subject to Medicare-negotiated prices

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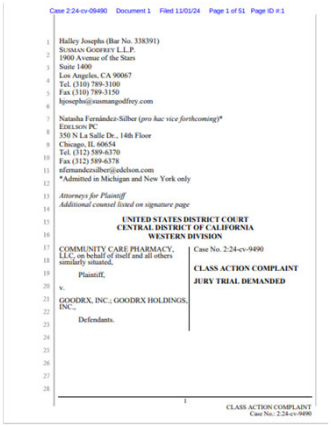
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Legal Updates

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Price Fixing Lawsuit

- *Community Care Pharmacy v. GoodRx*
- Lawsuit against GoodRx, CVS, ESI, MedImpact, Navitus
- NCPA joined Jan 2025



Case 2:24-cv-09490 Document 1 Filed 11/01/24 Page 1 of 51 Page ID #:1

Hailey Josephs (Bar No. 338391)
SUSMAN GODFREY L.L.P.
1900 Avenue of the Stars
Suite 1400
Los Angeles, CA 90067
Tel. (310) 789-3100
Fax (310) 789-3150
hjosephs@susmangodfrey.com

Natasha Fernández-Silber (*pro hac vice forthcoming*)*
EDELSON PC
350 N La Salle Dr., 14th Floor
Chicago, IL 60654
Tel. (312) 589-6370
Fax (312) 589-6378
nfernandezsilber@edelson.com
*Admitted in Michigan and New York only

Attorneys for Plaintiff
Additional counsel listed on signature page

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

COMMUNITY CARE PHARMACY, LLC, on behalf of itself and all others similarly situated,

Plaintiff,

v.

GOODRX, INC.; GOODRX HOLDINGS, INC.,

Defendants.

Case No. 2:24-cv-9490

CLASS ACTION COMPLAINT

JURY TRIAL DEMANDED

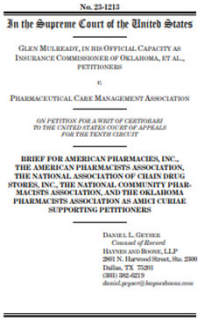
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CLASS ACTION COMPLAINT
Case No. 2:24-cv-9490

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States Rights to Regulate PBMs - OK

- *Mulready v. PCMA*
- NCPA, OPhA, APhA, NACDS
- Amicus brief filed June 2024
- 5 pharmacy groups, 32 State AGs urged SCOTUS to take case
- USSC asks Solicitor General for opinion
- USSC declined to review case, 10th circuit still in force



No. 23-1213

In the Supreme Court of the United States

GLEN MULREADY, IN HIS OFFICIAL CAPACITY AS INSURANCE COMMISSIONER OF OKLAHOMA, ET AL., PETITIONERS

v.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF FOR AMERICAN PHARMACIES, INC., THE AMERICAN PHARMACISTS ASSOCIATION, THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, INC., THE NATIONAL COMMUNITY PHARMACISTS ASSOCIATION, AND THE OKLAHOMA PHARMACISTS ASSOCIATION AS AMICI CURIAE SUPPORTING PETITIONERS

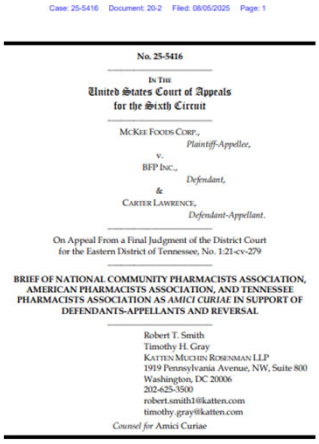
DANIEL L. GEYSER
Counsel of Record
HAYNES AND BOONE, LLP
2801 N. Harwood Street, Ste. 2300
Dallas, TX 75201
(303) 382-6219
daniel.geyser@haynesboone.com

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States Rights to Regulate PBMs - TN

- *McKee Foods Corporation v. BFP Inc., et al*
- NCPA, APhA, TPA
- Amicus brief filed Aug. 2025
- Support of 2021 TN Law
- Federal injunction against law
- Case before 6th Dist. Court of Appeals



Case: 25-5416 Document: 20-2 Filed: 08/05/2025 Page: 1

No. 25-5416

In The
United States Court of Appeals
for the Sixth Circuit

MCKEE FOODS CORP.,
Plaintiff-Appellee,
v.
BFP INC.,
Defendant,
&
CARTER LAWRENCE,
Defendant-Appellant.

On Appeal From a Final Judgment of the District Court for the Eastern District of Tennessee, No. 1:21-cv-279

BRIEF OF NATIONAL COMMUNITY PHARMACISTS ASSOCIATION, AMERICAN PHARMACISTS ASSOCIATION, AND TENNESSEE PHARMACISTS ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLANTS AND REVERSAL

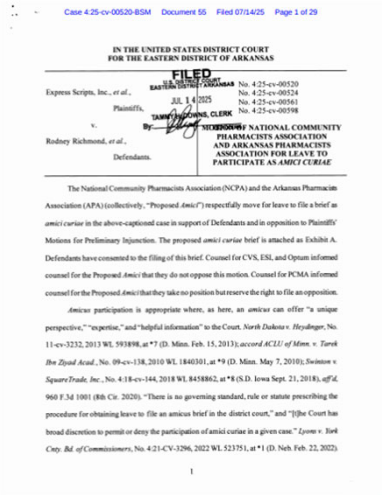
Robert T. Smith
Timothy H. Gray
KATTEN MUCHIN ROSENMAN LLP
1919 Pennsylvania Avenue, NW, Suite 800
Washington, DC 20006
202-625-3500
robert.smith1@katten.com
timothy.gray@katten.com
Counsel for Amici Curiae

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

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States Rights to Regulate PBMs - AR

- *Arkansas Act 624* – Becomes law April 2025
- Purpose: to address conflicts of interest and resulting harms arising from when PBMs own and operate their own pharmacies
- NCPA, APA file amicus brief: July 2025
- Arkansas federal judge pauses law



Case 4:25-cv-00520-BSM Document 55 Filed 07/14/25 Page 1 of 29

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS

FILED
U.S. DISTRICT COURT
EASTERN DISTRICT ARKANSAS
JUL 14 2025
TAMMY H. DOWNS, CLERK
By: DEP CLERK

Express Scripts, Inc., *et al.*, Plaintiffs, v. Rodney Richmond, *et al.*, Defendants.

No. 4:25-cv-00520
No. 4:25-cv-00524
No. 4:25-cv-00561
No. 4:25-cv-00598

MOTION OF NATIONAL COMMUNITY PHARMACISTS ASSOCIATION AND ARKANSAS PHARMACISTS ASSOCIATION FOR LEAVE TO PARTICIPATE AS *AMICI CURIAE*

The National Community Pharmacists Association (NCPA) and the Arkansas Pharmacists Association (APA) (collectively, "Proposed *Amici*") respectfully move for leave to file a brief as *amici curiae* in the above-captioned case in support of Defendants and in opposition to Plaintiffs' Motions for Preliminary Injunction. The proposed *amici curiae* brief is attached as Exhibit A. Defendants have consented to the filing of this brief. Counsel for CVS, ESI, and Optum informed counsel for the Proposed *Amici* that they do not oppose this motion. Counsel for PCMA informed counsel for the Proposed *Amici* that they take no position but reserve the right to file an opposition.

Amicus participation is appropriate where, as here, an *amicus* can offer "a unique perspective," "expertise," and "helpful information" to the Court. *North Dakota v. Heydinger*, No. 11-cv-3232, 2013 WL 593898, at *7 (D. Minn. Feb. 15, 2013); *accord ACLU of Minn. v. Tarek Ibn Ziyad Acad.*, No. 09-cv-138, 2010 WL 1840301, at *9 (D. Minn. May 7, 2010); *Swinton v. SquareTrade, Inc.*, No. 4:18-cv-144, 2018 WL 8458862, at *8 (S.D. Iowa Sept. 21, 2018), *aff'd*, 960 F.3d 1001 (8th Cir. 2020). "There is no governing standard, rule or statute prescribing the procedure for obtaining leave to file an amicus brief in the district court," and "[t]he Court has broad discretion to permit or deny the participation of amici curiae in a given case." *Lyons v. York Cnty. Bd. of Commissioners*, No. 4:21-CV-3296, 2022 WL 523751, at *1 (D. Neb. Feb. 22, 2022).

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DIR Fees

TRUST LLC

- Investigate, litigate, arbitrate DIR fees
- Federal antitrust, state contract laws
- https://www.fightpbms.com/

Osterhaus Pharmacy v. CVS Health, Caremark, and Aetna

- Class action
- To recoup DIR fees

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Resources

- Inflation Reduction Act: Resources and Advocacy | NCPA
- Regulatory Advocacy | NCPA
- Legislative Action Center | NCPA Advocacy
- Pharmacy and Dispensing Entity Resources | CMS
- Impact of MFP Effectuation on Pharmacies and Beneficiaries | Avalere Health Advisory
- ThreeAxisAdvisors MDPN Study

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Resources

- 2025 Roadmap to PBM Reform
- Vertical integration chart
- NCPA Advocacy
- https://www.fightpbms.com/

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Pharmacy Full Throttle



Jeff Harrell, PharmD
NCPA President
Cascadia Pharmacy Group
CEO

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

CASCADIA PHARMACY GROUP

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Outline

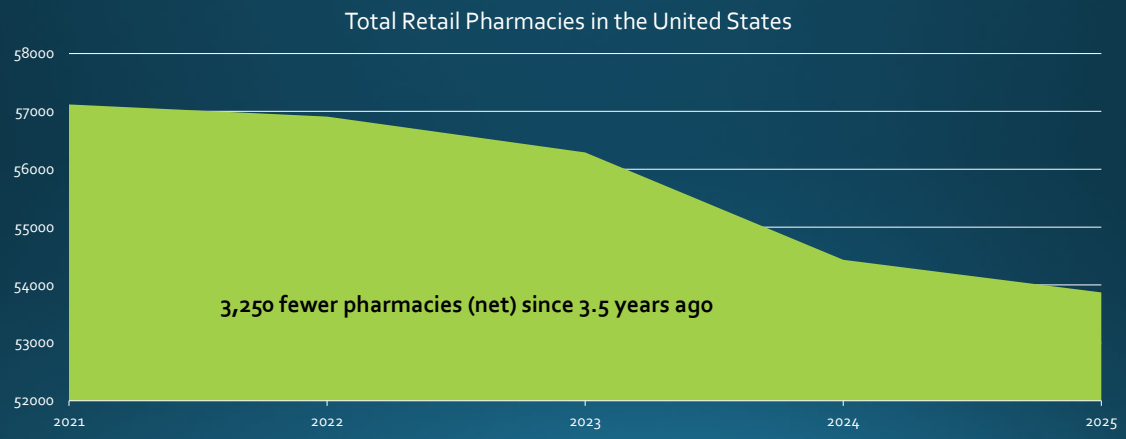
- Numbers / Business
- Around the World
- Technology / Data
- IRA / MFP / MTF
- Spring Cleaning / Money Saving
- Legislation / Outlook

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By the Numbers



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By the Numbers (Cont.)

CVS closed 900 stores 2022-2024 and plans to close another 270 this year (9,939 in 2021)

Walgreens is in the process of closing 1,200 of its 8,500 stores (9,569 in 2018)

Rite Aid 4,500 locations in 2000s, down to 1,240 mid 2025 and now ZERO

Number of total pharmacy choices in the U.S. has shrunk from 60,000 in 2018 to less than 54,000

Grocery store (9,177) and Mass Merchandiser (7,245) numbers holding relatively steady

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Pharmacy is a Business

Work **ON** Your Business…Not **IN** Your Business

Able to grow to 40 locations

Consolidate Admin, streamline processes, consistencies

Identify your strengths

Assemble a great team – only as good as the people you surround yourself with



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Around the World

- APP – Australia
  - 6000 Pharmacies
  - 3800 Guild Members
  - 7600 participants
  - Unity – lock step
- WPC – World Pharmacy Council – 14 Countries
  - Misery likes company
  - GLP1 – costs
  - Alternate revenue streams
  - Pharmacy First – Clinical Services



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"Data doesn't lie, people do"

- Contracting
- Negotiating
- Profitability
- COGS
- Mining for opportunity
- Target Marketing
- Analytics
- Inventory Management
- Ordering
- Out date management – multiple location



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Technology is Crucial

- Apps
- Remote check out – efficiency – reduce lines – play into your customer (phones)
- Video counseling
- AI / Bot – order entry
- Dispensing automation
- Packaging automation
- Remote patient compliance monitoring
- Remote Pharmacy – Pharmacy desert

- **"Enhance the customer experience"**



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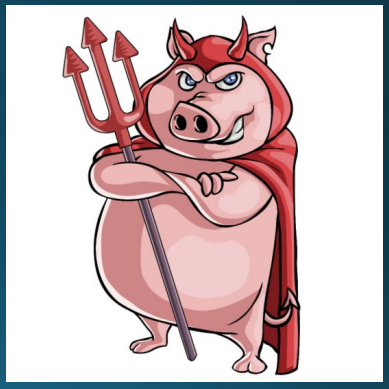
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PBM Negotiations/Access to Care

- Patients need: medicine & healthcare
- PBMs must ensure network adequacy
- Pharmacy Deserts – Geo Access

- Market share changes the conditions
  - Critical Access Pharmacy – CAP designation
    - Offer innovative and quality services
    - Clinical Services – Relationship with payers



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Think beyond dispensing - don't be handcuffed by the script.

- Multiple revenue streams – Get away from relying on dispensing
  - LTC, Compounding, Delivery, Compliance packaging
  - Immunizations – travel vaccines (huge opportunity for up sales), offsite clinics, B12, Shingles
  - Clinical Services – Tobacco Cessation , Hypertension, Diabetes (A1C), Contraception, Cholesterol – Improve quality scores
  - Test to treat – covid, influenza (bad year), Strep, Minor Ailments (bee stings, bites, burns, UTI, Yeast



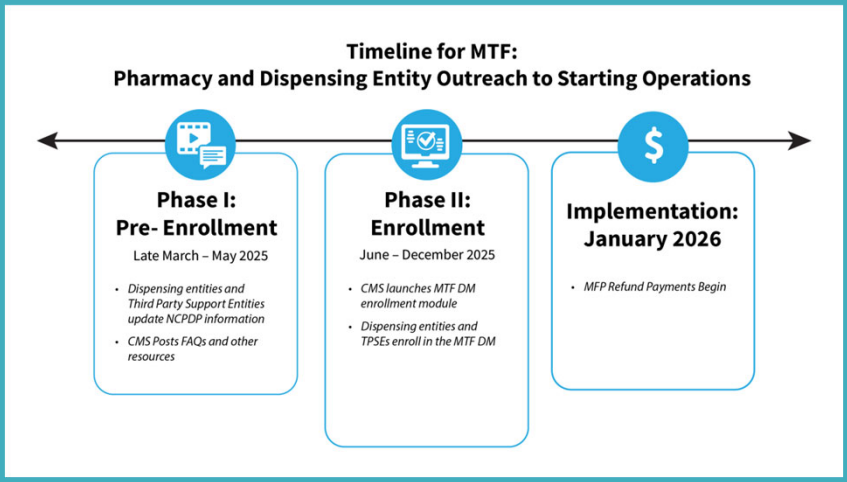
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IRA / MFP/ MTF

- The float
- 2 months
- 35-50k reserves
- Distribution management



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Clean Up with Cash Flow Tips

Spring Cleaning

- Review you CC statement – reoccurring unneeded expenses
- Shop you vials and labels – kill the tape
- Generic Labels – Customer doesn't care
- Renegotiate your ISP / Phone service
- Surcharge pass through

Cash Tips – Better Cash Flow

- GLP-1 management
- Adjust your wholesale payment terms
- Plan for payroll and large debits (Vaccines)
- Sweep accounts with line of credit
- AI driven AP Automation
- PVA Negotiation with growth
- -Cash Prescription rebates



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Community Pharmacy is a Premium Product

- Know Your Value
- Set yourself apart from chains
- Unique and quality
- Don't do things for free
- Don't be afraid to charge
- Can't get at the big box stores
- Enhanced patient experience
- Shout it out loud – Be boastful, Be proud



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Quality vs Quantity



Independent pharmacies are more than just a place to pick up your prescriptions, they're family owned businesses with deep roots in the community. We have a genuine connection to our patients so we offer premium service and deliver unrivaled quality in patient care.

Premium Service

- We Always Answer the Phone
- Consistent Staffing
- Medication Counseling
- Bilingual Counseling
- Remote Payment Options
- Extended Hours
- Drive-Thru
- Delivery Available

Personalized Care

- Quick & Convenient Care
- Home Visits
- Medication Synchronization
  - Get all your meds on day 1 to save trips to the pharmacy
- Compliance Packaging
- Naloxone Prescribing
- Supplements & Nutraceuticals
- Compounded Medications

Expanding Variety of Patient-Centered Services

- Chronic Disease Management (Diabetes, High Cholesterol, High Blood Pressure)
- Vaccine Assessments
- All Routine Immunizations
- Travel Consults, Medications & Immunizations
- Tobacco Cessation Programs
- Birth Control Prescribing
- Save Time at Urgent Care ... Our Pharmacists Can Help With:
  - Test to Treat: COVID, Flu, Strep
  - Other Ailments: Burns, Bites, Sfings, Pink Eye, Shingles
- Women's Health (i.e. Urinary Tract Infections & Yeast Infections)



Inconsistent Staffing

You never know who you'll get. There's no chance to build trust or a relationship with your pharmacist.



Longer Wait Times

Even for simple refills, patients are waiting way too long because pharmacists are overworked and overwhelmed.



Lack of Personalized Care

When pharmacists are stretched too thin, patients become just another number because they have no time to provide meaningful care.



Difficult to Reach

When you need help the most – the phone just rings or is shut off by the pharmacy because they have no one to answer.



Corporate Profits Over Patient Care

Decisions are made for share-holders, not for the patient's health. They put the company first, not you.



Poor Customer Service

Even when you do speak to someone, they're often too rushed to give proper answers.

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Legislation Update

THE PBM REFORM ACT (H.R. 4317):
Finalizing bipartisan, bicameral PBM reforms

- Medicaid managed care payment reform through enhanced transparency and a ban on spread pricing by reimbursing pharmacies at a rate equal to the National Average Drug Acquisition Cost (NADAC) plus the state's fee-for-service dispensing fee.
  - This would also save taxpayers over $2 billion.

- Medicare D contract reforms that require
  - CMS to define and enforce reasonable and relevant contract terms in Part D, including terms related to reimbursements, and requires the agency to establish a mechanism for pharmacies to report violations.

Overall, the PBM reform provisions create over $5 billion in taxpayer savings.

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Post-Test Question #1

Which of the following is a likely financial impact of the Medicare Drug Price Negotiation on pharmacies?

A) Payment delays
B) Weekly cash flow shortfalls
C) Annual revenue losses
D) All of the above

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Post-Test Question #1

Which of the following is a likely financial impact of the Medicare Drug Price Negotiation on pharmacies?

A) Payment delays
B) Weekly cash flow shortfalls
C) Annual revenue losses
D) All of the above

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Post-Test Question #2

If passed, how much in taxpayer savings would PBM reform save, according to the CBO?

A) $1 billion
B) $2 billion
C) $3 billion
D) $4 billion
E) Over $5 billion

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Post-Test Question #2

If passed, how much in taxpayer savings would PBM reform save, according to the CBO?

A) $1 billion
B) $2 billion
C) $3 billion
D) $4 billion
E) Over $5 billion

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Post-Test Question #3

Which of the following is the limited liability company created by NCPA to investigate and, when appropriate, litigate or arbitrate on behalf of community pharmacies to recover coerced price concessions?

A) NCPA LLC
B) FAIR LLC
C) TRUST LLC
D) STARK LLC

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Post-Test Question #3

Which of the following is the limited liability company created by NCPA to investigate and, when appropriate, litigate or arbitrate on behalf of community pharmacies to recover coerced price concessions?

A) NCPA LLC
B) FAIR LLC
C) TRUST LLC
D) STARK LLC

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Post-Test Question #4

What can pharmacists and pharmacy technicians do to become more involved in advocacy?

A) Keep updated by visiting NCPA's and CMS' websites

B) Visit NCPA's Legislative Action Center to support PBM reform

C) Come to NCPA's annual convention

D) All of the above

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Post-Test Question #4

What can pharmacists and pharmacy technicians do to become more involved in advocacy?

A) Keep updated by visiting NCPA's and CMS' websites

B) Visit NCPA's Legislative Action Center to support PBM reform

C) Come to NCPA's annual convention

D) All of the above

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Questions?

Steve Postal
steve.postal@ncpa.org

Jeff Harrell
jeff@cpg-rx.com

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The *voice* of the community pharmacist.
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Photo by Sora Shimazaki from Pexels

OREGON BOARD OF PHARMACY

Law Update

OSPA Annual Convention
September 27th, 2025

Gary Runyon, PharmD, RPh, Executive Director
Brian Murch, PharmD, RPh, Compliance Officer

The Oregon Board of Pharmacy serves to promote and protect public health, safety, and welfare by ensuring high standards in the practice of pharmacy and through effective regulation of the manufacture and distribution of drugs.

Equity statement

The Oregon Board of Pharmacy is committed to Diversity, Equity, Inclusion, and Belonging (DEIB) within its organization and for the public it serves. This commitment is reflected in board membership, agency staffing, the services provided, and its efforts to promote patient safety and ensure access to quality pharmacy care. Our actions, outlined in our DEIB and Affirmative Action Plans, demonstrate this commitment.

We are guided by the following principles:

- Promote a **welcoming, safe, and inclusive culture** for people of all backgrounds.
- Foster an inclusive environment where all current and prospective licensees and registrants receive **fair and unbiased service** from the agency staff and board.
- **Advance Diversity and Equity** in access through culturally responsive service delivery that addresses the changing climate within the pharmacy profession.
- Ensure all patients needing pharmacy services are able to receive **safe and timely access to medications, regardless of place of residence, economic or social status, physical ability, ethnicity, or gender identity.**

Disclosure Statement

Gary Runyon and Brian Murch, faculty for this CE activity, have no relevant financial relationship(s) with ineligible companies to disclose.

Outline

- Objectives and Pre-Test Questions
- Resources- tips for using common resources and references
- Regulations- highlighted rules, relevant legislation, and other topics
- Compliance Corner- common observations from on-site inspections
- Post-Assessment Questions and Conclusion
- Ways to Stay in Touch and in Tune

Learning Objectives

- Develop effective strategies to organize and search reference materials, including those on the Board of Pharmacy's website.
- Review current and proposed structure of OAR Chapter 855 Board of Pharmacy Rules to better understand rules framework.
- Discuss recent legislative changes, new rules, and proposed rule amendments that affect pharmacy practice in Oregon specifically for Pharmacists, Pharmacy Interns, Certified Oregon Pharmacy Technicians, and Pharmacy Technicians.
- Become familiar with common observations discovered during routine inspections.
- Review available pathways to communicate with and provide feedback to the Board of Pharmacy.

Pre-Assessment Question 1

Per OAR 855 and ORS 689, which of the following activities might non-licensed pharmacy personnel engage in, if properly trained and authorized? (Select all that apply)

a) Count medications for inventory.

b) Count medications for prescription.

c) Enter prescription refill number in computer

d) Label medications to returned to stock.

e) None of the above.

