

# HOUSE OF DELEGATES

## Current Adopted Policy Statements



1963–2020

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# POLICY STATEMENTS

## ADVERTISING

### *Advertising for Pharmacies*

**2016, 1997**

#### **Use of the Word “Pharmacy” in Unlicensed Environments**

APhA supports the establishment and enforcement of regulations through Boards of Pharmacy that restrict the use of the words “pharmacy,” “drug store,” “apothecary,” or any other words or symbols of similar meaning or signage and business names to entities in which the practice of pharmacy is conducted.

[JAPhA. NS37:460; July/August 1997] [Reviewed 2002] [Reviewed 2006] [Reviewed 2011] [JAPhA. 56(4):380; July/August 2016]

**2010**

#### **Transfer Incentives**

APhA advocates the elimination of coupons, rebates, discounts, and other incentives provided to patients that promote the transfer of prescriptions between competitors.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2015]

**2007, 2002, 1968**

#### **Directory Listings for Pharmacies**

APhA encourages the listing of all pharmacies in telephone, Internet, and other directories under “Pharmacies.”

[JAPhA. NS8:380; July 1968] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] [Reviewed 2006] [JAPhA. NS45(5):580; September/October 2007] [Reviewed 2012] [Reviewed 2017]

**2002, 1984**

#### **Depiction of Pharmacists in Public Media**

APhA supports the development of guidelines or standards to enhance the depiction of the pharmacy profession in all public media.

[Am Pharm. NS24(7):60; July 1984] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016] [Reviewed 2018]

**2002**

#### **Investigation of Discount Card Issuer Practices**

APhA encourages the Federal Trade Commission, the U.S. attorney general, or other appropriate agency to investigate misleading and deceptive marketing practices of issuers of discount cards.

[JAPhA. NS42(5)[suppl 1]:S61; September/October 2002] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

**2000**

#### **Use of the Phrase “Community Pharmacy”**

APhA supports use of the phrase “community pharmacy” rather than “retail pharmacy.”

[JAPhA. NS40(5)[suppl 1]:S8; September/October 2000] [Reviewed 2002] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

### *Drug Names*

**1996**

#### **Brand-Name Line Extensions**

APhA opposes the use of the same brand name (or minor modifications of the same name) for prescription and nonprescription drug products containing different active ingredients.

[JAPhA. NS36(6):396; June 1996] [Reviewed 2004] [Reviewed 2006] [Review 2011] [Reviewed 2016]

### *Prescription and Nonprescription Drugs*

**2004, 1977**

#### **Prescription Drug Advertising**

APhA does not oppose the dissemination of price information to patients, by advertising or by any other means.

[JAPhA. NS17:448; July 1977] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

1999

### **Direct-to-Consumer Advertising of Medications**

1. APhA supports legislative and regulatory activities permitting direct-to-consumer advertising concerning medical or health conditions treatable by prescription or nonprescription drug products. These advertisements must conform to rules and regulations that ensure complete, comprehensive, and understandable information that informs consumers of potential benefits and risks of the product.
2. APhA opposes false or misleading advertising for prescription or nonprescription drugs or any promotional efforts that encourage indiscriminate use of medication.
3. APhA supports the availability of accurate information to consumers about medication use and recognizes the responsibility of pharmacists to provide appropriate responses to consumer inquiries stimulated by direct-to-consumer advertising as a compensated pharmaceutical service. In addition, APhA recommends that health care professionals, including but not limited to pharmacists, receive new product information on direct-to-consumer advertising campaigns prior to this information being made available to consumers.

[JAPhA. 39(4):447; July/August 1999] [Reviewed 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

## **AUTOMATION AND TECHNOLOGY IN PHARMACY PRACTICE**

2020

### **Digital Health Integration in Pharmacy**

1. APhA supports education about digital health technologies and integration in pharmacy practice, in pharmacy school curricula, and for the pharmacy workforce.
2. APhA supports inclusion of pharmacists in the design and development of digital health technologies.
3. APhA supports that digital health technologies be interoperable with and integrated into pharmacy management systems and electronic health records.
4. APhA supports pharmacists applying digital health technologies to optimize patient care outcomes.