Pre-Assessment Question 2

Assuming no state of emergency has been declared, an Oregon-licensed pharmacist practicing in Oregon is authorized to administer which of the following via the board's current protocols? (Select all that apply)

a) Influenza vaccines to patients 6 months of age and older.

b) COVID-19 vaccines to patients 6 months of age and older.

c) COVID-19 vaccines to patients 3 years of age and older.

d) RSV vaccines to pregnant patients in the second trimester, at 14 to 27 weeks gestational age.

e) None of the above.

Pre-Assessment Question 3

Per OAR 855-041-1046 Secure Drug Disposal, which of the following is true regarding a pharmacy that operates a drug take back collection program?

a) A pharmacy may dispose of drugs in the receptacle if they're expired, adulterated, or misbranded.

b) Pharmacy personnel may assist the patient in counting, sorting, and handling medications for disposal but only at the patient's request.

c) The receptacle must be located in a secure location, within view of the pharmacy counter but not behind it.

d) Any tampering with a collection receptacle, liner, or theft of deposited drugs must be reported to the board in writing within 3 days of discovery.

e) None of the above.

Pre-Assessment Question 4

Effective 7/01/2025, in order to be a Pharmacist-in-Charge(PIC) in Oregon, a Pharmacist must: (select all that apply)

a) Have at least 1 year of management experience.

b) Complete a board-provided PIC training course either before the appointment or within 90 days after the appointment.

c) Complete a board-provided PIC training course at least every 10 years.

d) Be present at the outlet at least 20 hours per week.

e) None of the above.

Resources

New and proposed laws & rules



Commonly-Used Resources

- Below is a list of some commonly-used resources that Board Staff consult when interacting with licensees or stakeholders on phone duty

- **Federal Law**
  - United States Code (USC) - Congress/President
  - Code of Federal Regulations (CFR) - Agencies

- **State Law**
  - Oregon Revised Statues (ORS)
    - ORS 689 (Pharmacists; Drug Outlets; Drug Sales)
    - ORS 475 (Controlled Substances; Illegal Drug Cleanup; Miscellaneous Drugs)
  - Oregon Administrative Rules (OAR)
    - Chapter 855 – Board of Pharmacy
  - Oregon State Legislature
    - Bills and Laws

Commonly-Used Resources

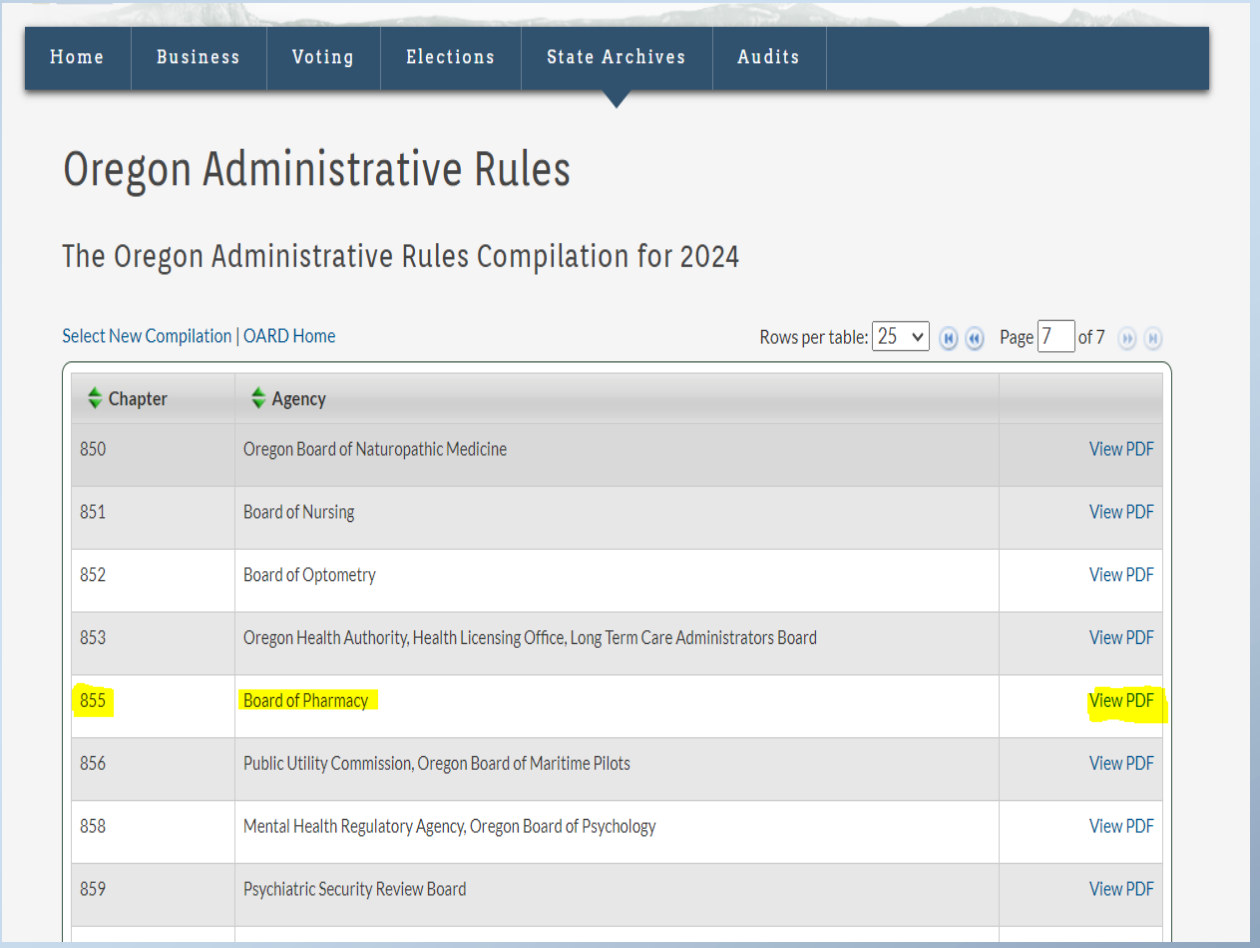
- **Compounding**
  - USP <795> Nonsterile Preparations
  - USP <797> Sterile Preparations
  - USP <800> Hazardous Drugs – Handling in Healthcare Settings
- **Non-controlled Substances**
  - Code of Federal Regulations (CFR) Title 21 Chapter I – Food and Drug Administration, Department of Health and Human Services
    - Subchapter A – General
    - Subchapter C – Drugs: General
    - Subchapter D – Drugs for Human Use
    - Subchapter F – Biologics
    - Subchapter H – Medical Devices
- **Controlled Substances**
  - Code of Federal Regulations (CFR) Title 21 Chapter II – Drug Enforcement Administration, Department of Justice
    - Part 1305 – Orders for Schedule I and Schedule II Controlled Substances
    - Part 1306 – Prescriptions
    - Part 1308 – Schedules of Controlled Substances
    - Part 1311 – Requirements for Electronic Orders and Prescriptions

Commonly-Used Resources

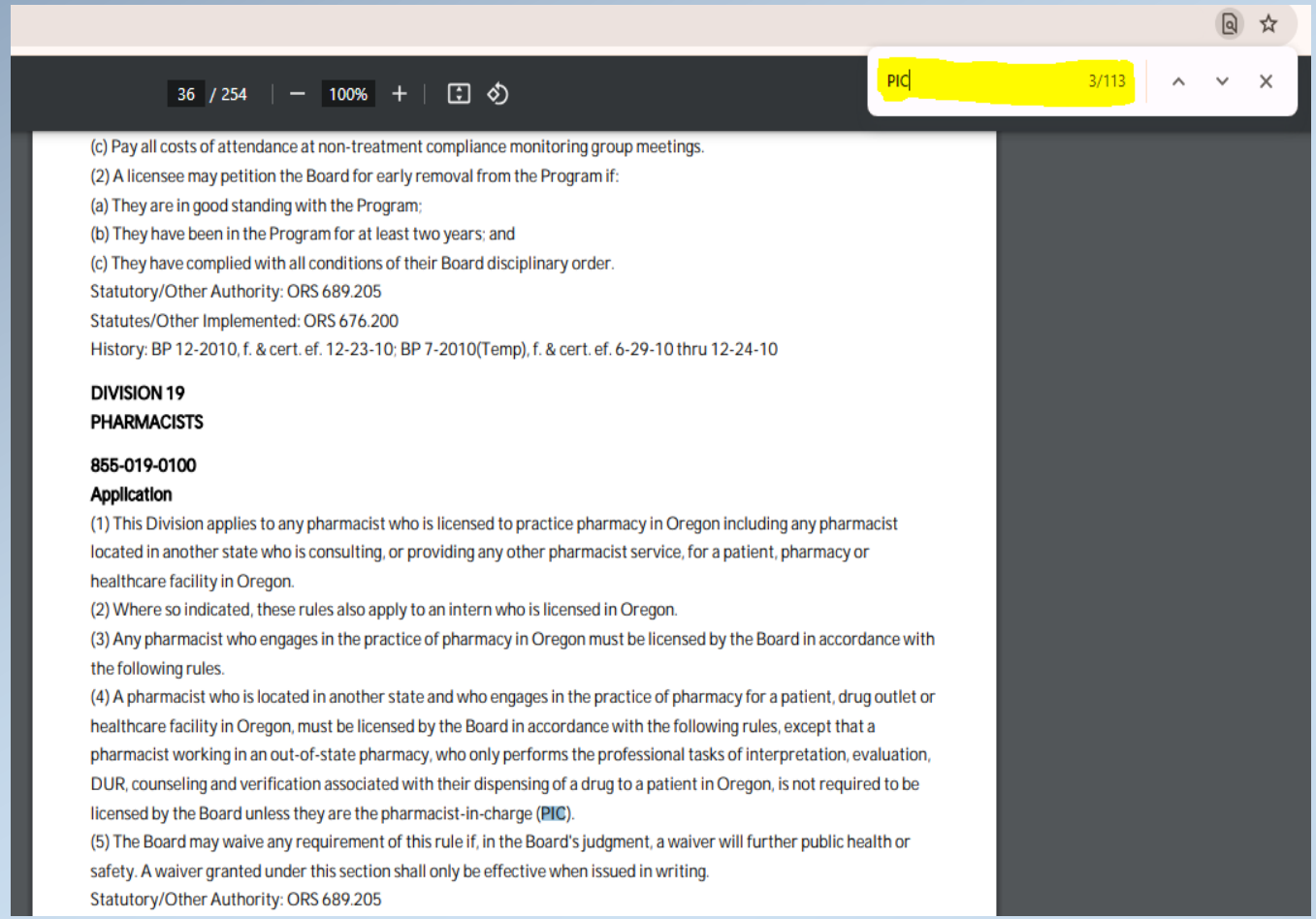
- **Vaccines**
  - OBOP PHPFAC Protocols
  - Food and Drug Administration (FDA)
  - Centers for Disease Control and Prevention (CDC)
  - Advisory Committee on Immunizations Practices (ACIP)
  - National Community Pharmacy Association (NCPA)
  - American Pharmacist Association (APhA)
  - Immunization Action Coalition (IAC)
- **Newsletters**
  - OBOP Subscriptions and Newsletters

Ways to Interact with our Rules: Annual Compilations.





Ways to Interact with our Rules: Annual Compilations.

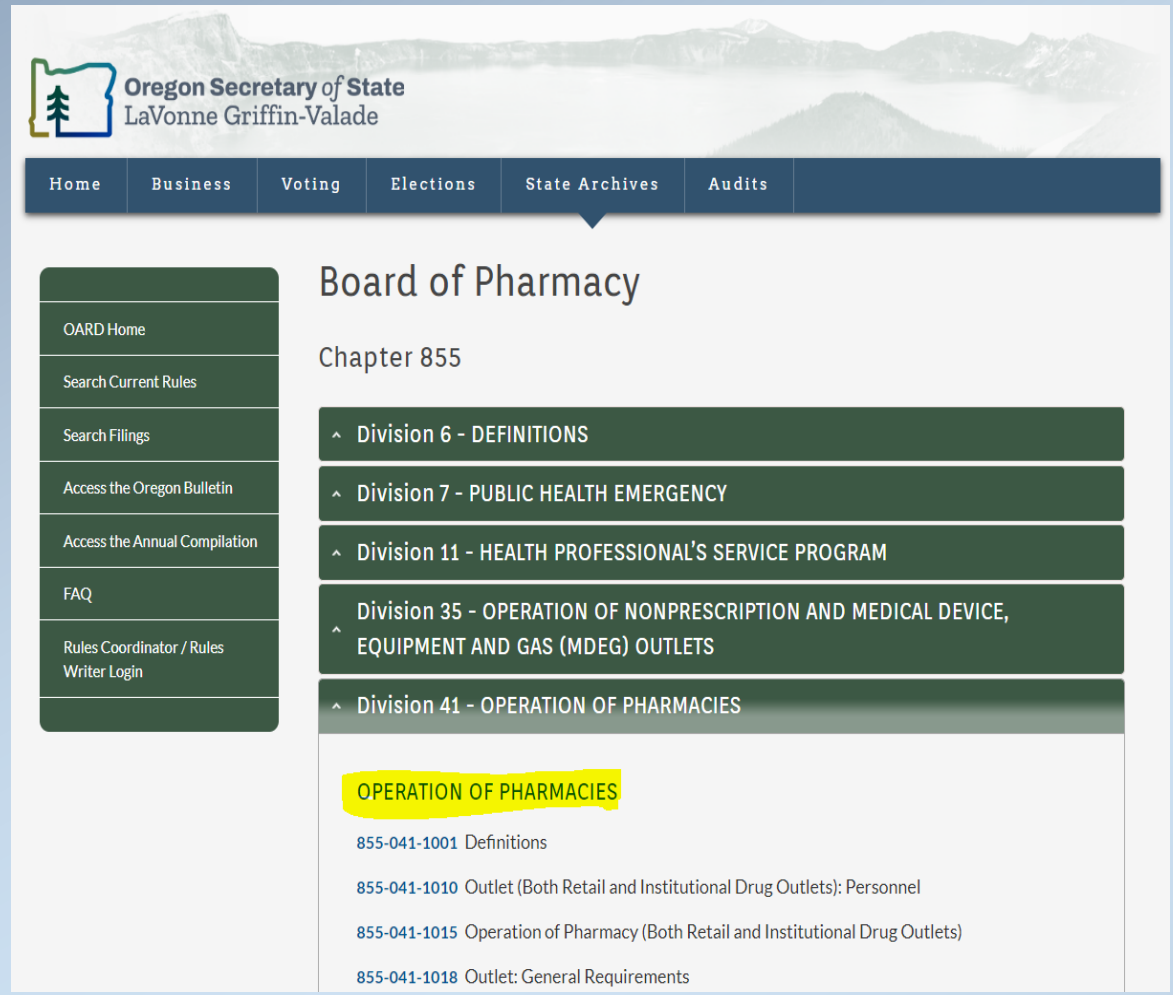


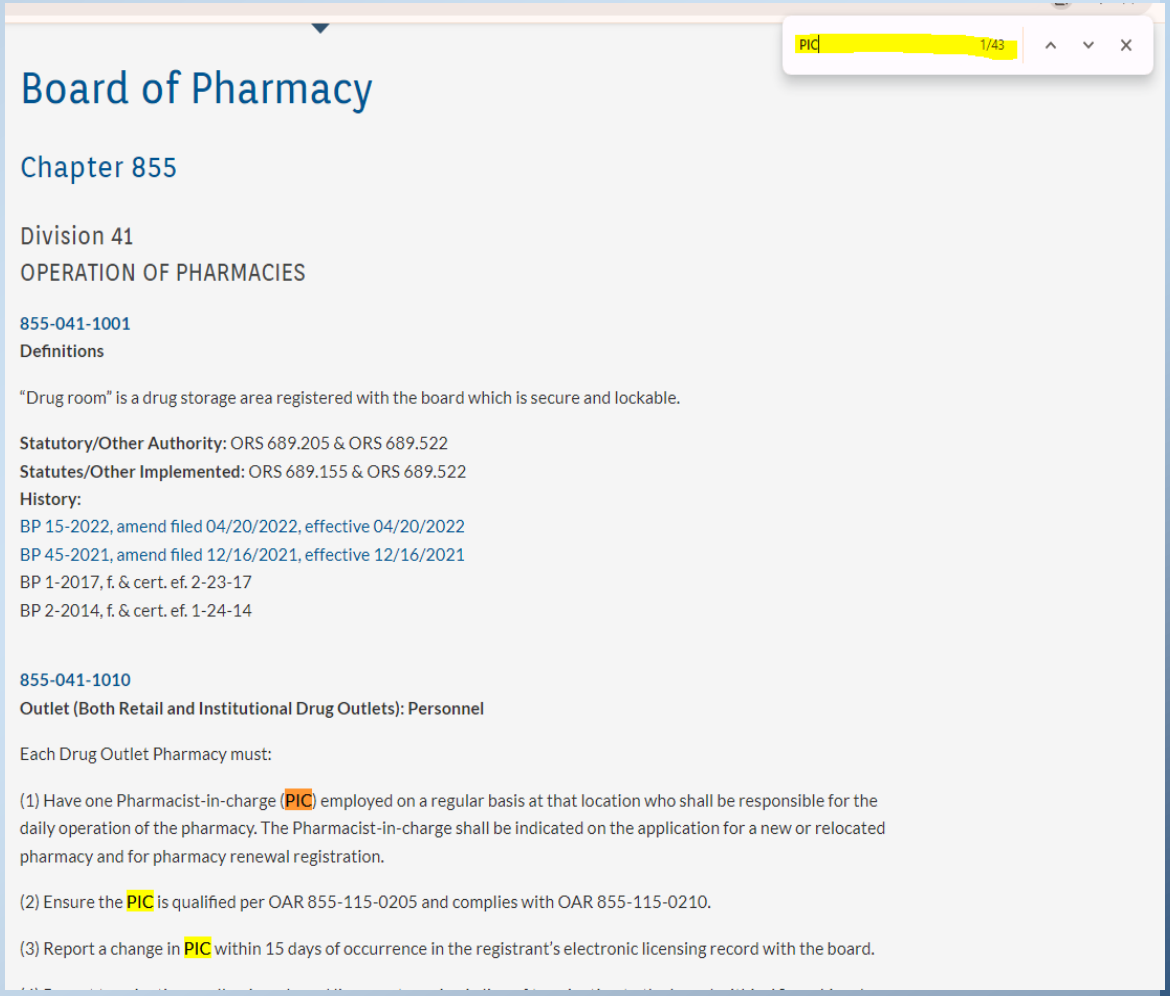
- Annual Compilations contain rules effective as of January 1st each year.
- Other rules available (e.g., 847 Oregon Medical Board, 818 Oregon Board of Dentistry, etc.)
- Great search method if you don't know where to start.
- Rules may not be up-to-date, so cross-reference with current rules where applicable.

Ways to Interact with our Rules: Key Word Search (Control F)

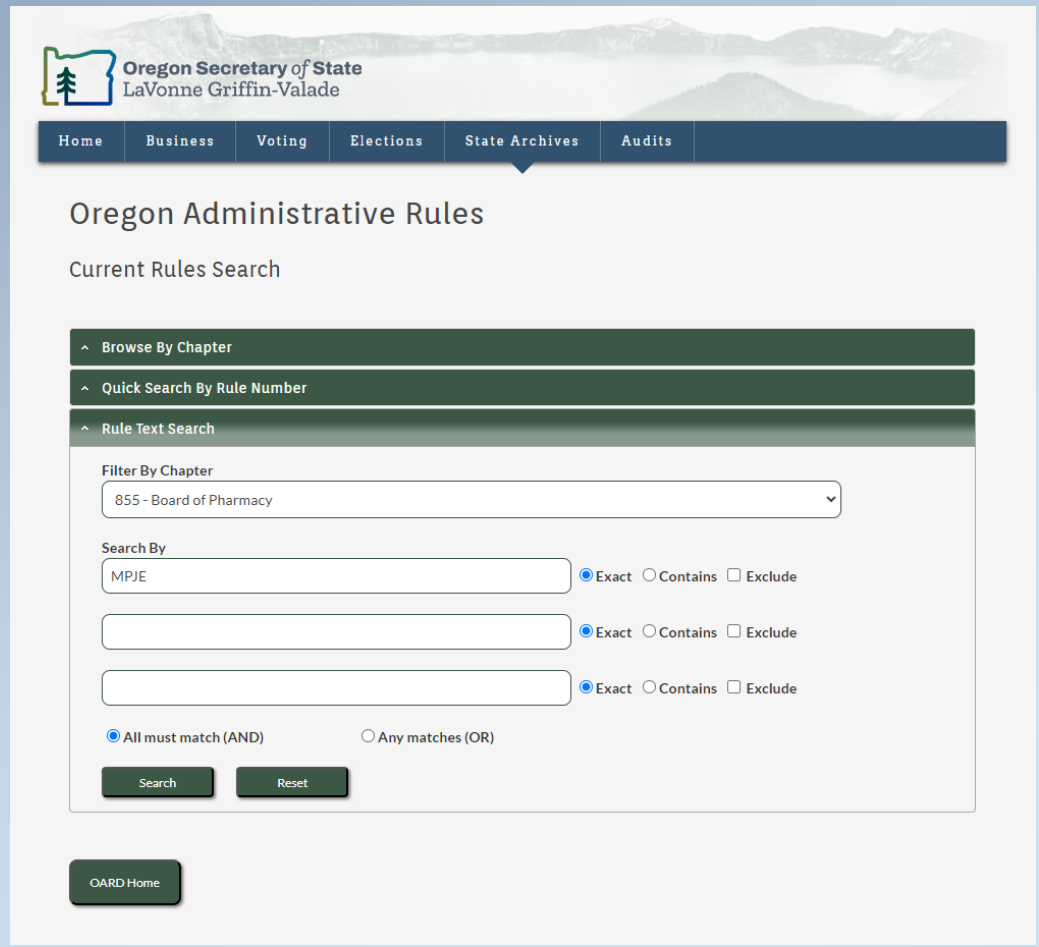
- If you have a general idea of where your potential answer is, pull up the applicable Division in its entirety and use the Keyword Search function (Control F on Windows).
- Generally speaking, the answers to our most-commonly-asked questions can be found in the following Divisions:
  - Division 6 – Definitions
  - Division 41 – Operation of Pharmacies
  - Division 104 – Universal Rules
  - Division 115 – Pharmacists
  - Division 120 – Interns
  - Division 125 Certified Oregon Pharmacy Technicians and Pharmacy Technicians

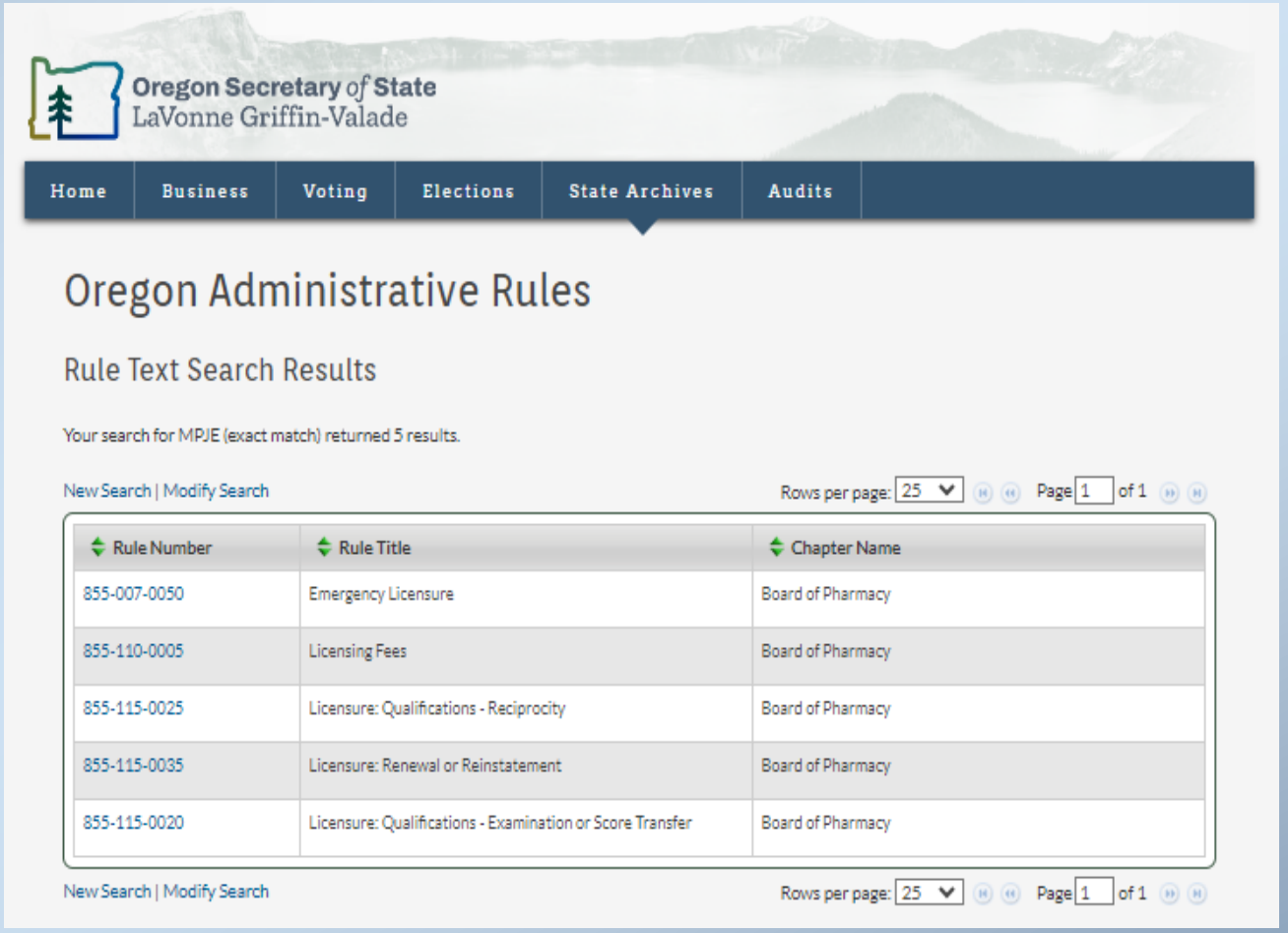
Ways to Interact with our Rules: Key Word Search (Control F)



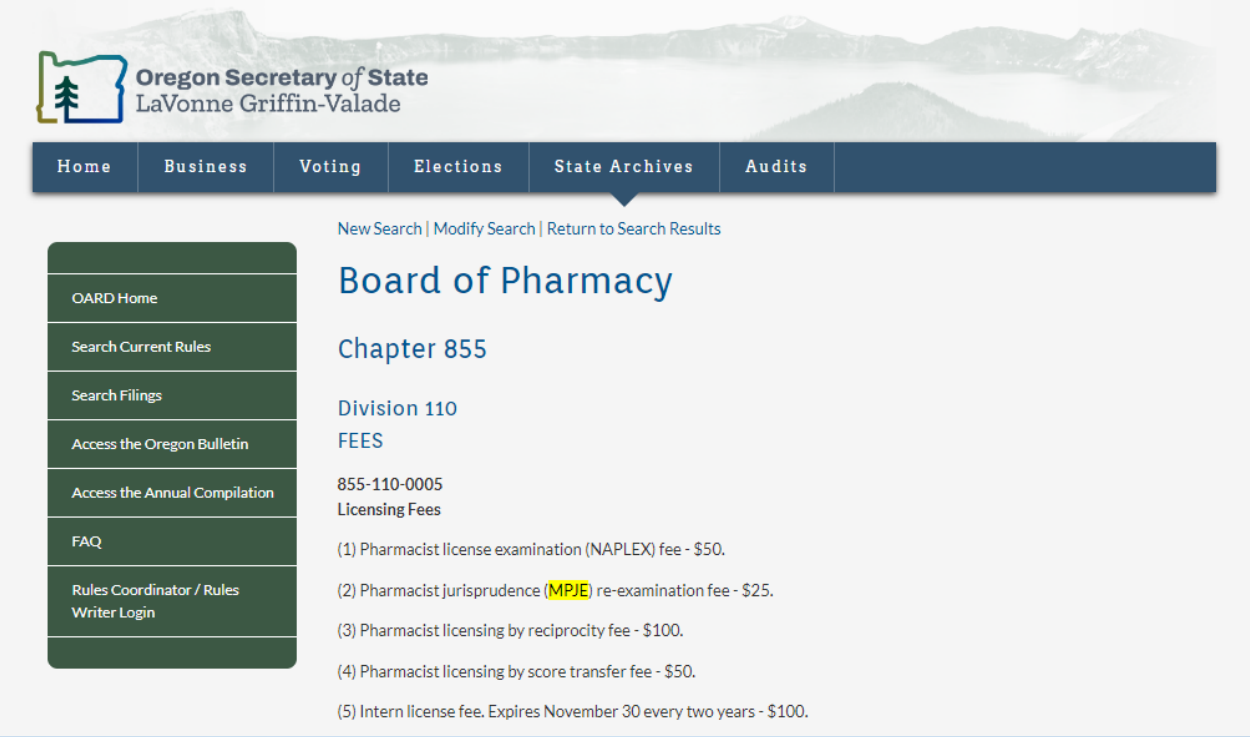


Ways to Interact with our Rules: "Rule Text Search" on OBOP Website





Ways to Interact with our Rules: "Rule Text Search" on OBOP Website

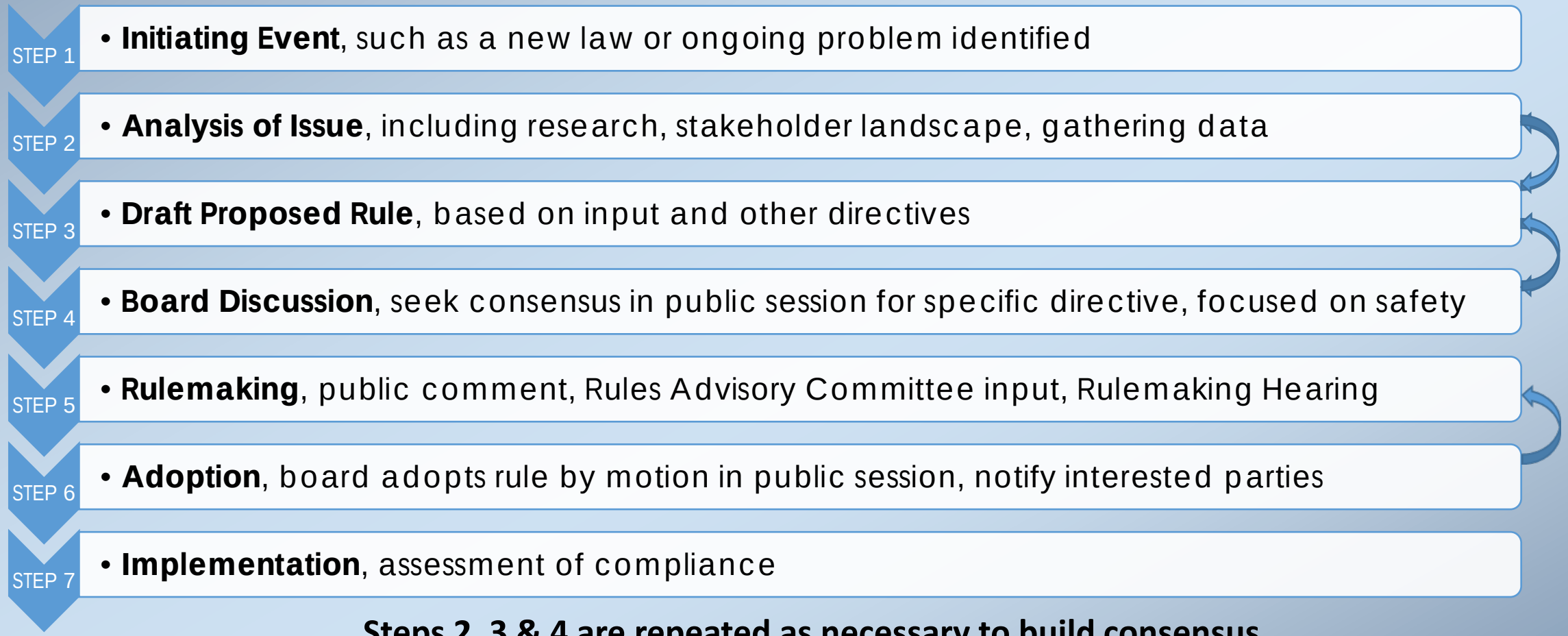


- Queried term will display in yellow highlight.
- Excellent way to search if you're unsure where to start, or the material might be covered in multiple divisions.
- Searches most-current rule iterations (unlike annual compilation).

Regulations

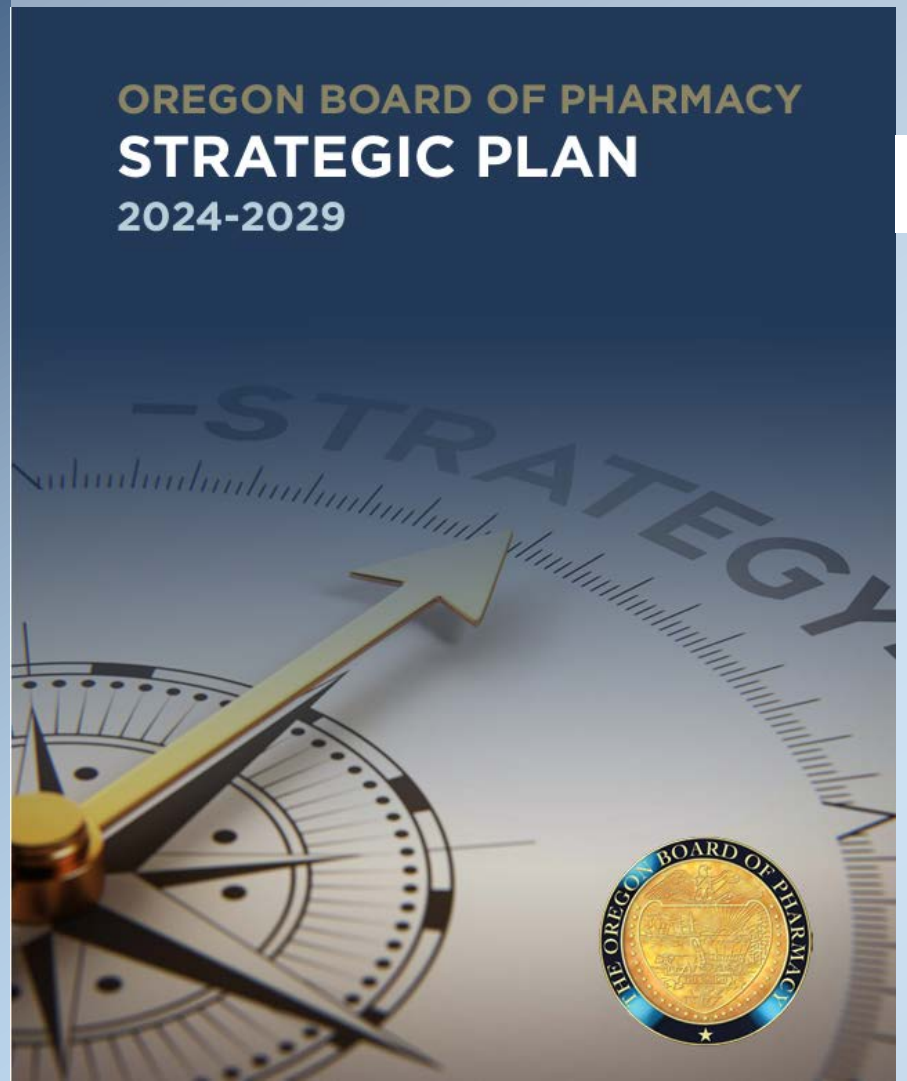
New and proposed laws & rules

How a Statute or Policy Directive Becomes a Rule



Steps 2, 3 & 4 are repeated as necessary to build consensus

Board Direction -> Rules



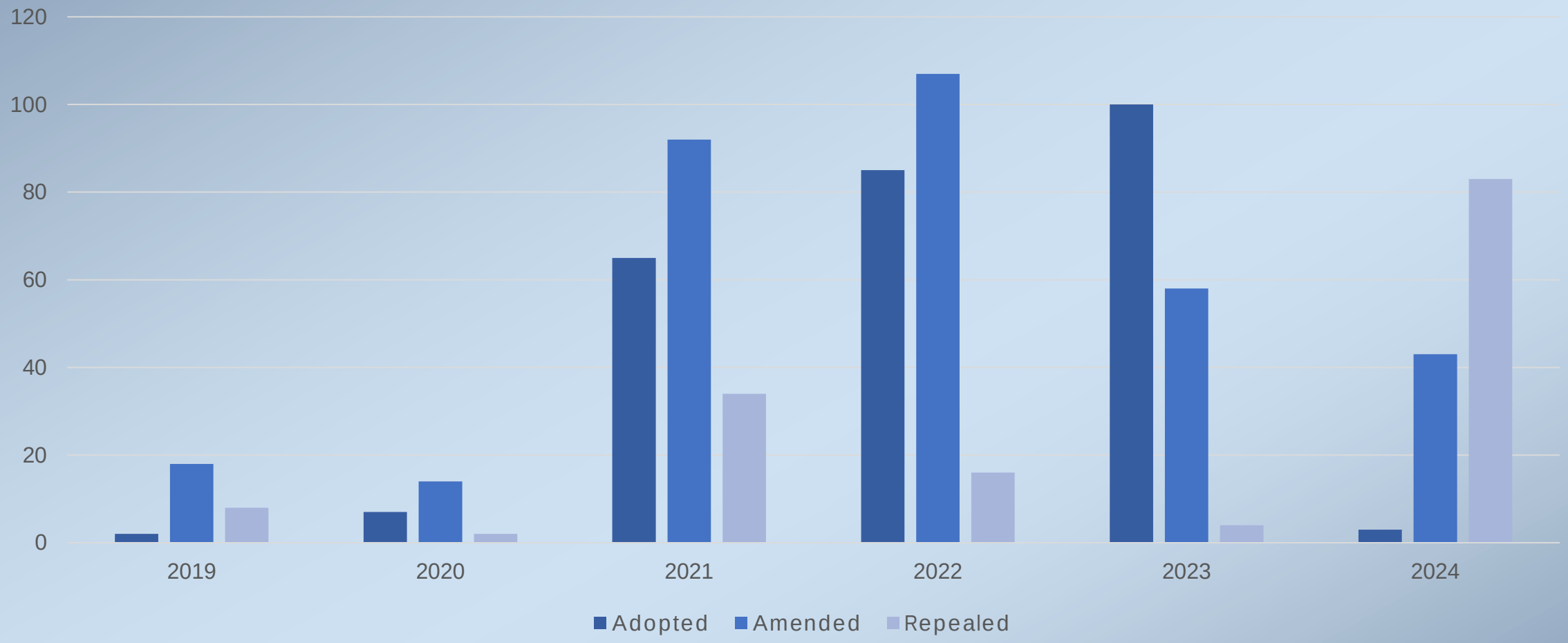
ORGANIZATIONAL PILLARS

OPERATIONS: Processes, procedures, and systems that support safe and equitable pharmacy practice in Oregon as well as the agency's own ability to deliver high quality services, while serving as a careful steward of public resources.

REGULATION & COMPLIANCE: Systematic review and updates to Oregon Administrative Rules that govern pharmacy practice and drug dispensing, distribution, and delivery. Continuous assessment of Licensees and Registrants which includes investigations and inspections to ensure adherence to regulations.

COMMUNICATION: Information conveyed to the public, Licensees and Registrants ensuring transparency, fostering effective collaboration, and promoting safety and equity in all aspects of pharmacy practice.

Permanent Board Rules by Year



OAR Chapter 855 – Board of Pharmacy

- Division 6 - DEFINITIONS
- Division 7 - PUBLIC HEALTH EMERGENCY
- Division 11 - HEALTH PROFESSIONAL'S SERVICE PROGRAM
- Division 35 - OPERATION OF NONPRESCRIPTION AND MEDICAL DEVICE, EQUIPMENT AND GAS (MDEG) OUTLETS
- Division 41 - OPERATION OF PHARMACIES
- Division 42 - NUCLEAR PHARMACIES AND PHARMACISTS
- Division 43 - PRACTITIONER DISPENSING
- Division 44 - CHARITABLE PHARMACIES
- Division 45 - DRUG COMPOUNDING
- Division 60 - PHARMACEUTICAL MANUFACTURERS
- Division 62 - DRUG DISTRIBUTION AGENT
- Division 65 - WHOLESALE DRUG OUTLETS
- Division 70 - PROPHYLACTICS AND CONTRACEPTIVES
- Division 80 - SCHEDULE OF CONTROLLED SUBSTANCES
- Division 102 - BOARD ADMINISTRATION
- Division 104 - UNIVERSAL RULES
- Division 110 - FEES
- Division 115 - PHARMACISTS
- Division 120 - INTERNS AND PRECEPTORS
- Division 125 - CERTIFIED OREGON PHARMACY TECHNICIANS AND PHARMACY TECHNICIANS
- Division 135 - CONTINUING PHARMACY EDUCATION
- Division 139 - REMOTE DISPENSING SITE PHARMACY
- Division 141 - PHARMACY PRESCRIPTION KIOSK
- Division 143 - PHARMACY PRESCRIPTION LOCKER
- Division 183 - DRUG COMPOUNDING

Vertical Unification of Rule Structure

Within the Divisions for **Pharmacists** (**115**), **Interns** (**120**),and **Certified Oregon Pharmacy Technicians and Pharmacy Technicians** (**125**), certain rule numbers and subjects have been standardized.

Rule Number (OAR 855-115/120/125-XX)	Rule Subject
0001	**Applicability**
0005	**Definitions**
0010	**Licensure**: Qualifications
0030	Application
0035	Renewal or Reinstatement
0040	Lapse
0050	Voluntary Surrender
0105	**Responsibilities:** General
0110	Confidentiality
0115	Duty to Report
0150	**Prohibited Practices**

Division 104- Universal Rules

Rule	Rule Title
OAR 855-104-0005	Duty to Cooperate
OAR 855-104-0010	Responsibilities: Duty to Report
OAR 855-104-0015	Responsibilities: Confidentiality
OAR 855-104-0050	Patients Access to Pharmacy Records
OAR 855-104-0055	Record and Document Retention
OAR 855-104-0060	Public Records Request to the Board
OAR 855-104-0100	Time for Requesting a Contested Case Hearing
OAR 855-104-0105	Filing Exceptions and Argument to the Board
OAR 855-104-0110	Petition for Reconsideration or Rehearing as Condition for Judicial Review
OAR 855-104-0115	Inspections
OAR 855-104-0150	Military Spouse or Domestic Partner Licensure Process

New Rules:
The Who/What/When/Where & Why

New Rules in OAR Chapter 855
WHO is primarily affected?
WHAT is the title of the rule?
WHEN did it go into effect?
WHERE can I find it?
WHY was it changed?

Rule Review (1)
Non-Licensed Personnel Functions

Rules in OAR Chapter 855
WHO : Non-licensed personnel (“clerks”)
WHAT: Responsibilities: Supervision - Pharmacists
WHEN: 3/01/2024
WHERE: OAR 855-**115**-0120
WHY: Sets parameters for non-licensed personnel

OAR 855-115-0120
Responsibilities: Supervision – Pharmacists

(1) When practicing pharmacy per ORS 689, each Pharmacist must:

(a) Ensure personnel that require licensure have been granted and maintain licensure with the board;

(b) Ensure licensed personnel work within the duties permitted by their licensure;

(c) Ensure non-Pharmacist personnel only perform duties they are licensed and trained to perform;

(f) Ensure each Certified Oregon Pharmacy Technician and Pharmacy Technician only assists in the practice of pharmacy under the supervision, direction, and control of a Pharmacist as outlined in OAR 855-125;

(g) Ensure licensed personnel do not engage in prohibited practices as outlined for Interns in OAR 855-120-0150 and for Certified Oregon Pharmacy Technicians and Pharmacy Technicians in OAR 855-125-0150;

(h) Ensure non-licensed personnel do not practice or assist in the practice of pharmacy;

What is the “practice of pharmacy?”

ORS 689.005

(29) “Practice of pharmacy” means:
(a) The interpretation and evaluation of prescription orders;
(b) The compounding, dispensing and labeling of drugs and devices, except labeling by a manufacturer, packer or distributor of nonprescription drugs and commercially packaged legend drugs and devices;
(c) The prescribing and administering of vaccines and immunizations and the providing of patient care services pursuant to ORS 689.645;
(d) The administering of drugs and devices to the extent permitted under ORS 689.655;
(e) The participation in drug selection and drug utilization reviews;
(f) The proper and safe storage of drugs and devices and the maintenance of proper records regarding the safe storage of drugs and devices;
(g) The responsibility for advising, where necessary or where regulated, of therapeutic values, content, hazards and use of drugs and devices;
(h) The monitoring of therapeutic response or adverse effect to drug therapy;
(i) The optimizing of drug therapy through the practice of clinical pharmacy;
(j) Patient care services, including medication therapy management and comprehensive medication review;
(k) The offering or performing of those acts, services, operations or transactions necessary in the conduct, operation, management and control of pharmacy;
(L) The prescribing and administering of injectable hormonal contraceptives and the prescribing and dispensing of self-administered hormonal contraceptives pursuant to ORS 689.689;
(m) The prescribing and dispensing of emergency refills of insulin and associated insulin-related devices and supplies pursuant to ORS 689.696;
(n) The prescribing, dispensing and administering of preexposure prophylactic antiretroviral therapies and post-exposure prophylactic antiretroviral therapies, pursuant to ORS 689.704 and rules adopted by the board under ORS 689.645 and 689.704; and
(o) The delegation of tasks to other health care providers who are appropriately trained and authorized to perform the delegated tasks.

Rule Review (2)
Identification Requirements

Rules in OAR Chapter 855
WHO : RPH, Techs, Interns
WHAT: Responsibilities: General
WHEN: 3/01/2024
WHERE: OAR 855-**115/120/125**-0105
WHY: Clarifies requirements for identification in all interactions and communications (see 2025 HB 3912)

OAR 855-115-0105
Responsibilities: General

When practicing pharmacy per ORS 689, each Pharmacist must:

(10) Be clearly identified as a Pharmacist in all interactions and communications (e.g., nametag, phone interaction, chart notations);

OAR 855-120-0105
Responsibilities: General - Intern

(h) Be clearly identified as an Intern in all interactions and communications (e.g., nametag, phone interaction, chart notations);

OAR 855-125-0105
Responsibilities: General - Certified Oregon Pharmacy Technician and Pharmacy Technician

(i) Be clearly identified as a Certified Oregon Pharmacy Technician or Pharmacy Technician in all interactions and communications (e.g., nametag, phone interaction, chart notations);

Rule Review (3)
Drug Take Back Collection Programs

Rules in OAR Chapter 855
WHO: Pharmacies
WHAT: Secure and Responsible Drug Disposal
WHEN: 2/23/2017 – 6/16/2025
WHERE: OAR 855-**041**-1046
WHY: Clarifies requirements for pharmacies operating drug take back collection programs

OAR 855-041-1046

Secure and Responsible Drug Disposal

(1) A pharmacy that operates a drug take back collection program or that participates in a drug take-back program under ORS 459A.200 to ORS 459A.266 as an authorized collector must be registered with the DEA as an authorized collector to collect controlled and non-controlled drugs for destruction.