[JAPhA. 2020;60(5):e11]

2020, 2010

### **E-prescribing Standardization**

1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.
2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce in order to improve health information technology systems and, ultimately, patient care.
3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.
4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.
5. APhA supports laws and regulations that require e-prescribing of controlled substances to reduce fraudulent prescriptions.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2012] [Reviewed 2014] [Reviewed 2015] [JAPhA. 2020;60(5):e10]

2020, 2015

### **Integrated Nationwide Prescription Drug Monitoring Program**

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.

5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for
  - (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud;
  - (b) providing focused provider education and patient referral to treatment programs; and
  - (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

[JAPhA. N55(4):364; July/August 2015] [JAPhA. 2020;60(5):e10]

**2020**

### **Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill**

APhA supports regulations that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

[JAPhA. 2020;60(5):e10]

**2018**

### **Pharmacists Electronic Referral Tracking**

1. APhA supports the development of electronic systems that enhance and simplify the ability of pharmacists in all practice settings to receive, send, and track referrals among all members of the health care team, including other pharmacists, irrespective of the health care system, model, or network in which the patient participates.
2. APhA supports the interoperability and integration of referral tracking systems with electronic health records so patients can receive the benefit of optimally coordinated care from all members of the health care team.

[JAPhA. 58(4):356; July/August 2018] [Reviewed 2020]

**2018**

### **Proactive Immunization Assessment and Immunization Information Systems**

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

[JAPhA. 58(4):355; July/August 2018]

**2018**

### **Use of Genomic Data Within Pharmacy Practice**

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.

7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct to consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

## 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and nonpunitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

[JAPhA. N55(4):364; July/August 2015] [Reviewed 2019]

## 2010 Personal Health Records

1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.
2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.
3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.
4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2013] [Reviewed 2014] [Reviewed 2015] [reviewed 2019]

2004

### **Automation and Technology in Pharmacy Practice**

1. APhA supports the use of automation and technology in pharmacy practice, with pharmacists maintaining oversight of these systems.
  2. APhA recommends that pharmacists and other pharmacy personnel implement policies and procedures addressing the use of technology and automation to ensure safety, accuracy, security, data integrity, and patient confidentiality.
  3. APhA supports initial and ongoing system-specific education and training of all affected personnel when automation and technology are utilized in the workplace.
  4. APhA shall work with all relevant parties to facilitate the appropriate use of automation and technology in pharmacy practice.
- [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2006] [Reviewed 2008] [Reviewed 2013] [Reviewed 2014] [Reviewed 2015] [Reviewed 2019]

2001

### **Automation and Technical Assistance**

APhA supports the use of automation for prescription preparation and supports technical and personnel assistance for performing administrative duties and facilitating pharmacists' provision of pharmaceutical care.

[JAPhA. NS41(5)(suppl 1):58; September/October 2001] [Reviewed 2004] [Reviewed 2007] [Reviewed 2008] [Reviewed 2013] [Reviewed 2015]

## **BIOTECHNOLOGY**

2018

### **Use of Genomic Data Within Pharmacy Practice**

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct to consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

2016

### **Biologic, Biosimilar, and Interchangeable Biologic Drug Products**

1. APhA urges the development of programs and policies that facilitate patient access to and affordability of biologic products.
2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.
3. APhA recognizes the Food and Drug Administration's (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.
4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.

5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.

[JAPhA. 56(4):369; July/August 2016]

**2012, 2007**

### **Biologic Drug Products**

APhA should initiate educational programs for pharmacists and other health care professionals concerning the determination of therapeutic equivalence of generic/biosimilar versions of biologic drug products.

[JAPhA. NS45(5):580 September/October 2007] [JAPhA. NS52(4):457; July/August 2012] [Reviewed 2016] [Reviewed 2017]

**2010**

### **Pharmacogenomics/Personalized Medicine**

4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.

[JAPhA. NS50(4):471; July/August 2010] [Reviewed 2015] [Reviewed 2019]

**2005, 1988**

### **Pharmaceutical Biotechnology Products**

APhA recognizes the urgent need for education and training of pharmacists and student pharmacists relative to the therapeutic and diagnostic use of pharmaceutical biotechnology products. APhA, therefore, supports the continuing development and implementation of such education and training.