(2) A pharmacy that operates as a Drug Enforcement Agency (DEA) authorized collector must notify the board within 30 days of initiating or terminating the program and must establish and enforce policies and procedures, including but not limited to:

(a) Provision of a secure location of the collection receptacle **inside the retail drug outlet**, which is accessible to the public, **within view of the pharmacy counter** and **must not be located behind the pharmacy counter**; and

(b) Provision of adequate security measures, including **proper installation and maintenance** of the collection receptacle, **tracking of liners**, documentation, and key accountability; and

(c) Personnel training and accountability.

OAR 855-115-1046
Secure and Responsible Drug Disposal

(3) A pharmacy must inform consumers to directly deposit drugs into the collection receptacle. **Pharmacy personnel must not count, sort, inventory, or otherwise handle drugs collected**.

(4) A pharmacy must not dispose of drugs from pharmacy stock in a collection receptacle.

(5) The liner must be inserted and removed from a locked collection receptacle only by or under the supervision of two employees of the pharmacy. Upon removal, the liner must be immediately sealed, and **the pharmacy employees must document their participation in the insertion and removal of each liner from a collection receptacle on a log**. Sealed liners must not be opened, analyzed, or penetrated at any time by the pharmacy or pharmacy personnel.

OAR 855-115-1046
Secure and Responsible Drug Disposal

(6) Liners that have been removed from a collection receptacle and immediately sealed must be directly transferred, **or otherwise stored in a secured, locked location in the pharmacy for no longer than 14 days prior to being transferred, by two pharmacy personnel to a registered drug distribution agent** (such as registered UPS, FedEx, or USPS) **or a reverse wholesaler registered with the DEA and the board.**

(7) Any tampering with a collection receptacle, liner or theft of deposited drugs **must be reported to the board in writing within one day of discovery**.

(8) A pharmacy must maintain all drug disposal records **for a minimum of 3 years.**

Rule Review (4)
Expiration/Beyond-Use Dates

Rules in OAR Chapter 855
WHO: Pharmacies
WHAT: Retail Drug Outlet Pharmacy Prescription Labeling
WHEN: 1979-2023
WHERE: OAR 855-**041**-1130
WHY: Clarified counseling requirements

OAR 855-041-1130

Retail Drug Outlet Pharmacy Prescription Labeling

Except as described in SB 450 (2023), prescriptions must be labeled with the following information:

(10) An expiration date after which the patient should not use the drug or medicine. Expiration dates on prescriptions must not exceed:

(a) That on the manufacturer's container if dispensed in the manufacturer's container; or

(b) The earliest date of either:

(A) The manufacturer's expiration date; or

(B) One year from the date the drug was repackaged and dispensed.

(11) Any drug expiring before the expected length of time for the course of therapy must not be dispensed.

Rule Review (5)
Annual CS Inventory (& Reconciliation)

Rules in OAR Chapter 855
WHO: Pharmacist-in-Charge
WHAT: Pharmacist-in-Charge: Responsibilities
WHEN: 03/01/2024
WHERE: OAR 855-**115**-0210
WHY: Clarifies responsibilities as Pharmacist-in-Charge (PIC)

OAR 855-115-0210

Pharmacist-in-Charge: Responsibilities

(1) In addition to the responsibilities of a Pharmacist outlined in OAR 855-115, a Pharmacist-in-Charge of a Drug Outlet pharmacy must:

(a) Be actively engaged in pharmacy activities at the Drug Outlet pharmacy;

(b) Be physically present at the Drug Outlet pharmacy on a regular basis for a sufficient amount of time as needed to ensure Drug Outlet pharmacy compliance;

(c) Be responsible for the ongoing conduct, operation, management and control of the Drug Outlet pharmacy;

(d) Establish, maintain, and enforce written policies and procedures governing the practice of pharmacy that are compliant with federal and state laws and rules;

OAR 855-115-0210

Pharmacist-in-Charge: Responsibilities

(e) Ensure maintenance of complete and accurate records;

(f) Establish, maintain and enforce a continuous quality improvement program;

(g) Develop, implement and submit a plan of correction for observations noted on an inspection within the time allowed by the board;

(h) Complete an annual self-inspection of the pharmacy using the Self-Inspection Form provided by the board, by **July 1** each year **and within 15 days of becoming PIC**. The completed self-inspection forms must be signed and dated by the PIC and retained for three years from the date of completion; and

OAR 855-115-0210

Pharmacist-in-Charge: Responsibilities

(i) Ensure a controlled substance inventory **with discrepancy reconciliation** is accurately completed and documented:

(A) For all controlled drugs either prior to the opening or after the close of business on the inventory date:

(i) Within 15 days of a change in PIC; and

(ii) **At least every 367 days**; and

(B) For all Schedule II controlled drugs:

(i) At least every **93 days** in a Retail Drug Outlet Pharmacy; and

(ii) At least every **31 days** in an Institutional Drug Outlet Pharmacy.

Rule Review (6)
PIC Training Class Requirements

Rules in OAR Chapter 855
WHO: Pharmacist-in-Charge
WHAT: Pharmacist-in-Charge: Responsibilities
WHEN: 3/01/2024 (see effective date on next slide)
WHERE: OAR 855-**115**-0205
WHY: Establishes interval for PIC Training Class

OAR 855-115-0205

Pharmacist-in-Charge: Responsibilities

(1) In order to be a Pharmacist-in-Charge (PIC), a Pharmacist must have:

(a) Completed at least one year of pharmacy practice; or

(b) Completed a board provided PIC training course either before the appointment or within 90 days after the appointment; and

(c) Be employed by the outlet.

(3) Effective July 1, 2025, in order to be a Pharmacist-in-Charge (PIC), a Pharmacist must complete a board provided PIC training course **at least every five years.**

Rule Review (7)
Universal Vaccination Protocols

Rules in OAR Chapter 855
WHO: Pharmacists
WHAT: Services: Prescribing Pursuant to - Protocol
WHEN: 8/08/2025 – 9/17/2025
WHERE: OAR 855-**115**-0345
WHY: Adopts Universal Vaccine Protocols as well as “Board-Excluded” Protocols

OAR 855-115-0345

Services: Prescribing Pursuant to - Protocol

A Pharmacist may prescribe, according to OAR 855-115-0330 and OAR 855-115-0335, FDA-approved drugs and devices pursuant to a Protocol. Protocols in their entirety are adopted by the board by this rule pursuant to the respective effective date referenced and can be found on the board website at https://www.oregon.gov/pharmacy/Pages/PFAC.aspx.

(4) Vaccine Protocols:

- (a) Vaccination Protocol for Adults 18 Years of Age and Older (v. 09/17/2025);
- (b) Vaccination Protocol for Ages 7 through 17 Years (v. 09/17/2025); and
- (c) Vaccination Protocol for Managing Adverse Reactions (v. 08/2025).

(5) Board Excluded Vaccine Protocols

- (a) Coronavirus 19 (v. 09/2025);
- (b) Influenza (v. 09/2025); and
- (c) Respiratory Syncytial Virus (v. 09/2025).

Rule Review (8)
Limited Delegated Authority- Vaccines

Rules in OAR Chapter 855
WHO: Board President/Board Staff; Pharmacists
WHAT: Amendment of Vaccine Protocol Rules to Adopt ACIP Recommendations
WHEN: 8/08 – 9/17/2025
WHERE: OAR 855-**102**-0130
WHY: Allows Board President limited authority to amend vaccine protocols in accordance with ACIP recommendations as adopted by the CDC; can be delegated to board staff.

OAR 855-102-0130

Amendment of Vaccine Protocol Rules to Adopt ACIP Recommendations

Pursuant to ORS 689.645(5), the board delegates to the Board President the limited authority to amend the board's vaccine protocols in OAR 855-115-0345 to adopt recommendations issued by the Advisory Committee on Immunization Practices (ACIP) adopted by the Centers for Disease Control and Prevention (CDC) except for vaccine protocols excluded by the Board. The Board President may further delegate this authority to board staff. ORS 689.649 does not apply to rule amendments made pursuant to the delegation of authority in this rule because those amendments are required and the board's only course of action.

Currently, there are three protocols "excluded by the board," based on recommendations that came from the West Coast Health Alliance:

1. Coronavirus 19
2. Influenza
3. Respiratory Syncytial Virus

West Coast Health Alliance 2025-2026 Respiratory Vaccine Recommendations

"The West Coast Health Alliance (WCHA) is issuing immunization recommendations for the 2025-2026 respiratory virus season. These recommendations are informed by trusted national medical organizations, including the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP). The WCHA believes that *all* recommended immunizations should be accessible to the people of our states.

Immunization is safe, effective, and the best protection available against respiratory viruses such as COVID-19, influenza, and RSV. Seasonal immunization is also a critical public health tool to reduce serious illness, community transmission, and health care systems strain."

West Coast Health Alliance 2025-2026 Respiratory Vaccine Recommendations

	2025-26 Respiratory Vaccine Recommendations		
	COVID-19 vaccine	**Influenza vaccine**	**RSV immunization**
Children	• All 6-23 months* • All 2-17 years with risk factors* • All with close contact with others with risk factors • All who choose protection	• All ≥ 6 months	• All < 8 months* • All 8-19 months with risk factors*
Pregnancy	• All planning, pregnant, postpartum, and lactating	• All planning, pregnant, postpartum, and lactating	• 32-36 weeks gestational age[1]
Adults	• All ≥ 65 years • All 18-64 years with risk factors • All with close contact with others with risk factors • All who choose protection	• All ≥ 18 years	• All ≥ 75 years • All 50-74 years with risk factors

* Other than influenza vaccines, an Oregon-licensed pharmacist practicing in Oregon may only prescribe and administer vaccines to individuals 7 years of age and older (see ORS 689.645 for more details).

Legislative Sessions -> Laws

- Several Senate Bills (SB) and House Bills (HB) impacting Oregon pharmacy are passed during each session. Many bills require new rules.
- Let's take a look at recent and upcoming legislation related to the practice of pharmacy.
- Stay up to date at: https://www.oregonlegislature.gov/bills_laws

Ongoing communications concerning rulemaking are sent to licensees via list-serv and are available on the OBOP website

2025 Legislative Session

Bill	Subject	Changes
HB 3045	HPSP	Authorizes the State Board of Pharmacy to require a person under investigation by the board to undergo a mental, physical, chemical dependency or competency evaluation.
HB 3912	Use of title “doctor”	Requires an individual who uses the title "doctor" in connection with a health care profession to designate on specified material.
HB 5028	Licensing Fees	Limits biennial expenditures from fees, moneys or other revenues, collected or received by the State Board of Pharmacy.
SB 236	MOUDs	Clarifies that a pharmacist may prescribe, dispense and administer medications for treatment of opioid use disorder. Defines PPL and waives registration requirements under certain conditions.

Common Retail Drug Outlet Observations

Documentation
- Counseling
- Interpreter use
- Training
- C-II quarterly reconciliation
- Vaccines- VIS dates, lot/expiration
- Temperature logs
- RTS/relabeled drugs missing RPH initials

Expiration Dates
- Expired drugs on shelf
- “Use-by” date on patient prescription label greater than manufacturer expiration date.
- Emergency kit supplies

Drug storage violations
- Temperature excursions not responded to adequately or at all.

Pharmacist Prescriptive Authority
- Not using most recent iteration of approved protocols.

Post-Assessment Question 1

Per OAR 855 and ORS 689, which of the following activities might non-licensed pharmacy personnel engage in, if properly trained and authorized? (Select all that apply)

a) Count medications for inventory.

b) Count medications for prescription.

c) Enter prescription refill number in computer.

d) Label medications to returned to stock.

e) None of the above.

Post-Assessment Question 2

Assuming no state of emergency has been declared, an Oregon-licensed pharmacist practicing in Oregon is authorized to administer which of the following via the board's current protocols? (Select all that apply)

a) Influenza vaccines to patients 6 months of age and older.

b) COVID-19 vaccines to patients 6 months of age and older.

c) COVID-19 vaccines to patients 3 years of age and older.

d) RSV vaccines to pregnant patients in the second trimester, at 14 to 27 weeks gestational age.

e) None of the above.

Post-Assessment Question 3

Per OAR 855-041-1046 Secure Drug Disposal, which of the following is true regarding a pharmacy that operates a drug take back collection program?

a) A pharmacy may dispose of drugs in the receptacle if they're expired, adulterated, or misbranded.

b) Pharmacy personnel may assist the patient in counting, sorting, and handling medications for disposal but only at the patient's request.

c) The receptacle must be located in a secure location, within view of the pharmacy counter but not behind it.

d) Any tampering with a collection receptacle, liner, or theft of deposited drugs must be reported to the board in writing within 3 days of discovery.

e) None of the above.

Post-Assessment Question 4

Effective 7/01/2025, in order to be a Pharmacist-in-Charge(PIC) in Oregon, a Pharmacist must: (select all that apply)

a) Have at least 1 year of management experience.

b) Complete a board-provided PIC training course either before the appointment or within 90 days after the appointment.

c) Complete a board-provided PIC training course at least every 10 years.

d) Be present at the outlet at least 20 hours per week.

e) None of the above.

Stay in Tune and Stay in Touch

Rulemaking: pharmacy.rulemaking@bop.oregon.gov

PHPFAC Concepts: https://www.oregon.gov/pharmacy/Pages/PFAC.aspx

PHPFAC: pharmacy.formulary@bop.oregon.gov

Self-Inspection Forms: https://www.oregon.gov/pharmacy/Pages/Self-Inspection-Forms.aspx

Stay in Tune and Stay in Touch

Phone: 971-673-0001

Fax: 971-673-0002

General Inquiries - pharmacy.board@bop.oregon.gov

Compliance Inquiries - pharmacy.compliance@bop.oregon.gov

Licensing Inquiries - pharmacy.licensing@bop.oregon.gov

OTC Self-Care Challenge presentation slides are not available for distribution.

integrating harm reduction into medical practice

Felicia Stivahtis

CAP

Outreach Specialist

there are no affiliations to disclose

Objectives:

- Discuss harm reduction basics
- Recognize stigma
- Identify ways to interact with people with substance use disorder
- Explain the reasoning behind the mistrust between medical providers and patients in the SUD and HIV community
- Utilize tools for difficult situations
- List where to find additional training and local resources

Question 1:

Who can benefit from Harm reduction?

A: SUD patients and their families

B: Care providers and their staff

C: All of the Above

Question 2 :

What is one of these situations shows bias towards patients with SUD?

A: Giving standard but quick care to a SUD patient during a busy time

B: Leaving an elderly SUD patient alone with open wounds and no catheter alone in an ER room for hours

C: Being unwilling to be the point person for certain difficult situations

Question 3 :

Which one of these questions could you ask to help bridge the gap between providers and SUD patients?

A: “what are your plans for this medication?”

B: “where is your family?”

C: “would you like some info on local resources before you leave today?”

Question 4 :

Which of the following is a common reason that SUD patients might have mistrust with medical providers?

A: patient dumping

B: being asked too many questions

C: the price of medications

Question 5:

How can targeted trainings help bridge the gap between SUD patients and provider?

A: by showing the best way to get a SUD patient in and out as quickly as possible

B: by providing Tools for difficult situations and knowledge about how to integrate compassion into your practice

C: by teaching the lingo and culture of SUD patients

Question 6:

Which of these is a good way to help eliminate internal bias and gain more understanding about SUD patient needs?

A: volunteering at day shelters and testing centers

B: courses and lectures from people without lived experience

C: sharing stories about difficult patients with colleagues

BASICS OF HARM REDUCTION

What is the definition of Harm reduction?

Harm reduction is used to decrease negative consequences of recreational drug use and sexual activity without requiring abstinence, recognizing that those unable or unwilling to stop can still make positive change to protect themselves and others.

* The act of reducing harm caused by social stigma and public policy
*the implementation of compassion and resources in social services
*harm reduction is grounded in compassion, dignity in care and respect

Why does harm reduction matter and how can it benefit your community?

*implementing harm reduction tools and strategies into your practice is proven to decrease OD's, communicable diseases, and increase chances of recovery in people who use drugs and alcohol.

*traingings aimed towards harm reduction and knowledge of SUD demographics helps reduce burnout and work fatigue

*Harm reduction provides tools for providers to safely and effectively manage difficult situations and provides a bridge between clients and providers

*people who are provided with harm reduction services are proven to find recover sooner than those without

Stigma and Statistics

Harm reduction statistics:

*people with access to nalaxone and syringe exchange programs are 5x more likely to recover

*access to HIV and HEP C testing and education reduces infection rates by 50%

*People with any type of substance use disorder (SUD) stand a 24% higher risk of having an unplanned hospital readmission within 30 days of a previous discharge compared with those without the disorder, new UCLA-led research finds.

Where does this stigma show up?

*not looking clean enough/odor and personal hygiene affect how we interact with and treat people

*sweeps and theft make it hard to keep ahold of essential medications which also exacerbate excessive visits and frustration from both sides

*mental instability can make dealing with certain people dangerous and difficult. (Your safety comes first always but it’s important to try to use all de escalation and T.I.C. Skills before calling in security)

*burn out and traumatic experiences can lead to more internal bias and tension between provider and patient

Stigma and Statistics

Why is there so much mistrust?

*chronic illness in SUD and other patients results in repeat visits (iritation and anxiety in providers and patients)
*internal bias creates barriers and communication difficulties
*general idea that people who look a certain way are drug seeking even when medication is properly prescribed
*previous bad experiences with first responder, and other medical professionals whether first or secondhand
*patient dumping (transferring or discharging without treatment)

Ways to bridge that gap

staff trainings:

*trauma informed care

*compassionate care training

*De-escalation training

*local houseless focused nonprofits

*local Health authority

Volunteering and submersion:

*volunteering at local food banks and housless food services

*seek out medical volunteer opportunities and collaborations with local day shelters

*donate and visit local housless resource center

Have a plan and backups:

*prepare a plan for difficult situations:
*hand signals/designated take over buddy

*discuss triggers and boundaries with coworkers and staff before situations arise

*make a de-briefing plan for staff for after tense situations

*make specific de escalation plans for reoccurring patients

Tools and trainings

Trauma informed care

*OHSU trauma informed care

*The trauma healing project

*Local houseless based non profits (lived experience based)

De-escalation

*Behavioral health and Cristi response through Oregon gov

*Bridging divide initiative

*Oregon peace institute

Compassionate care

*Stanford CCC

*TalkOregon through OHSU

Tools and trainings

Trauma informed care

Trauma-informed care (TIC) is a framework for understanding and responding to the effects of trauma in healthcare, social services, and other settings. It aims to create safe and supportive environments that promote healing and recovery for individuals who have experienced traumatic events

De-escalation

De-escalation training **teaches individuals techniques to reduce the intensity of a conflict and prevent it from becoming violent or aggressive, prioritizing safety for everyone involved.**

Compassionate care

Compassionate care is a holistic approach to healthcare that emphasizes the emotional, social, and spiritual well-being of patients in addition to their physical health. It involves treating patients with empathy, respect, and dignity, while providing them with the support and resources they need to cope with their illness or condition

Tools and trainings

Interal things to implement

*Case worker/liaison with lived experience on site

*find local SUD facing orgs that have clients with medical needs to partner with

*reoccurring SUD specific trainings

*familiarize yourself with resources near your facility and have a contact person from that org

Types of Local resources

*day shelters/cooling and warming centers

*Temporary/transitional housing programs

*shower hubs

*free STI testing centers

*syringe exchanges

*wellness fairs

*centers with walk in services

Immediate resources and actions

*have take away options:
*snacks and water bottles, cooling rags, hand warmers, emergency blankets and bus passes

*if able, allow patient to sleep it off for a bit in a quiet safe place

*recognizing reoccurring patients and learn their base line reactions/their triggers and address them by their first name

*remember your safety comes first, forcing yourself to deal with difficult situations will only add to the resentment and burn out

*take away material from local resources and bus route maps/bus tickets

*naloxone and fentanyl testing strips

Resources in pdx

Day shelters:

Rahabs
Saints love
Rose haven
NAFY

Recovery programs:

4D Recovery
NARA
Cascadia health
Bridges to change
True colors
MH/AO
New Avenues for Youth

Testing and harm reduction:

CAP
CCC
Outside In
Ava Health (women only)
county clinics with walk in services (Sunnyside, beaver creek)

Other services:

Blanchet house
Boulder telehealth
TPI
Ground score/can depot
H4A
Portland street medicine
DoGood Multnomah
Steet roots
Sex Worker Resource Project
One Love
Portland rescue mission
Oregon food bank
Marie Equi
Quest center for integrative health
Q center
cultivate initiatives

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letter from a paramedic

“I feel stigma is a major issue with some medical professionals, especially in emergency settings or when people call 911. Too often, there's this assumption that patients are just looking for food or warmth, instead of being taken seriously for their medical concerns. And when that happens, real medical issues can get overlooked, undertreated, or even delayed — which is completely unacceptable.

Another way I see it is with mental health and substance use. There's a blanket assumption that all unhoused people are using drugs, which isn't true. And even when someone does have a history of use, their symptoms often get misread. If a patient comes in with delusions or hallucinations, providers may assume it's drug-induced psychosis, when sometimes the drug use actually started as self-medication for an existing condition. When that assumption is made, the underlying mental health issue never gets treated.

And I know you only asked for two, but I think this last one i feel is also super important. Too often, unhoused people aren't treated like full human beings. They have feelings, they have families who love them, and they deserve dignity. I always say if providers treated patients like they were being tipped, we'd see a whole different level of care.”

letter from a paramedic

“There are so many barriers that people with substance use disorders face, and a lot of them go unseen by those of us who haven't lived it. Depending on where someone is in their addiction, they may have lost nearly everything - their family connections, their phone, their car, even the basic tools most of us use every day to get things done. So something that seems simple, like calling to schedule a bed for inpatient detox, can actually be impossible.

On top of that, there are the systemic barriers - whether insurance will cover detox, whether there's even an open bed, and what happens afterward. Getting sober is one thing, but staying sober is another, and that's where the social side becomes a huge barrier. Many people have built their whole support system and social circle around others who are also using. When they try to step away from that, they're left isolated. It can feel like they've lost not only their coping mechanisms but also their community, which leads to depression and loneliness.

So yes, the obvious barriers are the socioeconomic ones — the loss of stability, resources, and access. But just as important are the social and cultural factors. Recovery isn't just about detoxing from a substance — it's about rebuilding your entire life and support system from scratch, which is an enormous challenge.”