[Am Pharm. NS28(6):394; June 1988] [JAPhA. NS45(5):559; September/October 2005] [Reviewed 2006] [Reviewed 2007] [Reviewed 2010] [Reviewed 2015] [Reviewed 2016] [Reviewed 2017]

**1991**

### **Biotechnology**

APhA encourages the development of appropriate educational materials and guidelines to assist pharmacists in addressing the ethical issues associated with the appropriate use of biotechnology-based products.

[Am Pharm. NS31(6):29; June 1991] [Reviewed 2004] [Reviewed 2007] [Reviewed 2010] [Reviewed 2015] [Reviewed 2016] [Reviewed 2017]

## **DISASTER PREPAREDNESS**

**2020**

### **Pharmaceutical Safety and Access During Emergencies**

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

[JAPhA. 2020;60(5):e11]

**2020**

### **Protecting Pharmaceuticals as a Strategic Asset**

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for regulatory and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.

7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

[JAPhA. 2020;60(5):e9]

**2020**

### **Protecting Pharmacy Personnel During Public Health Crisis**

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as “frontline providers” who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

[JAPhA. 2020;60(5):e11]

**2016, 2011, 2002, 1963**

### **Role of the Pharmacist in National Defense**

APhA endorses the position that the pharmacist, as a member of the health care team, has the ethical responsibility to assume a role in disaster preparedness and emergency care operations. These responsibilities include the following:

1. Pharmacists, by their education and training as medication experts, should be involved intimately in all elements of the procurement, storage, handling, compounding, and dispensing of drugs and supplies in planning for as well as during any national emergency.
2. Pharmacists, by their education in anatomy, physiology, and pharmacology, are readily adaptable to assist in the emergency medical treatment of patients and for training the public in medical self-help.
3. Pharmacists, by their constant contact with the members of the health team, as well as a significant portion of their communities, provide the potential for coordinating preparedness measures, and establishing meaningful standby emergency operational plans.

In view of these responsibilities, it shall be the further policy of APhA to

1. Cooperate with all responsible agencies and departments of the federal government;
2. provide leadership and guidance for the profession of pharmacy by properly assuming its role with other health profession organizations at the national level (e.g., American Medical Association, American Hospital Association, American Dental Association, American Nurses Association, and American Veterinary Medical Association);
3. assist and cooperate with all national specialty pharmaceutical organizations to provide assistance and coordination in civil defense matters relevant to their area of concern;
4. encourage and assist the state and local pharmacy associations in their efforts to cooperate with the state and local governments as well as the state and local health profession organizations in order that the pharmacist may assume his proper place in civil defense operations; and
5. provide leadership and guidance so that individual pharmacists can contribute their services to civil defense and disaster planning, training, and operations in a manner consistent with their position as a member of the health team.

[JAPhA. NS3:330; June 1963] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] [Reviewed 2006] [Reviewed 2010] [JAPhA. NS51(4):483; July/August 2011] [JAPhA. 56(4):379; July/August 2016]

**2015**

### **Disaster Preparedness**

APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to terrorism and infectious diseases.

[JAPhA. N55(4):365; July/August 2015]

2014

## **Use of Social Media**

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

[JAPhA. 54(4):357; July/August 2014] [Reviewed 2019]

2011, 2002, 1996

## **Health Mobilization**

APhA should continue to

1. Emphasize its support for programs on disaster preparedness that involve the services of pharmacists (e.g., Medical Reserve Corps) and emergency responder registration networks [e.g., Emergency System for Advance Registration of Volunteer Health Professions (ESAR-VHP)];
2. Improve and expand established channels of communication among pharmacists; local, state, and national pharmacy associations; boards and colleges of pharmacy; and allied health professions;
3. Maintain its present liaison with the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the Department of Health and Human Services and continue to seek Office of Emergency Management (OEM) assistance through professional service contracts to further develop pharmacy's activities in all phases of preparation before disasters; and
4. Encourage routine inspection of drug stockpiles and disaster kits by state boards of pharmacy.

[JAPhA. NS6:328; June 1996] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] [Reviewed 2006] [JAPhA. NS51(4):483; July/August 2011] [Reviewed 2016]

2007

## **Pharmacy Personnel Immunization Rates**

1. APhA supports efforts to increase immunization rates of health care professionals for the purposes of protecting patients and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for health care workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (e.g., physicians, nurses, police) and to prioritize pharmacists to receive medications and immunizations.