Take aways

Remember, your safety comes first, forcing yourself to deal with difficult situations will only add to the resentment and burn out

There is no perfect approach to SUDs and medical mistrust. Harm reduction offers a path to bettering out community through compassion, knowledge and understanding

The best way to serve housless/SUD patients is to lead with compassion and understanding. Trainings based around working with these communities as well as feet on the ground volunteering will give you a greater understanding of their experience, and in turn provide a better overall experience for providers and patients

New Drug Update 2025

Natalea Braden-Suchy, PharmD, BCACP
OSU College of Pharmacy

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Conflict of Interest

- I have no conflict of interest to declare

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1

Objectives

- Identify new pharmacotherapy choices
- List indications, mechanism of action, common adverse effects, and significant drug interactions for those products
- Recognize safety concerns with selected new choices

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2

Assessment Question

Which of the following medications is indicated for UTI?

a) Arbli (losartan potassium)

b) Blujepa (gepotidacin)

c) Anzupgo (delgocitinib)

3

3

Assessment Question

Which of the following can cause lab abnormalities in liver enzymes?

a) Livdelzi (seladelpar)

b) Ebglyss (lebrikizumab-lbkz)

c) Tryptyr (acoltremon)

4

4

Assessment Question

Which of the following is a biosimilar of insulin aspart?

a) Yesintek

b) Starjemza

c) Kirsty

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Our Agenda

- Novel agents
- New formulations/combinations
- Biosimilars

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NOVEL AGENTS

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Cobenfy (xanomeline and trospium chloride)

- **Indications:** treatment of schizophrenia in adults
- **Mechanism of action:** xanomeline is a muscarinic agonist

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Cobenfy (xanomeline and trospium chloride)

- **Contraindications:**
  - Urinary retention
  - Moderate or severe hepatic impairment
  - Gastric retention
  - Hypersensitivity to the medication or any components
  - Untreated narrow-angle glaucoma

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Cobenfy (xanomeline and trospium chloride)

- **Warnings/precautions:**
  - Urinary retention
  - Risk of use in patients with biliary disease
  - Decreased gastric motility
  - Risk of angioedema
  - Increases in heart rate
  - Anticholinergic side effects in those with renal impairment
  - Central nervous system effects

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Cobenfy (xanomeline and trospium chloride)

- **Adverse effects:** *nausea, dyspepsia, constipation, vomiting, hypertension, abdominal pain, diarrhea, tachycardia, dizziness, GERD,* dry mouth, somnolence, blurred vision, salivary hypersecretion, orthostatic hypotension, cough, extrapyramidal side effects

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Cobenfy (xanomeline and trospium chloride)

- **Drug interactions:**
  - CYP2D6 inhibitors
  - CYP3A4 substrates
  - Drugs eliminated by active tubular secretion
  - P-glycoprotein substrates
  - Other anticholinergic medications
  - Can affect absorption of other medications due to changes in motility

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Ebglyss (lebrikizumab-lbkz)

- **Indications:** treatment of moderate to severe atopic dermatitis in those 12 years of age and older who weigh at least 40 kg

- **Mechanism of action:** binds to interleukin 13

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Ebglyss (lebrikizumab-lbkz)

- **Contraindications:** hypersensitivity

- **Warnings/precautions:**
  - Hypersensitivity
  - Conjunctivitis and keratitis
  - Parasitic (helminth) infections
  - Avoid use of live vaccines

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Ebglyss (lebrikizumab-lbkz)

- **Adverse effects:** conjunctivitis, injection site reactions, herpes zoster

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Nemluvio (nemolizumab-ilto)

- **Indications:**
  - Those 12 years of age and older with moderate to severe atopic dermatitis in combination with topical steroids and/or calcineurin inhibitors
  - Treatment of adults with prurigo nodularis
- **Mechanism of action:** interleukin 31 receptor antagonist

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Nemluvio (nemolizumab-ilto)

- **Contraindications:** hypersensitivity to the product or its ingredients
- **Warnings/precautions:**
  - Hypersensitivity
  - Avoid live vaccines

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Nemluvio (nemolizumab-ilto)

- **Adverse effects:**
  - For atopic dermatitis: headache, injection site reactions, arthralgia, urticaria, myalgia
  - For prurigo nodularis: headache, dermatitis atopic, eczema, eczema nummular
- **Drug interactions:**
  - None listed for atopic dermatitis
  - For prurigo nodularis it stated that cytokines can affect CYP levels

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Anzupgo (delgocitinib)

- **Indications:** topical treatment of moderate to severe chronic hand eczema in adults

- **Mechanism of action:** topical janus kinase inhibitor

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Anzupgo (delgocitinib)

- **Warnings/precautions:**
  - Serious infections
  - Non-melanoma skin cancers
  - Immunizations
  - Potential risks related to JAK inhibition

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Anzupgo (delgocitinib)

- **Adverse effects:** site pain, paresthesia, pruritus, erythema, skin infections, leukopenia, neutropenia

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Tryptyr (acoltremon)

- **Indications:** treatment of the signs and symptoms of dry eye disease

- **Mechanism of action:** an agonist of transient receptor potential melastatin 8 (TRPM8) thermoreceptors

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Tryptyr (acoltremon)

- **Warnings/precautions:** avoid contact with eye and other surfaces

- **Adverse effects:** site pain

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Vizz (aceclidine)

- **Indications:** treatment of presbyopia
- **Mechanism of action:** pupil selective cholinergic muscarinic agonist

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Vizz (aceclidine)

- **Warnings/precautions:**
  - Blurred vision
  - Risk or retinal tears/detachment
  - Iritis
- **Adverse effects:** site irritation, dim vision, headache, conjunctival hyperemia, ocular hyperemia

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Livdelzi (seladelpar)

- **Indications:** primary biliary cholangitis
- **Mechanism of action:** it is a proliferator-activated receptor delta agonist

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Livdelzi (seladelpar)

- **Warnings/precautions:**
  - Fractures
  - Liver test abnormalities
  - Biliary obstruction
- **Adverse effects:** headache, abdominal pain, nausea, abdominal distention, dizziness, decrease in eGFR

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Livdelzi (seladelpar)

- **Drug interactions**
  - OAT3 (organic anion transporter) substrate
  - CYP2C9 substrate
  - BCRP (Breast Cancer Resistance Protein) substrate
  - Bile acid sequestrants

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Blujepa (gepotidacin)

- **Indications:** uncomplicated UTI in females 12 years or older and at least 40 kg

- **Mechanism of action:** topoisomerase inhibitor, thus prevents replication

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Blujepa (gepotidacin)

- **Contraindications:** hypersensitivity
- **Warnings/Precautions**
  - QT prolongation
  - Acetylcholinesterase inhibition
  - Hypersensitivity reactions
  - *C. difficile infections*

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Blujepa (gepotidacin)

- **Adverse effects:** diarrhea, nausea, abdominal pain, flatulence, headache, soft feces, dizziness, vomiting and vulvovaginal candidiasis
- **Drug interactions:**
  - Avoid strong CYP3A4 inhibitors, inducers, and substrates
  - Digoxin
  - Midazolam

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Orlynvah (sulopenem etzadroxil and probenecid)

- **Indications:** uncomplicated UTIs in adult women
- **Mechanism of action:** prevents bacterial cell wall production

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Orlynvah (sulopenem etzadroxil and probenecid)

- **Contraindications:**
  - Hypersensitivity to beta-lactams
  - Patients with known blood dyscrasias
  - Patients with known uric acid kidney stones
  - Concomitant use of ketorolac tromethamine

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Orlynvah (sulopenem etzadroxil and probenecid)

- **Warnings/precautions:**
  - Hypersensitivity reactions
  - *C. difficile*-associated diarrhea
  - Risk of uric acid kidney stone development
  - Exacerbation of gout
  - Development of drug-resistant bacteria

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Orlynvah (sulopenem etzadroxil and probenecid)

- **Adverse effects:** diarrhea, nausea, vulvovaginal mycotic infection, headache, vomiting, abdominal pain
- **Drug interactions:**
  - OAT1/3 substrates
  - Ketorolac tromethamine, ketoprofen, indomethacin, naproxen
  - Methotrexate
  - Rifampin
  - Lorazepam
  - Oral sulfonylureas

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Journavx (suzetrigine)

- **Indications:** treatment of moderate to severe acute pain in adults
- **Mechanism of action:** selective blocker of the $Na_v1.8$ voltage gated sodium channel

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Journavx (suzetrigine)

- **Contraindications:** strong CYP3A inhibitors
- **Warnings/precautions:** moderate and severe hepatic impairment

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Journavx (suzetrigine)

- **Adverse effects:**
  - Nausea/vomiting, pruritus, muscle spasms, increased blood creatine phosphokinase, rash
  - Decrease in estimated glomerular filtration rate
- **Drug interactions:**
  - CYP3A4 inhibitors, inducers and substrates
  - Hormonal contraceptives

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Other Interesting Approvals

- **Vanrafia** (artrasentan)
- **Vykat XR** (diazoxide choline)

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Cancer Agents

- **Vorangio (vorasidenib):** astrocytoma or oligodendroglioma
- **Ensacove (ensartinib):** non-small cell lung cancer
- **Zegfrovy (sunvozertinib):** non-small cell lung cancer
- **Ibtrozi (taletrectinib adipate):** non-small cell lung cancer

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Cancer Agents

- **Romvimza (vimseltinib):** giant cell tumor
- **Itovebi (inavolisib):** breast cancer
- **Revuforj (revumenib):** acute leukemia
- **Avmapki Fakzynja Co-Pack:** avutometinib potassium, defactinib hydrochloride

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NEW FORMULATIONS

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New Formulations

- **Vostally:** ramipril
- **Sdamlo:** amlodipine
- **Arbli**: losartan potassium
- **Hemichlor:**

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New Formulations

- **Vostally:** ramipril
- **Sdamlo:** amlodipine
- **Arbli**: losartan potassium
- **Hemichlor:** chlorthalidone

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New Formulations

- **Aususvar:** rivaroxaban

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New Formulations

- **Ontralfy:** tizanidine hydrochloride
- **Atmeksi:** methocarbamol
- **Vyscoxa:** celecoxib
- **Qamzova:** meloxicam

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New Formulations

- **Libervant:** diazepam
- **Mezofy:** aripiprazole
- **Arynta:** lisdexamfetamine dimesylate
- **Raldesy:** trazodone

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New Formulations

- **Emrosi:** minocycline XR
- **Rezenopy:** naloxone
- **Zurnai:** nalmefene
- **Yeztugo:** lenacapavir

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New Formulations

- **Atzumi:** dihydroergotamine mesylate
- **Brekiya:** dihydroergotamine mesylate
- **Khindivi:** hydrocortisone
- **Neffy:** epinephrine

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New Combinations

- **Widaplik:** amlodipine besylate, indapamide, telmisartan

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BIOLSIMILARS

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Biosimilars

- **Steqeyma** (ustekinumab-stab)
- **Otulfi** (ustekinumab-aauz)
- **Imuldosa** (ustekinumab-srlf)
- **Yesintek** (ustekinumab-kfce)

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Biosimilars

- **Starjemza** (ustekinumab-hmny)
- **Jobevne** (bevacizumab-nwgd)
- **Omlyclo** (omalizimab-igec)
- **Tyenne** (tocilizumab-aazg)

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Biosimilars

- **Bomyntra** (denosumab-bnht)
- **Conexxence** (denosumab-bnht)
- **Ospomyv** (denosumab-dssb)
- **Xbryk** (denosumab-dssb)
- **Osenvelt** (denosumab-bmwo)
- **Stoboclo** (denosumab-bmwo)

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Biosimilars

- **Kirsty** (insulin aspart-xjhz)
- **Merilog** (insulin aspart-szjj)

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Workflow and Mindset Shifts:
Enabling Clinical Program Growth in Community Pharmacy

OSPA Annual Seminar

2025

1

Speakers



Tara Pfund, PharmD
Chief Strategy Officer
Cascadia Pharmacy Group



Crystal Bryan, PharmD
Chief Clinical Officer
Cascadia Pharmacy Group

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Disclosure Statement

There are no relevant financial relationships with ACPE defined commercial interests for anyone who was in control of the content of the activity.

3

Pharmacist Learning Objectives

1. Compare and contrast various workflow approaches for advanced pharmacy clinical services.
2. Describe existing medical billing opportunities and clinical programs available within community pharmacy practice.
3. Design an action plan for supporting positive mindset transformation when implementing and expanding new clinical services.

4

Technician Learning Objectives

1. Compare and contrast various workflow approaches for advanced pharmacy clinical services.
2. Describe existing medical billing opportunities and clinical programs available within community pharmacy practice.
3. Design an action plan for supporting positive mindset transformation when implementing and expanding new clinical services.

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Outline

1. Workflow
   - Today vs Future State
   - Vaccine Case Study- Vashon Pharmacy
2. Other Billable Clinical Services & Reimagined Workflow
3. Mindset Transformation
   - Pharmacy
   - Providers
   - Payors
   - Patients
4. Activity & Goal Sharing (as time allows)

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Pharmacist Self-Evaluation Question #1

Which components of a clinical service within a pharmacy can ancillary staff assist with?

a. Patient Identification
b. Documentation of Clinical Encounters
c. Payment Collection
d. A and C
e. All of the Above

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Pharmacist Self-Evaluation Question #2

True or False: Pharmacies in Oregon are receiving reimbursement for office visit encounters related to vaccine indications and assessments.

a. True
b. False

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Pharmacist Self-Evaluation Question #3

Which Stakeholder plays the most critical role in mindset transformation when pharmacies implement clinical programs?

a. Pharmacy Team
b. Providers
c. Payers
d. Patients
e. All of the Above

9

Technician Self-Evaluation Question #1

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Technician Self-Evaluation Question #2

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Technician Self-Evaluation Question #3

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b. Providers
c. Payers
d. Patients
e. All of the Above

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Workflow for Pharmacy and Clinical Services

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Workflow Today vs Tomorrow

Today:
Designed to shorten wait time

Future State:
Designed around quality patient care

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Technicians & Clerks

- Ancillary staff need ownership and specific roles
  - Help support workflow
    - Patient Identification
    - Documentation
    - And more
  - Autonomy and mastery can also help with job satisfaction
- Practice at the top of everyone's license



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Students & Residents

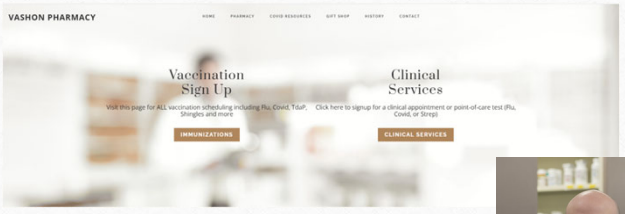
- Preparation for clinical encounter
- Patient recruitment during provision of clinical services
- Medical decision-making
- Charting and billing



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Vashon Pharmacy

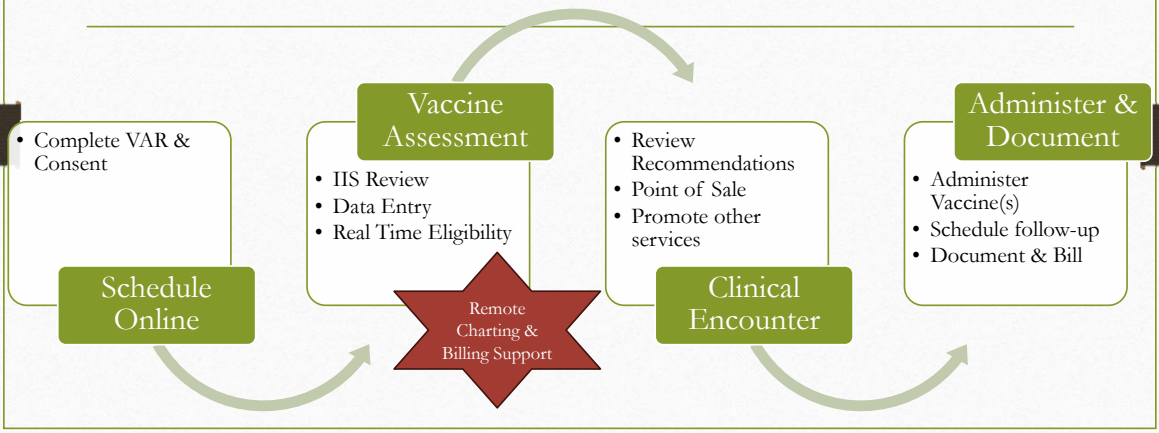
- Website
- Robust Programs
- Credentialed Providers
- Clinic Rooms
- Community Ties
- Performance/Financial Analysis





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Vashon Vaccine Program



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Vaccine Workflow: Profitability

Vaccine Encounter (Today):
Provide Flu Shot
Time: 7 minutes
Profit: ~$20

Vaccine Encounter (Future State):
Provide Flu shot (and 1-2 others)
Time: 10 minutes
Profit: ~$60-$100

PLUS: Bill Vaccine Assessment ~$40-$80

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Other Billable Clinical Services and a Reimagined Workflow

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Public Health & Pharmacy Formulary Advisory Committee

Preventative Care

- Condoms
- Contraception
- Emergency Contraception
- HIV Pre and Post-Exposure Prophylaxis (PrEP & PEP)
- STI PEP
- Tobacco Cessation
- Travel Medications

Cough & Cold

- Benzonatate
- Intranasal Corticosteroids
- Pseudoephedrine
- SABAs

Vaccines

Miscellaneous

- Emergency Refill Of Insulin
- Naloxone & Opioid Overdose Prevention
- Device & Supplies
- Covid-19 Antigen Self-Test
- SARS-CoV2 Antiviral
- Continuation of Therapy

21

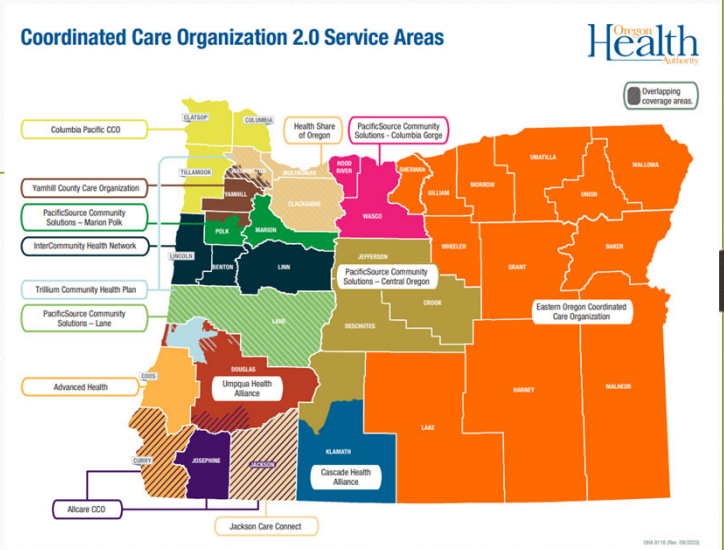
Vaccine Access Program (VAP)

- Requires credentialing and enrollment with Oregon Medicaid and CCOs and ability to transmit medical claims for reimbursement
- Community pharmacies can participate
- Enables no cost and low-cost vaccine to clinics who serve a broad client base
- Covers and Includes:
  - Uninsured
  - Adults on Medicaid/Oregon Health Plan (OHP)
  - Vaccines for Children (VFC)
  - Commercially Insured

22

Oregon Medicaid & CCOs

FFS Provider Enrollment is the 1st Step



23

Oregon – Grants Pass



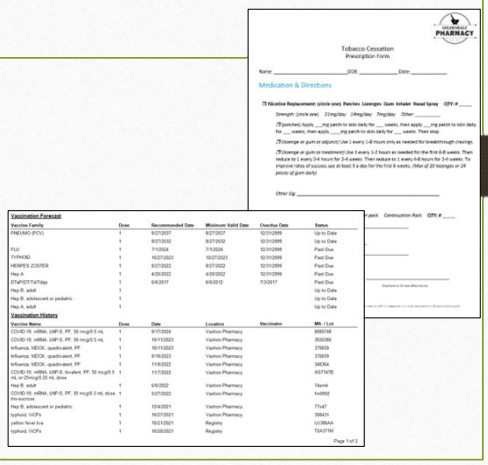


- Variety of Statewide Protocols
- Alternative Payment Model with a Payor
  - Program Management Monthly Payment
  - Increased FFS
  - Packaging, Delivery, Shipping Payment
- They provide and bill for
  - Vaccine assessments
  - Tobacco Cessation
  - Hormonal Contraception
  - Care coordination
    - Diabetes
    - Mental Health

24

Making Your PMS Work for You

- PMS (Pharmacy Management System) Optimization
  - Alerts
    - Targeting specific patients
    - Counseling blocks at checkout window
  - Forms
  - Immunization registry integration
- Clinical Paperwork
  - Intake Form
  - Prescription Template
  - Provider Template



25

Vashon Pharmacy is excited to launch clinical services to help bridge the healthcare gap on Vashon.

Note: In complex or higher risk cases, patients may be referred to a primary care or urgent care for further evaluation. We will make every attempt to notify patients we know will be excluded from our treatment criteria prior to their appointment time. Filling out the following form as completely as possible will aid greatly in our preparation for your appointment.

Next

09/20/2024

September 2024

SUN MON TUE WED THU FRI SAT

Friday, September 20

2:30 PM 3:00 PM 3:30 PM 4:00 PM 4:30 PM

America/Los Angeles (09:27 AM)

Reason for this appointment? (*not covered by insurance, payment will be collected at time of appointment) *

- Point-of-Care Test (Covid, Flu, Strep)
- Medication Injection by Provider
- Blood Pressure Screening
- Acute Ailment (UTI, Yeast Infection, Burn, Bite or Sting)
- Birth Control Consultation
- Tobacco Cessation
- Other
- Vaccine Assessment
- Travel Vaccine Consult
- Nutrition Consult $50*
- Medication Therapy Review
- Lab Draw (available on Wednesdays only currently, please select Wednesday appt)
- Chronic Disease Consult (Diabetes, Cholesterol, Blood Pressure, Asthma)

Please select an option below

- I will enter my information through this web portal
- I will complete the patient intake form upon arrival for the appointment and understand I should arrive 15-20 minutes prior to the time selected above.

26

Pharmacy Workflow- Reimagined

- Drop-off
- Data Entry
- Dispensing
- Verification
- Check Out

27

Pharmacy Workflow- Reimagined

- ~~Drop-off~~ Check-in
- Data Entry

Chart Review & Med Sync

- Dispensing
- Verification
- Check Out

28

Pharmacy Workflow- Reimagined

~~Drop off~~ Check-in

Data Entry

Dispensing

Verification

Check Out

Chart Review & Med Sync

Clinical Review

29

Pharmacy Workflow- Reimagined

~~Drop off~~ Check-in

Data Entry

Dispensing

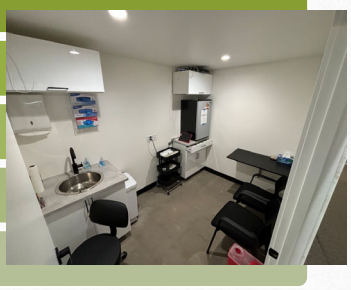
Verification

Intervention

Check Out

Chart Review & Med Sync

Clinical Review



30

Mindset Transformation

Pharmacy Team

Providers

Payors

Patients

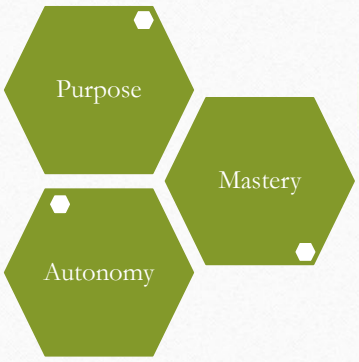
31



32

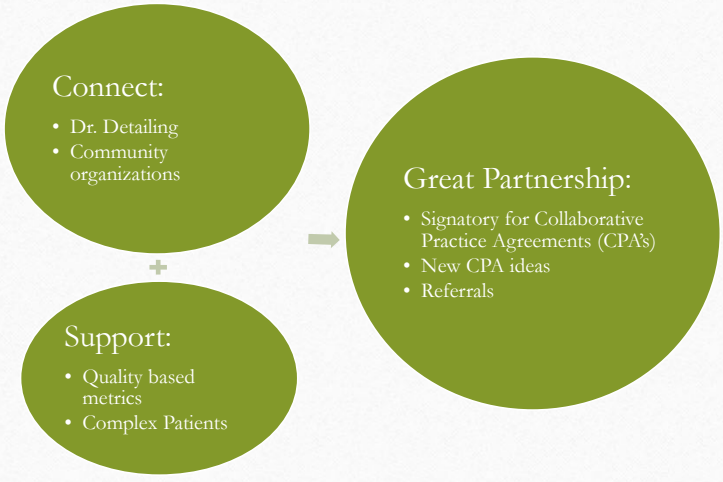
Pharmacy Team

- Consider Intrinsic Motivation
  - Dan Pink: The Puzzle of Motivation
  - Team Members want to matter
- Communication:
  - Huddles, Sunday Meeting, Bulletin board, Email/Text
  - Communicate the Vision, Progress and Successes
- Extrinsic Motivation:
  - Competition, performance incentive



33

Providers



34

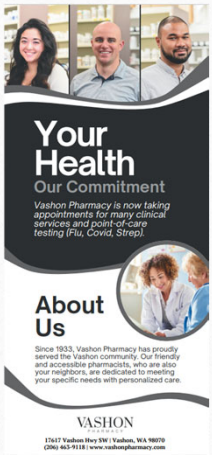


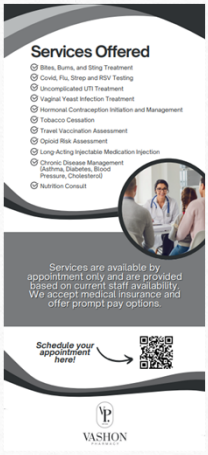
Payors

- Quality Measures
- Incentive Payments
- Grant Funding
- Patient referral streams

35

Patients





- Meet & Exceed their Expectations
  - Quality dispensing & Communication
  - Basic clinical programs
  - Urgent needs
  - Chronic disease interventions
- Market
  - Relationships & Word of Mouth
  - Social Media
  - Website
  - Community Events
- Clinical Destination Vs. Fast Food

36

Wrap-up

Workflow: Today vs the Future

Other Billable Clinical Services & Reimagined Workflow

Mindset Transformation

37

Pharmacist Self-Evaluation Question #1

Which components of a clinical service within a pharmacy can ancillary staff assist with?

a. Patient Identification
b. Documentation of Clinical Encounters
c. Payment Collection
d. A and C
e. All of the Above

38

Pharmacist Self-Evaluation Question #2

True or False: Pharmacies in Oregon are receiving reimbursement for office visit encounters related to vaccine indications and assessments.

a. True
b. False

39

Pharmacist Self-Evaluation Question #3

Which Stakeholder plays the most critical role in mindset transformation when pharmacies implement clinical programs?

a. Pharmacy Team
b. Providers
c. Payers
d. Patients
e. All of the Above

40

Technician Self-Evaluation Question #1

Which components of a clinical service within a pharmacy can ancillary staff assist with?

a. Patient Identification
b. Documentation of Clinical Encounters
c. Payment Collection
d. A and C
e. All of the Above

41

Technician Self-Evaluation Question #2

True or False: Pharmacies in Oregon are receiving reimbursement for office visit encounters related to vaccine indications and assessments.

a. True
b. False

42

Technician Self-Evaluation Question #3

Which Stakeholder plays the most critical role in mindset transformation when pharmacies implement clinical programs?

a. Pharmacy Team
b. Providers
c. Payers
d. Patients
e. All of the Above

43

Activity:

Spend a few minutes writing down 3 goals

Workflow and Ability to Support Clinical Programs

Additional or Expanded Program Opportunity in Your Community

Way to connect and build up your team

44

Contact Information



Tara Pfund, PharmD
Chief Strategy Officer
Cascadia Pharmacy Group
tara@cascadiapharmacygroup.com



Crystal Bryan, PharmD
Chief Clinical Officer
Cascadia Pharmacy Group
crystal@cascadiapharmacygroup.com

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Additional Resources

- **YouTube Video: *The Puzzle of Motivation* by Dan Pink.** In this TED Talk, Dan Pink discusses the surprising science behind motivation. He explains how traditional rewards, like bonuses and incentives, often fail to improve performance for tasks requiring creativity and critical thinking. Instead, he highlights the importance of intrinsic motivators like autonomy, mastery, and purpose as drivers of better performance and satisfaction. This talk is especially relevant for leaders and organizations seeking to foster innovation and engagement.
  - https://youtu.be/SILC8ZCsBGk?si=wf3sdcRDo9RGPqGe
- **Oregon Pharmacy Public Health & Pharmacy Formulary Advisory Committee (PHPFAC)** This resource outlines the role of the PHPFAC in Oregon, which develops and recommends protocols and formularies allowing pharmacists to prescribe specific drugs and devices. It includes laws, committee updates, and resources to guide pharmacists in providing enhanced patient care, such as for vaccines, COVID-19 testing, and other preventative measures.
  - https://www.oregon.gov/pharmacy/pages/pfac.aspx

46

Questions?

47

THE POWER OF OUR VOICE: ADVOCACY FOR THE MODERN ERA



AMANDA MEEKER, PHARMD

OSPA PRESIDENT

1

DISCLOSURE STATEMENT

I HAVE NO FINANCIAL INTERESTS WITH ANY COMPANIES TO DISCLOSE.

2

LEARNING OBJECTIVES

- Describe the key steps in legislative and regulatory decision making that affect pharmacy practice.
- Recall how to identify your state representatives, state senator, and mayor using the online tool
- Identify individual actions to engage in the legislative process

3

SELF-EVALUATION QUESTIONS

- What happens if the Governor does not sign a bill that has passed through both the House and Senate?
- What is the website where you can find contact information for your State Legislators and other elected officials?
- What are some individual actions you can take to personally engage in the legislative process?

4

WHY SHOULD YOU CARE ABOUT LOBBYING?

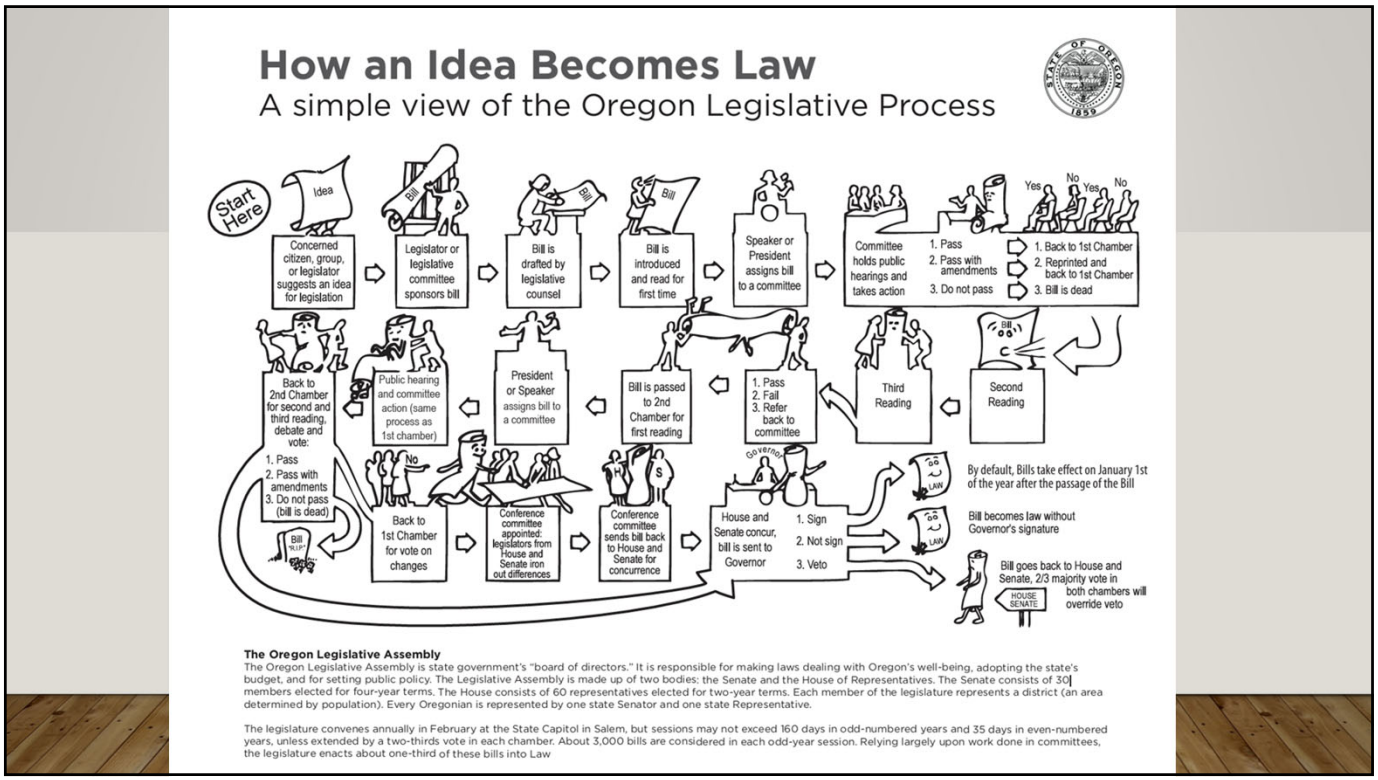
Because like it or not, the government is your business partner.

5

THE BRASS TACKS

- 90 Citizen Legislators Serve in Salem
  - 30 Senators & 60 Representatives
- Even-numbered Years bring the "Short Session"
  - Convening February 2024
- Odd-numbered Years bring the "Long Session"
  - Convening February 2025
- Deadlines ensure the process moves at a steady pace
  - Bill Introduction, Committee Vote, Chamber of Origin

6



7

LET'S REVISIT….

- #1: Presiding Officer Assigns the bill to Policy Committee
- #2: Committee Chair Schedules a Public Hearing
- #3: Committee Chair Schedules a Vote ("work session")
- #4: Bill is voted on by Originating Chamber - meets fate
- #5: Presiding Officer Assigns the bill to Policy Committee
- #6: Committee Chair Schedules a Public Hearing
- #7: Committee Chair Schedules a Vote ("work session")
- #8: Bill is voted on by Originating Chamber - meets fate
- #9: Governor does NOT actively veto the bill
- #10: Law goes into effect and lives are made better

8

AND THAT'S PRECISELY WHY….

……ADVOCACY MATTERS!!!

9

LOBBYING

Lobbying is the practice of influencing decisions made by the government.

Everybody Lobbies
Everybody Gets Lobbied

… OSPA Advocacy Emerges

10

ADVOCATES FILL THE ROLE OF PROVIDING INFORMATION AND INSIGHT INTO ISSUES.

The practice of lobbying in order to influence political decisions is a **legitimate and necessary** part of the democratic process.

Individuals and organizations reasonably want to influence **decisions that may affect them**, those around them and their environment.

Government in turn needs access to **the expertise and perspectives** that advocates bring to the table.

11

HALLMARKS OF SUCCESSFUL ADVOCATES:

- Integrity - Steadfast adherence to a strict ethical code
- Accuracy - Conformity to fact, precise, exact
- Straight-talk - Direct, not deceptive, candid
- Nonpartisanship - Be.A. Pharm-o-crat or -can.

12

DO NOT LET POLITICS DETER YOU FROM CONTACTING A LEGISLATOR ON POLICY:

In politics, today's opponent may be tomorrow's ally… even if you do not agree 90% of the time.

OUR best allies - Democrat or Republican, Urban or Rural - are always going to be YOUR Legislators.

13

"ALL POLITICS IS LOCAL:"

- Legislators do want to hear from their constituents.
- They want to know how pending legislation will affect the people they represent.
- This is true even if their philosophy is entirely different from yours.

14

WHO REPRESENTS YOU IN SALEM?

Oregon Legislature: *www.oregonlegislature.gov*

- Find out who represents you & how to reach them, sign up for their newsletters and "office hours"
- Search laws and proposed laws, and relevant documents like analysis or testimony, online
- Watch committee hearings and floor debates from the archives or live, streaming in real time

15

2025 LEGISLATIVE SESSION AT A GLANCE

- OSPA prepared to lean into priorities that make life easier for pharmacists in addition to PBMs.
- OSPA actively engaged on legislative proposals & played defense with other groups' ideas.
- OSPA continued to participate in rule-making and advisory capacities for agency implementation.

16

PBM LEGISLATION

2025 saw a new bill sponsor - Rep. Rob Nosse

Summer work group to come to consensus (spoiler, no consensus met)

OSPA presented the problem and the solution, more PBM regulation

Not surprisingly, insurers/PBMs disagree that this is a legislative solution

17

PBM LEGISLATION - HB 3212

Payment stabilization

Spread pricing ban

Any willing pharmacy

Allow pharmacies to decline to fill at loss

Ban steering and paying PBM owned pharmacies more

Ban bad contract practices

18

2025 PBM REFORM DYNAMICS

Legislators wanted there to less controversy

Small workgroup during session

Insurers offered an "enhanced MAC" of $0.50 for CAP pharmacies

Relationship breakdown with bill champion

Dash 6 amendment offered for only policy reform

Speaker of the House blocked progress

19

CAT TAX REFORM (CORPORATE ACTIVITIES TAX)

Sadly, also a loss

Will work to see if this is something that we can pass in 2026, even though it is a short session

- This may be hard given financial picture

20

BETTER NEWS! 2025 LEGISLATIVE WINS

2024 HB 4002 fix: SB 236

Technical fixes that remove opposition from OBOP to HB 4002 proposals of pharmacists being able to prescribe buprenorphine and barriers to using prescription lockers

Prescription lockers may now be used freely without overly burdensome rules

Codefies CDTM into statute

Pharmacists can now obtain DEA number as a mid-level practitioner

21

SB 285

Removes sunset on test and treat for COVID 19 only

Were hoping for more comprehensive test and treat bill

Dynamics came in to play; if you want test and treat legislation to pass, lobby your legislators!!!

22

HB 2385

Prohibits drug manufacturers from interfering directly or indirectly with a pharmacy or drug outlet acquiring 340B drugs, delivering 340B drugs to certain health care providers or dispensing 340B drugs.

PhRMA has already sued to block implementation, effectively stalling this bill

23

HB 2942

HB 2942 limits what pharmacists must be reimbursed similarly to other healthcare providers to PrEP/PEP drugs

Not meant to be limiting, but sometimes limited ideas unintentionally limit

Should stop thinking about piecemealing reimbursement and just get reimbursed as healthcare providers for everything within our scope

24

HB 3226

HB 3226 was an attempt to regulate PSAOs

PSAOs wanted to be exempt from regulation

The way the language is written instead exempts PSAOs from registering as a PBM

Legislative intent matters, but so do the words on the page if you are relying on an agency to enforce the law

25

2026 AND BEYOND

OSPA needs to know what it's members need so we can best advocate for you

Watch out for opportunities for vehicles to put your solutions in

Get to know your legislators

26

DON'T FORGET ABOUT AFTER THE LEGISLATIVE SESSION

One of the most important advocacy tools we have happen after legislative session

Rulemaking participation is vital!

The Oregon Board of Pharmacy rules are incredibly broad and as a profession we need to pay more attention to what rules are being passed before they are final

Please submit PBM complaints to PBM.complaint@oregon.gov

27

QUESTIONS?

28

Test questions:

- What happens if the Governor does not sign a bill that has passed through both the House and Senate?
  - ***It becomes a law without the Governor's signature**
  - It is sent back to the House and Senate to be voted on
  - It is dead
- What is the website where you can find contact information for your State Legislators and other elected officials?
  - www.oregon.com
  - ***www.oregonlegislature.gov**
  - www.legislation.net
  - www.amazon.com
- What are some individual actions you can take to personally engage in the legislative process?
  - Direct contact via email
  - Direct contact via phone call
  - Invitation for a pharmacy tour
  - Attending in-district meetings
  - ***All the above**

29

FIREARMS & SUICIDE





1

DISCLAIMER

We have no financial conflicts of interest to disclose. This presentation is for educational purposes only and does not replace clinical judgment or individualized care. The views expressed are those of the presenters and do not necessarily reflect the policies or positions of Clackamas County.

2

Learning Objectives

- Summarize the relationship between firearm access and suicide risk, with attention to Oregon-specific data and Veteran populations.
- Identify and list observable suicide warning signs and relevant risk factors during patient interactions.
- Articulate how temporary secure storage of firearms contributes to suicide prevention by increasing time and distance during a crisis.
- Demonstrate effective strategies to initiate a respectful, compassionate conversation with a patient or family member about firearm safety and suicide risk.
- Locate and recommend appropriate local and national suicide prevention resources for patients and families.

3

WHY ARE WE HERE? RESEARCH TELLS US….

Community pharmacists, as accessible health care providers, can play a key role in prevention but face challenges like limited training and societal stigma.

Binsaleh, S. A. R. S. (2025). Roles and perceptions of community pharmacists in suicide prevention in Jordan: A cross-sectional study. *Journal of the American Pharmacists Association, 65*(4), 102388. https://doi.org/10.1016/j.japh.2025.102388

4

TRAINING MAKES THE DIFFERENCE

Our findings showed that the majority of pharmacists are not yet prepared to be involved in suicide prevention due to personal barriers such as a lack of confidence and knowledge or system-related barriers.

However, factors that facilitated pharmacists' participation in suicide prevention included the accessible environment and gatekeeper role. **Training improved pharmacists' attitudes and had a positive influence on pharmacists' experiences.**

Kamal, L., & Jacob, S. A. (2023). Pharmacists' experiences, perceptions, and attitudes towards suicide and suicide prevention: A scoping review. *Pharmacy, 11*(1), 25. https://doi.org/10.3390/pharmacy11010025

5

CONTENT WARNING

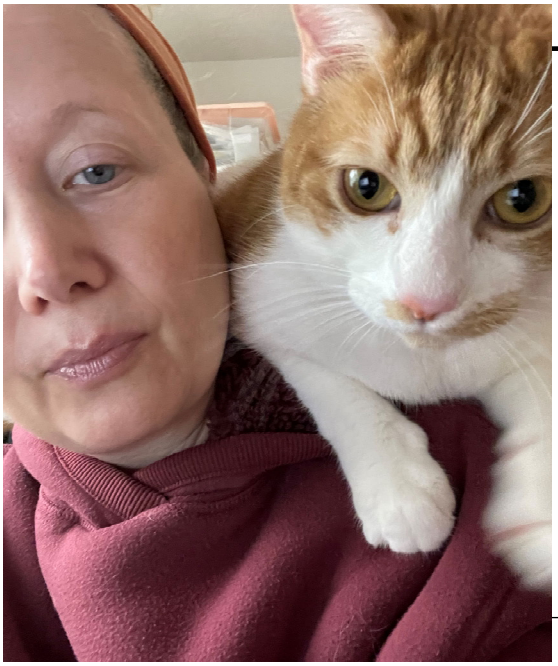
Discussing suicide can be emotionally activating. If this presentation brings up difficult emotions, please reach out for support: **988** answers calls 24/7.

Veterans 988 - Press 1

Spanish 988 - Press 2



6



Donna-Marie Drucker, MA, APC. Mental Health Promotion & Prevention Coordinator, Clackamas County

- 988, VCL, Military Help Line
- Victim Advocate (SARC, CCVA)
- Wife of a Combat Veteran
- Oregon Firearm Safety Coalition/Together with Veterans NW Oregon
- Mental Healthcare Professional
- Gun Owner
- Survivor of youth suicide attempt

7



Galli Murray, LCSW

Suicide Prevention Coordinator, Clackamas County

Galli Murray is a Licensed Clinical Social Worker who specializes in crisis trauma and suicide prevention. In her current position as Clackamas County's Suicide Prevention Coordinator, she works within the county health and various other systems in order to reach Clackamas County's goal of zero suicide. Prior to serving in this position, Murray led a team of clinicians and case managers working towards addressing the critical mental health needs of Clackamas County residents. She earned her Master of Social Work degree at Portland State University, spent ten years as an outpatient and psychiatric residential treatment services child and family therapist and has worked for Clackamas County for the better part of 20 years since completing her degree. Murray is honored at the opportunity to continue to serve Clackamas County and specifically to lead the County in reaching the goal of zero suicide.

8

To All Those That Have Lost Someone to Suicide

9

ACCESS TO FIREARMS, PARTICULARLY HANDGUNS, IS A MAJOR RISK FACTOR FOR SUICIDE

Male handgun owners were **eight times** more likely to die via their handguns than non-gun owners

Female handgun owners were **35 times** more likely to die via their handguns than other women who didn't own guns.

Duff-Brown, B. (2020, June 3). Handgun ownership associated with much higher suicide risk. *Stanford Medicine News Center.* https://med.stanford.edu/news/all-news/2020/06/handgun-ownership-associated-with-much-higher-suicide-risk.html

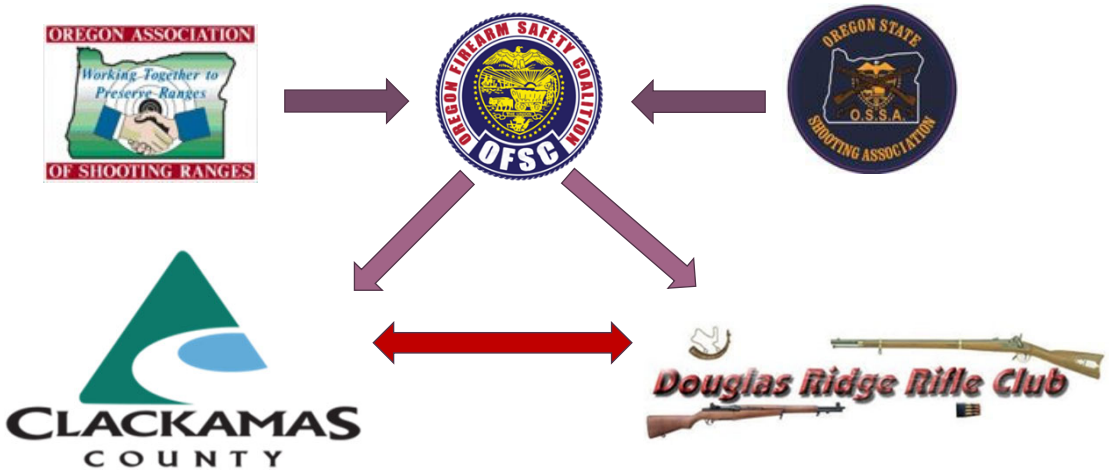
10

CLACKAMAS COUNTY

Clackamas County formed a partnership with the Oregon Firearm Safety Coalition, and through this partnership has built trust within the firearm community, provided trainings on suicide prevention and secure firearm storage, collaborated with firearm owners to develop messaging around secure storage, and provided free firearm secure storage devic

11

BRINGING THE COMMUNITY TOGETHER



12

CHANGING THE NARRATIVE

CLACKAMAS COUNTY

Douglas Ridge Rifle Club

Firearm owners are no longer seen as the problem but part of the solution when it comes to lethal means safety

MORE ENGAGEMENT BY FIREARM OWNERS

13

CLACKAMAS COUNTY

Douglas Ridge Rifle Club

OFSC

Oregon Alliance to Prevent Suicide
Hope • Help • Healing

CLACKAMAS COUNTY SHERIFF

Partnerships and Ongoing Work

- Suicide prevention training for New Member Orientation a Douglas Ridge Rifle Club.
- Developed trusted messaging to assist in distribution of secure storage devices.
- Provided firearm and suicide prevention training to gun owners and Veterans throughout the County.
- Partnered with Sheriffs Dept to produce firearm secure storage video – to both educate on Oregon secure storage law and safe handling of a firearm are when using secure storage devices.
- Secured funding to develop 'Welcome Boxes' to be given to gun owners to provide secure storage devices, injury reducing devices (ear and eye protection), connection to firearm safety training, community resources, and suicide prevention training.
- Developing of Firearm Culture training for providers – working directly with gun owners to develop training.

14

What Has Been Achieved

Through these partnerships over 2000 firearm owners have been trained in suicide prevention.

Approximately 4000 no-cost secure firearm storage devices have been distributed to community members

The voices and involvement of firearm owners are now seen as an essential core element of preventing firearm suicide.

15

THIS IS NOT ABOUT GUN CONTROL

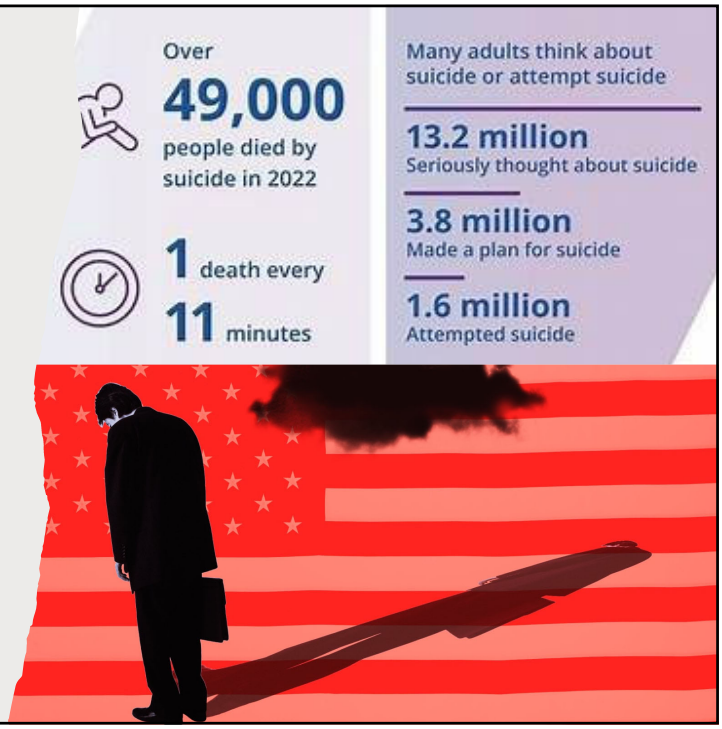
This is for Oregon firearm owners to work together as a community to lead the way in preventing firearm related suicide.



16

11 Minutes?

4383?



17

Summarize the relationship between firearm access and suicide risk, with attention to Oregon-specific data and Veteran populations.

Question: Which of the following statements is most accurate about the relationship between firearm access and suicide in Oregon?

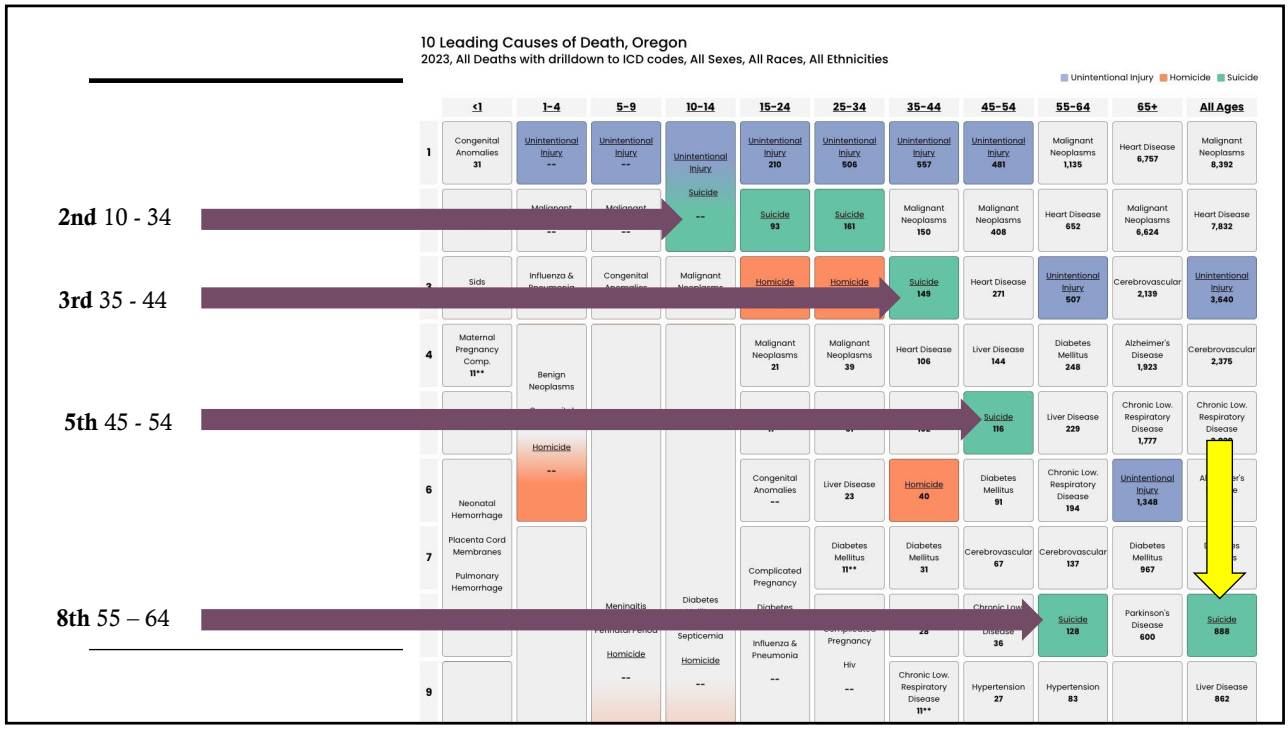
A. Most firearm deaths in Oregon are the result of homicides.

B. Only about 10% of suicides in Oregon involve a firearm.

C. Suicide accounts for the majority of firearm deaths in Oregon.

D. Firearm suicide risk is higher among civilians than among Veterans

18



19

Veteran Suicide

The suicide rate in 2022 among female Veterans was 92.4% higher than for female non-Veteran U.S. adults, and the for male Veterans it was 44.3% higher than for male non-Veteran U.S. adults.

Among female and male U.S. adults, rates of firearm and of poisoning suicide mortality were greater for Veterans than for non-Veterans, and differentials in rates by Veteran status were particularly high among female adults (e.g., the firearm suicide rate among female Veterans was 144.4% higher than for female non-Veteran adults, while the firearm suicide rate among male Veterans was 69.6% higher than for male non-Veteran adults).



U.S. Department of Veterans Affairs, Office of Suicide Prevention. (2024, December). ***2024 National Veteran Suicide Prevention Annual Report: Part 2 of 2 – Report findings*** **[PDF].** Retrieved from https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf

20

Oregon, Western Region, and National Veteran Suicide Deaths and Rates by Age Group, 2022[c]

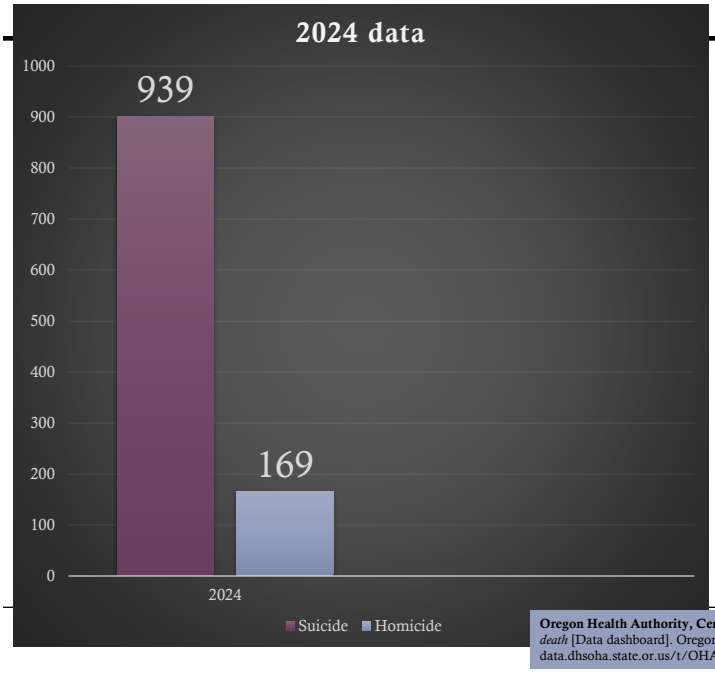
Age Group	Oregon Veteran Suicides	Western Region Veteran Suicides	National Veteran Suicides	Oregon Veteran Suicide Rate per 100,000	Western Region Veteran Suicide Rate per 100,000	National Veteran Suicide Rate per 100,000
18–34	15	192	849	68.2*	45.2	47.6
35–54	31	420	1,670	49.2	39.4	35.5
55–74	47	604	2,263	42.7	38.6	31.2
75+	47	448	1,597	61.8	41.6	33.8
All	140	1,669	6,407	51.7	40.4	34.7

Oregon Veteran and Total Oregon, Western Region, and National Suicide Deaths and Rates by Age Group, 2022[c]

Age Group	Oregon Veteran Suicides	Oregon Total Suicides	Western Region Total Suicides	National Total Suicides	Oregon Veteran Suicide Rate per 100,000	Oregon Suicide Rate per 100,000	Western Region Suicide Rate per 100,000	National Suicide Rate per 100,000
18–34	15	242	3,486	13,623	68.2*	25.1	18.5	17.7
35–54	31	263	3,967	15,966	49.2	23.7	19.5	19.0
55–74	47	236	3,381	13,260	42.7	23.6	19.9	17.5
75+	47	119	1,400	5,042	61.8	36.1	26.1	21.0
All	140	860	12,234	47,891	51.7	25.3	19.9	18.4

U.S. Department of Veterans Affairs. (2022). *2022 state data sheets: Oregon [PDF].* Veterans Health Administration, Office of Mental Health and Suicide Prevention. https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022_State_Data_Sheets_Oregon_508.pdf

21



What do we hear about In the media?

Oregon Health Authority, Center for Health Statistics. (n.d.). *Year-to-date preliminary death data: Manner of death* [Data dashboard]. Oregon Health Authority. Retrieved [Sept 1 2025], from https://visual-data.dhsoha.state.or.us/t/OHA/views/Year-to-datepreliminarydeathwebtables/Manner?

22

IT'S OK TO TALK ABOUT FIREARMS



23

Why do we need to normalize talking about firearms?

1999 – 2025: 508,423,061

US Population (2024): 340 Million

168,423,067

Federal Bureau of Investigation. (n.d.). *NICS firearm checks: Month/Year by state* [Data set]. U.S. Department of Justice. Retrieved [Month Day, Year], from https://www.fbi.gov/file-repository/nics_firearm_checks_-_month_year_by_state.pdf

24

Who Owns Firearms in Oregon?

At least 50-60% of ALL homes have firearms



CBS News. (2015, October 6). *Gun ownership rates by state.* CBS Interactive. https://www.cbsnews.com/pictures/gun-ownership-rates-by-state/

RAND Corporation. (2018). *Household firearm ownership rates in 2016: RAND estimates.* RAND Corporation. https://www.rand.org/research/gun-policy/gun-ownership.html

25

Means Matter

55

Harvard T.H. Chan School of Public Health. (n.d.). *Means Matter.* Harvard T.H. Chan School of Public Health.

26



Harvard T.H. Chan School of Public Health. (n.d.). *Means Matter.* Harvard T.H. Chan School of Public Health. Retrieved [Sept 1, 2023], from https://hsph.harvard.edu/research/means-matter/

90 – 95%

27

VETERAN SUICIDE

- **75%** of Veterans use a firearm as a means for suicide.



U.S. Department of Veterans Affairs. (2022). *2022 state data sheets: Oregon [PDF].* Veterans Health Administration, Office of Mental Health and Suicide Prevention. https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022_State_Data_Sheets_Oregon_508.pdf

28

Summarize the relationship between firearm access and suicide risk, with attention to Oregon-specific data and Veteran populations.

Question: Which of the following statements is most accurate about the relationship between firearm access and suicide in Oregon?

A. Most firearm deaths in Oregon are the result of homicides (!)

B. Only about 10% of suicides in Oregon involve a firearm (!)

C. Suicide accounts for the majority of firearm deaths in Oregon (*)

D. Firearm suicide risk is higher among civilians than among Veterans (!)

29

Articulate how temporary secure storage of firearms contributes to suicide prevention by increasing time and distance during a crisis.

Question: Why is temporary secure firearm storage an important strategy in suicide prevention?

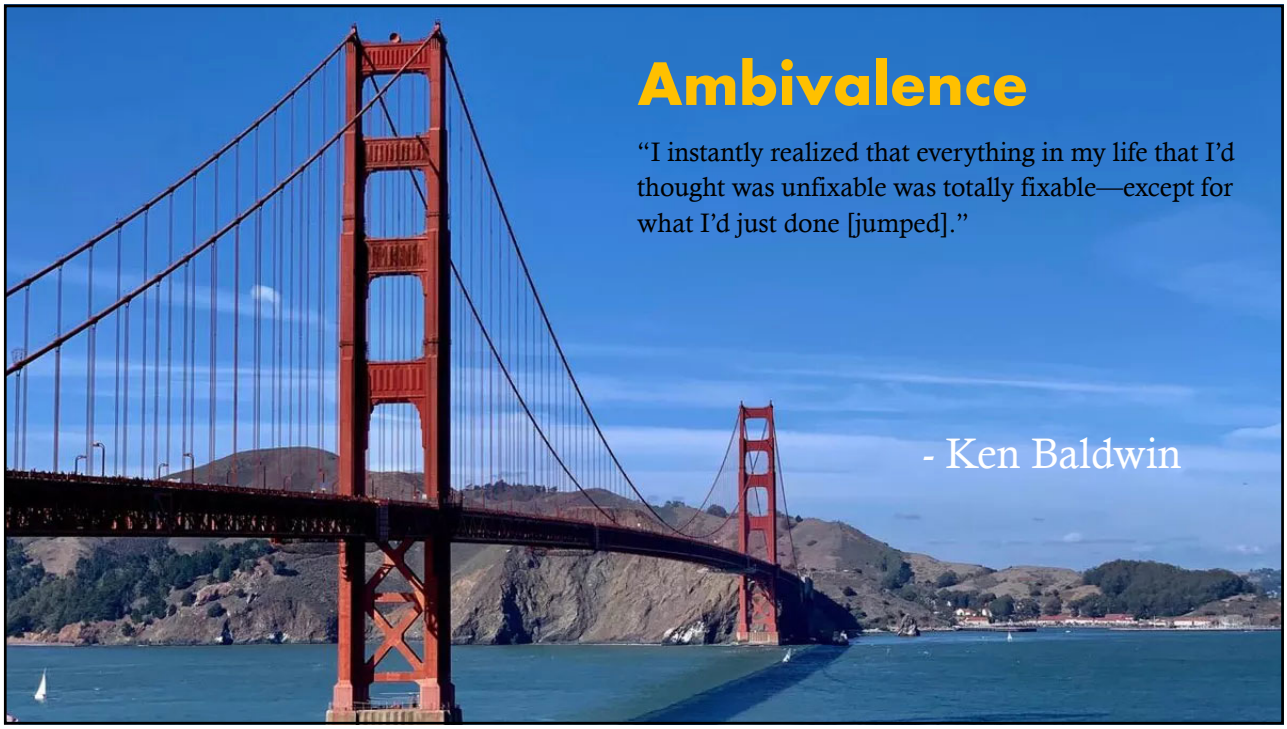
A. It discourages people from owning firearms

B. It prevents access to a lethal means during a time of crisis

C. It allows law enforcement to confiscate firearms

D. It permanently removes firearms from the home

30


Ambivalence
"I instantly realized that everything in my life that I'd thought was unfixable was totally fixable—except for what I'd just done [jumped]."
- Ken Baldwin

31


Time and Distance Saves Lives

32

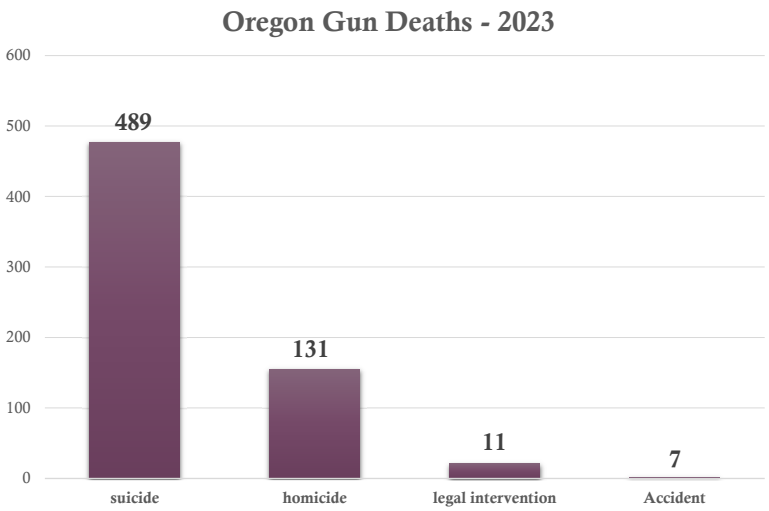
Why Do Second Chances Matter?

70% **90%**

33

FIREARMS FOR SELF DEFENSE/PROTECT FAMILY FROM A THREAT?

34



80% of Gun Deaths Are Suicide

Oregon Health Authority, Center for Health Statistics. (n.d.). *Oregon deaths from external injuries: Demographics dashboard* [Injury Death Rates]. Oregon Health Authority. Retrieved *[Sept 1 2025]*, from https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregondeathsfromexternalinjuries/DemogDash?%3Aembed=y&%3AisGuestRedirectFromVizportal=y

35

🔐 How to Talk to Someone About Firearms When They May Be at Risk for Suicide

When someone is at risk for suicide, putting time and space between them and a firearm can save their life. You don't have to convince them to give up their rights — just offer support during a difficult time.

36

Start with Care and Respect

Use a calm, nonjudgmental tone. Lead with concern for their safety, not control.

"I care about you, and I want to make sure you stay safe while you're going through this."

"A lot of people who are struggling find it helpful to make their environment safer, just for now."

37

Make It About Temporary Safety

Emphasize that this is about reducing immediate risk — not forever, not about taking away their firearms.

"What would it look like to lock up your firearms or store them offsite for a little while, just until things settle down?"

"Would you consider asking a friend or family member to hold onto them temporarily?"

38

🧰 Offer Options — Not Ultimatums

Be collaborative. Ask what feels possible, not what they "should" do.	Locked storage (gun safes, cable locks)	Disabling the firearm (remove non-regulated parts)
Storing with a trusted friend, family member, or FFL (if state law allows)	Asking a veteran service org, gun club, or law enforcement agency if they offer storage	*"There are ways to do this that still respect your rights and dignity — it's just about staying safe right now."*

39

YOUR ROLE

Pharmacists and Pharmacy Technicians are perfectly positioned to hand out cable locks, firearm safety information, and other county resources such as mental health support and where to obtain other secure storage devices for firearms and medications – you can help normalize these conversations in a supportive nonjudgmental manner.

40

TEMPORARILY REMOVING FIREARMS FROM THE HOME

Trust a Buddy:

In a crisis have a trusted friend temporarily hold your firearms.



ORS 166.435 Firearm transfer by unlicensed persons – Section F – For the purpose of preventing imminent death or serious injury, and the provision lasts only as is necessary to prevent death or serious physical injury (Oregonlaws.org 2020).

Oregon law permits a friend member to hold firearms while needed, requiring firearms to be returned once safe.

41

Temporary Transfers for Suicide Prevention are Legal in Washington State

Have a trusted individual or other organization hold firearms until the crisis resolves. Temporary transfers to prevent suicide are legal in Washington without a background check (see RCW 9.41.113(4)(a) and (4)(d) for clarification).

RCW 9.41.113: Firearm sales or transfers—Background checks—Requirements—Exceptions

(4) This section does not apply to:

(a) A transfer between immediate family members, which for this subsection shall be limited to spouses, domestic partners, parents, parents-in-law, children, siblings, siblings-in-law, grandparents, grandchildren, nieces, nephews, first cousins, aunts, and uncles, that is a bona fide gift or loan;

(d) A temporary transfer of possession of a firearm if: (i) The transfer is intended to prevent suicide or self-inflicted great bodily harm; (ii) the transfer lasts only as long as reasonably necessary to prevent death or great bodily harm; and (iii) the firearm is not utilized by the transferee for any purpose for the duration of the temporary transfer;

42

Articulate how temporary secure storage of firearms contributes to suicide prevention by increasing time and distance during a crisis.

Question: Why is temporary secure firearm storage an important strategy in suicide prevention?

A. It discourages people from owning firearms (!)

B. It prevents access to a lethal means during a time of crisis (*)

C. It allows law enforcement to confiscate firearms (!)

D. It permanently removes firearms from the home (!)

43

Identify and list observable suicide warning signs and relevant risk factors during patient interactions.

Question: Which of the following is **NOT** typically considered a warning sign of suicide?

A. Giving away prized possessions

B. Talking about not wanting to be alive

C. Talking about feeling like a burden

D. Asking for a refill on a prescription

44

Myths, Clues, and Tips

45

Myth: Talking about suicide will give someone the idea.
Fact: Talking openly about suicide does not plant the idea in someone's mind. In fact, discussing it can provide an opportunity for those struggling to express their feelings and seek help.

Myth: People who talk about suicide are just seeking attention.
Fact: Any talk of suicide should be taken seriously. It's often a plea for help and addressing it promptly can prevent a tragedy.

Myth: Suicide happens without warning.
Fact: Most people who die by suicide show warning signs, such as talking about wanting to die, withdrawing from others, or exhibiting extreme mood swings.

Myth: Once someone decides to die by suicide, nothing can stop them.
Fact: Suicidal thoughts can be temporary. Intervening with support and appropriate care can save lives.

Myth: People who attempt suicide are determined to die.
Fact: Many individuals who attempt suicide are ambivalent about death and are seeking relief from intense pain. Intervention can help them find other ways to cope.

Myth: Suicide only affects people with mental health disorders.
Fact: While mental health issues can increase the risk, suicide can affect anyone, regardless of their mental health status. Stressful life events, trauma, and other factors also play a role.

46

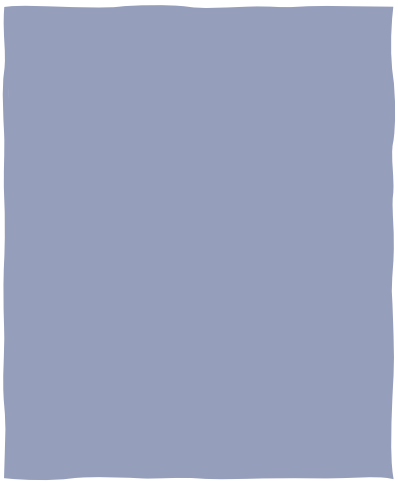
ONLY EXPERTS CAN PREVENT SUICIDE.

FACT 3

Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide.

47

Warning Signs of Suicide Risk



48

SUICIDE DOES NOT HAVE A SINGLE CAUSE; CLUES TO LOOK OUT FOR

Changing behavior, such as:

- Withdrawing from friends
- Calling or visiting to say goodbye or giving away important possessions
- Avoiding activities and people they normally enjoy
- Eating or sleeping too much or too little
- Using drugs or alcohol more often

Stressful Life situations:

- Relationship break-up or divorce
- Loss of a job
- Death of a loved one or a pet
- Transitioning from the military
- Housing instability
- Political stressors

49

Feelings of:

- **Hopelessness**
- Empty, hopeless, trapped,
- Extremely sad, more anxious, agitated.
- Unbearable emotional or physical pain
- Depressed
- Angry
- Suddenly and unexpectedly happy

Talking about:

- Wanting to die
- Guilt or shame – Moral Injury
- Being **a <u>burden</u>** to others
- Having no reason to live
- Others will be better off without them

Having a history of:

- Previous suicide attempts
- Mental health concerns
- Substance use problems
- A family history of suicide

50

Identify and list observable suicide warning signs and relevant risk factors during patient interactions.

Question: Which of the following is **NOT** typically considered a warning sign of suicide?

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B. Talking about not wanting to be alive (!)

C. Talking about feeling like a burden (!)

D. Asking for a refill on a prescription (*)

51

Demonstrate effective strategies to initiate a respectful, compassionate conversation with a patient or family member about firearm safety and suicide risk.

You're a pharmacy technician filling a prescription for a middle-aged man. He appears agitated and distracted. While talking, he mentions recent job loss and says, "I've just been feeling like everyone would be better off without me." He also tells you he has a gun at home for protection.

What is the are the appropriate responses?

A. "I'm not sure what to say, but it's probably best to focus on getting your medication."

B. "It sounds like you're going through a lot. Are you thinking about suicide?"

C. "Why would you say something like that?"

D. "Can I offer you some resources?" (988 - gun lock)

52

Tips for Asking About Suicide:

53

Create a Safe, Nonjudgmental Space

- Be calm, direct, and grounded.
- Maintain a supportive tone and open body language.
- If possible, choose a private setting with minimal distractions.

"I want to check in with you. I care about how you're doing, and it's okay to talk honestly with me."

54

Ask Directly and Clearly
Asking about suicide will not plant the idea. It shows you're open to hearing the truth. Use plain, caring language:

"Sometimes people going through what you are feel overwhelmed or hopeless. Have you had any thoughts of wanting to die or not be here anymore?"
"Have you been thinking about suicide?"

55

If the answer is "yes – I am having thoughts of suicide".

Don't panic – you've got this

- Connect them to support resources – Oregon has both national and local crisis lines available that answer calls 24/7, walk in clinics, emergency rooms, therapists, medical professional.
- **Offer to help LOCK, LIMIT, or help temporarily REMOVE firearms (or medications or car keys) by providing secure storage items/secure storage resources.**
- Ask how you can hep them stay safe for now – you can call 988 together and collaborate with the crisis counselor to develop a safety plan.
- With consent, connect them to someone they trust – family member, therapist, friend.
- If you feel a person is in immediate danger, please call 911.

56



How not to ask the suicide question:

- × "You're not thinking of killing yourself, are you?"
- × "You wouldn't do anything stupid would you?"
- × "Suicide is a dumb idea. Surely you are not thinking about suicide?"

57

It's okay, take a Deep breath And let them Know you care

I'm sorry, that didn't quite come out right.

I want you know that I care,, so let me try asking that question again.

I can tell you are having a hard time, and sometimes when folks are experiencing what you going through, they can have thoughts of suicide.

Are you having thoughts of suicide?

58

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What is the are the appropriate responses? (!)

A. "I'm not sure what to say, but it's probably best to focus on getting your medication." (!)

B. "It sounds like you're going through a lot. Are you thinking about suicide?" (!)

C. "Why would you say something like that?" (!)

D. "Can I offer you some resources?" (988 - gun lock) (*)

59

Locate and recommend appropriate local and national suicide prevention resources for patients and families.

A customer confides that their teenage child has been struggling with depression and has access to firearms at home. Which of the following would be an appropriate next step?

A. Tell them it's probably just a phase.

B. Recommend they contact 988 and consider securing or temporarily removing firearms.

C. Suggest they return tomorrow to speak with a pharmacist.

D. Encourage them not to overreact, since their child hasn't made a suicide attempt.

60

IMPORTANT:
If you cannot ask the question, find someone who can.

61

Call 988



Call a county crisis line



Go to a walk-in clinic

62

Refer to Support

- County Suicide Prevention Website
- 988
- Friend or family member – with permission
- Local ER
- Local Walk in Clinic
- Appointment with a therapist
- If needed 911
- County Crisis Team
- County Crisis Line

63

Locate and recommend appropriate local and national suicide prevention resources for patients and families.

A customer confides that their teenage child has been struggling with depression and has access to firearms at home. Which of the following would be an appropriate next step?

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B. Recommend they contact 988 and consider securing or temporarily removing firearms.(*)

C. Suggest they return tomorrow to speak with a pharmacist. (!)

D. Encourage them not to overreact, since their child hasn't made a suicide attempt. (!)

64

Tips to Encourage Someone to Stay Alive

When someone is in pain, your steady presence and belief in their worth can be life-saving. You don't need to have all the answers — you just need to show up, listen, and connect.

65

Stay Present and Calm

- Speak slowly and clearly.
- Let the person talk — don't rush to fix it.
- *"I'm really glad you told me. I'm here with you, and I'm not going anywhere right now."*

66

We want to help so we try to fix problems but…..

Listen

Validate

Validate

Validate

67



68

Acknowledge the Pain, Don't Minimize It

Avoid trying to "cheer them up" or give advice too quickly. Instead, show empathy and validation.

"It sounds like things have been unbelievably heavy lately. I can understand why it feels like too much."

69

Remind Them That This Moment Can Pass

Help them understand that how they feel now doesn't mean it will always be this way.

"I know things feel impossible right now. But you don't have to go through this alone. There is help, and things can change."

70

Gently Explore What's Keeping Them Here

Even in despair, most people have something — or someone — that matters.

"Can you tell me about a time when you got through something really hard?"

"What's something that's helped even just a little before?"

71

OFFER REASONS TO STAY AND SUPPORT TO GET THERE

People often just need help getting through the next hour or day. Offer hope in small steps:

"You don't have to do this alone. I can help get you connected to someone who knows how to help."

72

Be Clear: Their Life Matters

Say it plainly and sincerely:

"I care about you. Your life matters. I want you to stay."

73

TO RECAP AS WE WRAP UP

- Firearm ownership is normal – we can talk about firearms
- Question – something doesn't feel right
- Question – are you thinking about suicide
- Persuade – I want to help get you help
- Refer – Let's get you some help……

74



75

Continue your Training Journey

Donna-Marie Drucker
917 960 4089
donnamarie.ofsc@gmail.com
ddrucker@Clackamas.us

Galli Murray
971 201 8468
GalliMur@Clackamas.us

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Looking Out for Drug-Induced Disease in Older Adults

Danielle Backus, PharmD, BCGP
Associate Professor of Pharmacy Practice

Pacific University Oregon

1

Bio and Disclosures

- Pacific University Teaching
  - Geriatric pharmacotherapy
  - Group-based learning
  - Interprofessional education
- Providence ElderPlace
  - Program of All-Inclusive Care for the Elderly
- No conflicts of interest to disclose

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Learning Objectives

1. Identify common drug-disease interactions as indicated in the Beers Criteria
2. Relate patient-reported symptoms to potential drug-induced disease and drug-drug interactions
3. Provide a patient-centered plan to address a drug-induced disease or drug-disease interaction

Resources:

1. 2023 Beers Criteria
2. Drug-Induced Diseases, ASHP Publications textbook

Pre-Test Questions

Case #1

78 y/o feels weak and dizzy lately

- Meds: lisinopril, rosuvastatin, donepezil, metoprolol tartrate, apixaban, metformin, pioglitazone
- Med Hx: AD (mild), HTN, HLD, Afib, DM2

What drug-disease interaction might this patient be experiencing, per the 2023 Beers Criteria?

a) Delirium – rosuvastatin
b) Syncope – donepezil
c) Heart failure – pioglitazone
d) Falls or fractures – apixaban

Learning objective:

1. Identify common drug-disease interactions as indicated in the Beers Criteria

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Case #2

68 y/o female regular customer is purchasing incontinence products while picking up her Rxs

- You ask if she found the products she needed, as you don't recall her ever purchasing those before
- She is also drinking a large soda, and mentions that she just can't seem to quench her thirst lately
- Meds: naproxen, vitamin C, lithium, calcium carbonate, quetiapine, allopurinol
- Med Hx: bipolar disorder type 2, gout

What drug-induced injury is she most likely experiencing?

a) Nephrolithiasis – calcium carbonate
b) Nephrolithiasis - allopurinol
c) Pre-renal injury – naproxen
d) Diabetes insipidus – lithium

Learning Objective:

2. Relate patient-reported symptoms to potential drug-induced disease and drug-drug interactions

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Case #3

Situation:

- Patient's adult child arrives to pick up mom's new Rx for tolterodine ER taken qHS for nocturia

Background:

- Patient is an 86 y/o female, lives with adult children
- Uses walker outside the home, cane inside the home
- Also fills metoprolol succinate qDay, atorvastatin qDay, furosemide BID, losartan qDay
- Med Hx: Heart failure (well-controlled), mild cognitive impairment

What is your assessment of this situation?
What is your plan?

Learning Objective
3. Provide a patient-centered plan to address a drug-induced disease or drug-disease interaction

7

2023 Beers Criteria
Table 3: PIMs that exacerbate disease

PIMs – Potentially Inappropriate Medications

- Heart Failure
- Syncope
- Delirium
- Dementia or Cognitive Impairment
- Hx of Falls or Fractures
- Parkinson's Disease
- Hx of Gastric or Duodenal Ulcers
- Urinary Incontinence
- Lower Urinary Tract Symptoms, Benign Prostatic Hyperplasia

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PIMs Pop Quiz!

PIMs < • Potentially Inappropriate Medications

For each disease, can you name the PIMs before I reveal the slide?

Let's try with Heart Failure first….

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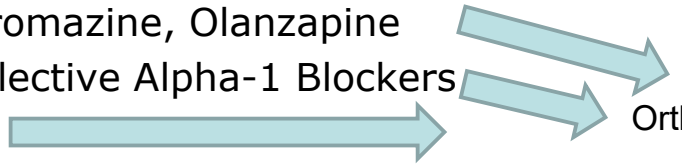
PIMs: Heart Failure

- AVOID
  - Cilostazol
    - Increased mortality
  - Dextromethorphan/ Quinidine
    - QT prolongation
  - Diltiazem, Verapamil
    - Exacerbate HF
- Use with CAUTION
  - Dronedarone
    - Increased mortality
  - NSAIDs, COX-2 Inhibitors
    - Fluid retention
  - Pioglitazone
    - Fluid retention

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PIMs: Syncope

- AVOID
  - Chlorpromazine, Olanzapine
  - Non-selective Alpha-1 Blockers
  - TCAs
  - AChE-Is
    - Bradycardia



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11

PIMs: Delirium

- AVOID
  - Anticholinergics
  - Antipsychotics
  - Benzodiazepines
  - Non-BZD RA hypnotics
  - Corticosteroids
  - H2RAs
  - Opioids

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PIMs: Dementia or Cognitive Impairment

- AVOID
  - Anticholinergics
  - Antipsychotics (routine use)
    - Risk of stroke + mortality
    - Increased rate of cognitive decline
  - Benzodiazepines
  - Non-BZD RA hypnotics

PIMs: Falls or Fractures

- AVOID
  - Anticholinergics
  - Antidepressants
  - Antiepileptics
  - Antipsychotics
  - Benzodiazepines
  - Non-BZD RA hypnotics
  - Opioids

PIMs: Parkinson's Disease

- AVOID
  - Metoclopramide, prochlorperazine, promethazine
  - Antipsychotics
    - Except: clozapine, pimavanserin, quetiapine

15

15

PIMs: Hx Gastric or Duodenal Ulcers

- AVOID
  - Aspirin
  - Non-COX-2 selective NSAIDs

Unless: no other alternatives are effective and patient can take gastroprotective agent (i.e., PPI or misoprostol)

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PIMs: Urinary Incontinence in Women

- AVOID
  - Non-selective peripheral alpha-1 blockers
    - Worsen incontinence
  - Oral Estrogen
    - Lack of efficacy

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PIMs: LUTS, BPH (in men)

- AVOID
  - Strongly anticholinergic drugs (Table 7)
    - Includes certain: antidepressants, antiemetics, first-generation antihistamines, antipsychotics, antiparkinsonian agents, antispasmodics, skeletal muscle relaxants
    - Excludes antimuscarinics if used for urinary incontinence

18

18

Case #1

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Diving Deeper on Drug-Induced Disease

- Covered in presentation
  - Renal injury
  - Urinary incontinence
  - Cognitive impairment
- Not covered in presentation
  - Fecal incontinence
  - Heart failure
  - Fall / Fracture
  - Hepatic
  - Anemia
  - So many!
    - Time reserved for audience to share pearls

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Drug-Induced Pre-Renal Injury

- Risk-Factors
  - Increased age
  - Use of multiple nephrotoxic drugs
  - Pre-existing renal disease (e.g., CKD)
  - Decreased effective circulating blood volume (e.g., dehydration, CHF, cirrhosis)
  - Diabetes Mellitus
- S/S:
  - Edema, elevated BP, rapid weight gain



Altered blood supply to kidney → Nutrients don't reach kidney cells → Kidney cell death

22

22

Drug-Induced Pre-Renal Injury

- Prevention and Management
  - Minimize use of nephrotoxic drugs → Only use nephrotoxic drugs when the benefits outweigh the risks
  - Maintain hemodynamic stability → Adequate hydration is key!

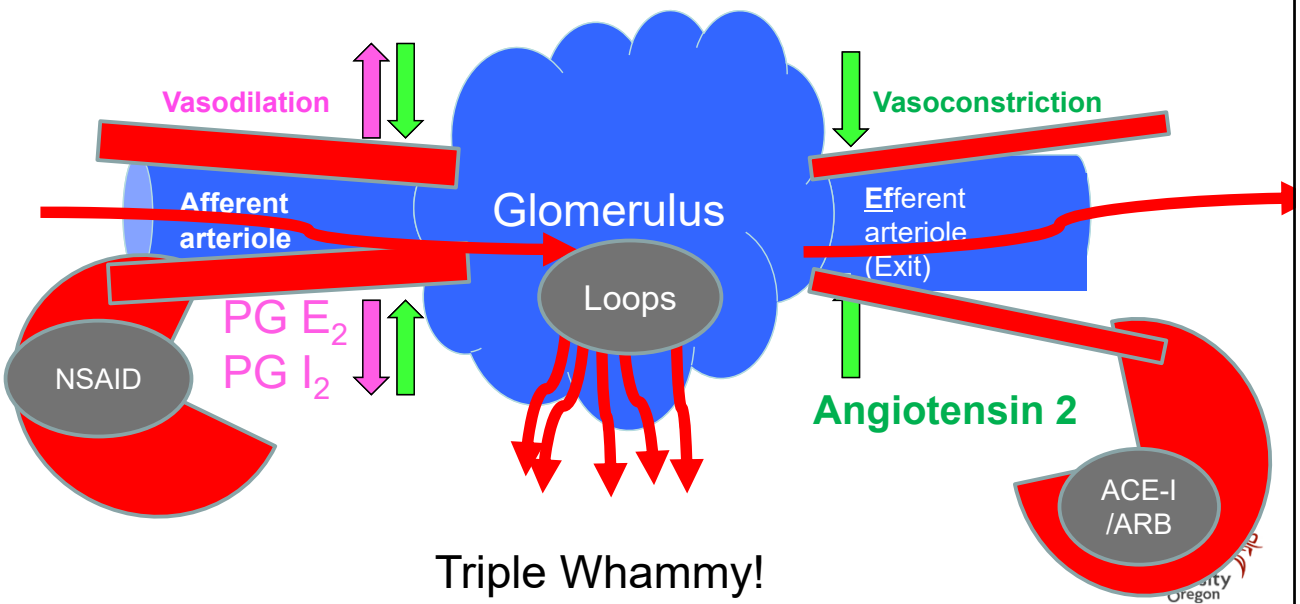
- NSAIDs
  - Inhibits prostaglandin synthesis, decreases afferent arteriole vasodilation
- Diuretics
  - Decreases sodium + water retention, decreases blood supply to kidney
- ACE-I/ARBs
  - In setting of hypoperfusion, kidney unable to vasoconstrict efferent arteriole and obtain sufficient pressure to push blood through

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23

Drug-Induced Pre-Renal Injury



Triple Whammy!

24

Drug-Induced Diabetes Insipidus

- Lithium
  - Nephrogenic diabetes insipidus
    - Renal cells not responding correctly to ADH – lose hyponatremic fluid through open collecting ducts
    - CC: polyuria, polydipsia – results in dehydration
    - Labs: abnormally high Na in BMP
    - Life-threatening → send to ED
  - Dehydration decreases blood flow through efferent arteriole, causes hypoperfusion and renal injury

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Allergic/Acute Interstitial Nephritis

- SMX, Ciprofloxacin, Beta-lactams, Erythromycin, Rifampin
  - Many infectious organisms can also cause AIN
- NSAIDs
- Loop and Thiazide diuretics
- Lithium, Valproic acid
- Allopurinol
- H2RAs, PPIs
- Cyclosporin

- Rare
- Severe inflammation and edema of renal interstitium
  - ~2 weeks after drug exposure, unless previously sensitized
- S/S:
  - Fever
  - Flank pain, Joint pain
  - Urine: eosinophils, protein, pus
  - Skin rash



Drug causes immunologic response within nephron

Renal interstitium becomes inflamed and edematous



Kidney recovers

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Drug-Induced Nephrolithiasis

- Acyclovir
- Sulfamethoxazole
- Furosemide
- Topiramate
- Zonisamide
- Allopurinol
  - Increases uric acid in urine, higher risk with thiazide diuretics
- Calcium + Vitamin C
  - Increase risk for those with calcium-containing kidney stones

- Nephrolithiasis = Kidney stones

- S/S:
  - Severe cramping + flank pain
  - Fever
  - Vomiting
  - Urine: blood, stone crystals

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Drug-Induced Glomerulonephritis

- NSAIDs
- Allopurinol
- Lithium
- Hydralazine
- Phenytoin
- Propylthiouracil
- Rifampin

- Rare
- Nephrotic syndrome (proteinuria > 3.5 g/day)
- S/S:
  - Skin rash
  - Eosinophilia
  - Edema: facial and lower extremity
  - Urine: foamy, oliguria, protein
  - Kidney biopsy
    - Membranous nephropathy: immune complex deposition within glomerular capillary walls
    - Minimal-change nephropathy: appears normal



Drug causes immunologic response within glomerular basement membrane

Compromises filtration, increases permeability, protein passes into urine



Kidney recovers

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Case #2

68 y/o female regular customer is purchasing incontinence products while picking up her Rxs

- You ask if she found the products she needed, as you don't recall her ever purchasing those before
- She is also drinking a large soda, and mentions that she just can't seem to quench her thirst lately
- Meds: naproxen, vitamin C, lithium, calcium carbonate, quetiapine, allopurinol
- Med Hx: bipolar disorder type 2, gout

What drug-induced injury is she most likely experiencing?

a) Nephrolithiasis – calcium carbonate
b) Nephrolithiasis - allopurinol
c) Pre-renal injury – naproxen
d) Diabetes insipidus – lithium

Learning Objective:

2. Relate patient-reported symptoms to potential drug-induced disease and drug-drug interactions

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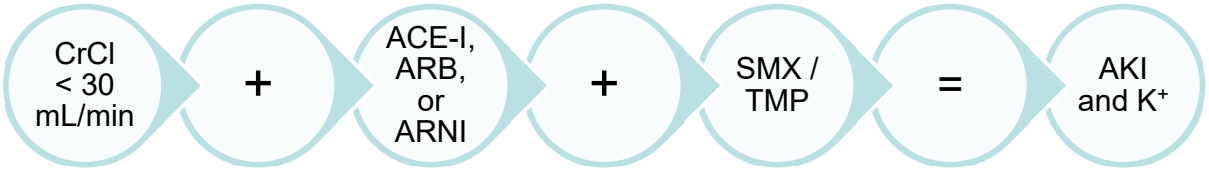
Learning Objective:

2. Relate patient-reported symptoms to potential drug-induced disease and drug-drug interactions

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Beers Criteria: Drug-Induced Hyperkalemia



- 2023 Beers Criteria Recommendation:
  - Reduce SMX/TMP dosage if CrCl 15 – 29 mL/min
  - AVOID if CrCl < 15 mL/min
- Mechanisms:
  - Baseline renal disease predisposes to AKI and hyperkalemia
  - SMX associated with AKI
  - TMP acts as a potassium-sparing diuretic
  - RAAS inhibition predisposes to hyperkalemia

Drug-Induced Urinary Incontinence

- Diuretics
  - Don't forget about SGLT2-Is, caffeine, alcohol
- Muscle relaxers
  - Relax bladder muscle
  - e.g., baclofen in MS
- CNS depressants
  - Lessen awareness of need to urinate, slow reaction time
- Antipsychotics
  - Anti-alpha-adrenergic and anti-dopaminergic effects → enuresis
  - Anticholinergic effects → overflow
- Enuresis
  - involuntary urination
- Functional incontinence
  - Can't recognize need to urinate or quickly move to toilet
- Urge Incontinence
  - Sudden strong urge, followed by leakage
- Overflow Incontinence
  - Retention of urine leads to sudden release of urine
- Stress incontinence
  - Urine released due to coughing, sneezing, jumping

Arasteh et al. An association between incontinence and antipsychotic drugs: A systematic review. Biomedicine & Pharmacotherapy, Volume 142, 2021,112027. ISSN 0753-3322. https://doi.org/10.1016/j.biopha.2021.112027.

Drug-Induced Cognitive Impairment

- Anticholinergics
  - Exacerbate age-related ACh and cholinergic neuron loss
- Antiepileptics
  - Reduce neuronal excitability
- Antipsychotics
  - Anticholinergic effects
  - Decrease nerve growth factor and brain-derived growth factor
- Glucocorticoids
  - Hippocampal cell loss
- Benzodiazepines
  - Enhancement of GABA activity
- Opioids
  - Inhibition of cholinergic system
- SSRIs
  - Hyponatremia / SIADH
- TCAs
  - Anticholinergic and antihistaminergic effects

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Drug-Induced Cognitive Impairment

- Dehydration
  - Diuretics
  - Could be mechanism behind the long-standing myth that confusion in elderly = UTI
    - First step in UTI treatment is hydration
- Anemia
  - Metformin → B12 deficiency
  - Methotrexate → folate deficiency
  - Anticoagulants, Antiplatelets → bleeding
- Thyroid disorders
  - Amiodarone
  - Quetiapine
  - Lithium
- Depression
  - Beta-blockers
- Insomnia
  - Glucocorticoids
  - Diuretics
  - Stimulants at night
  - CNS depressants during day

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Case #3

Situation:

- Patient's adult child arrives to pick up mom's new Rx for tolterodine ER taken qHS for nocturia

Background:

- Patient is an 86 y/o female, lives with adult children
- Uses walker outside the home, cane inside the home
- Also fills metoprolol succinate qDay, atorvastatin qDay, furosemide BID, losartan qDay
- Med Hx: Heart failure (well-controlled), mild cognitive impairment

Assessment:

What is your assessment of this situation?

Learning Objective

3. Provide a patient-centered plan to address a drug-induced disease or drug-disease interaction

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Assessment:

- **Second dose of furosemide likely contributing to nocturia**
- **High risk for falls**
- **Tolterodine has drug-disease interaction with cognitive impairment**

Recommendation:

What is your plan?

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Case #3

Learning Objective

3. Provide a patient-centered plan to address a drug-induced disease or drug-disease interaction

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Assessment:

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- Tolterodine has drug-disease interaction with cognitive impairment

Recommendation:

- **Either stop second furosemide dose or take earlier in the day**
- **Avoid tolterodine**

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THANK YOU!

Please share your pearls with us

Not covered in presentation

- Fecal incontinence
- Heart failure
- Fall / Fracture
- Hepatic
- Anemia
- So many!

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