[JAPhA. NS45(5):580; September/October 2007] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

2006, 2002, 1971

## **Model Disaster Plan for Pharmacists**

1. The committee recommends that APhA develop a disaster plan for the guidance of pharmacy organizations in responding to the needs of pharmacists who experience losses from disasters and that this model plan be disseminated to state associations for their reference.
2. The committee recommends that APhA cooperate with associations representing pharmaceutical manufacturers, wholesale distributors, and others in the pharmaceutical supply system in developing a mechanism to facilitate the communication of information about the losses incurred by pharmacists as a result of disasters. Those firms that make it a practice to replace uninsured losses of inventories of their products could do so promptly and efficiently so that normal pharmaceutical services to the affected community are resumed as soon as possible.

[JAPhA. NS11:256 May 1971] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] [JAPhA. NS46(5):562; September/October 2006] [Reviewed 2011] [Reviewed 2016]

# DISPENSING AUTHORITY

2018, 2013

## Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws and regulations to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

[JAPhA. 53(4):365; July/August 2013] [JAPhA. 58(4):356; July/August 2018]

2017

## Patient Access to Pharmacist-Prescribed Medications

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

[JAPhA. 57(4):441; July/August 2017] [Reviewed 2019] [Reviewed 2020]

2015

## Role of the Pharmacist in the Care of Patients Using Cannabis

1. APhA supports regulatory changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in furnishing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to furnish them.
5. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.

[JAPhA. N55(4):365; July/August 2015]

**2006, 2004, 1978**

### **Dispensing Criteria**

APhA supports vigorous enforcement of laws to ensure that all those who sell or dispense prescription and nonprescription drugs comply with legal criteria.

[Am Pharm. NS18(8):42; July 1978] [JAPhA. NS44(5):551; September/October 2004] [JAPhA. NS46(5):562; September/October 2006] [Reviewed 2015]

**2005, 1998**

### **Administration of Medications**

1. APhA recognizes and supports pharmacist administration of prescription and nonprescription drugs as a component of pharmacy practice.
2. APhA supports the development of educational programs and practice guidelines for student pharmacists and practitioners for the administration of prescription and nonprescription drugs.
3. APhA supports pharmacist compensation for administration of prescription and nonprescription drugs and services related to such administration.
4. APhA urges adoption of state laws and regulations authorizing pharmacist administration of prescription and nonprescription drugs.

[JAPhA. 38(4):417; July/August 1998] [JAPhA. NS45(5):559; September/October 2005] [Reviewed 2006] [Reviewed 2011] [Reviewed 2012] [Reviewed 2017] [Reviewed 2020]

**2004, 1984**

### **Issuing of Drugs by Nonpharmacists**

APhA supports issuing drug products to patients by nonpharmacists under the control and direction of pharmacists.

[Am Pharm. NS24(7):60; July 1984] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

**2003, 2000**

### **Emergency Contraception**

APhA supports the voluntary involvement of pharmacists, in collaboration with other health care providers, in emergency contraceptive programs that include patient evaluation, patient education, and direct provision of emergency contraceptive medications.

[JAPhA. NS40(5)[suppl 1]:S8; September/October 2000] [JAPhA. NS43(5)[suppl 1]:S58; September/October 2003] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009] [Reviewed 2014] [Reviewed 2018]

**1979**

### **Dispensing and/or Administration of Legend Drugs in Emergency Situations**

1. APhA supports making insect sting kits and other lifesaving emergency treatment kits available for lawful dispensing by pharmacists without a prescription order, based on the pharmacist's professional judgment.
2. APhA supports permitting pharmacists to lawfully dispense and administer legend drugs in emergency situations, without an order from a licensed prescriber, provided that
  - (a) There is an assessment on the part of the pharmacist and the patient that the drug is needed immediately to preserve the well-being of the patient; (a) patient, and;
  - (b) The normal legal means for obtaining authorization to dispense the drug must not be immediately available, such as in cases where the patient's physician is not available; and
  - (c) The quantity of the drug that can be dispensed in an emergency situation is enough so that the emergency situation can subside, and the patient can be sustained for the immediate emergency, as determined by the pharmacist's professional judgment.
3. APhA supports expansion of state Good Samaritan Acts to provide pharmacists immunity from professional liability for dispensing in emergency situations without order from a licensed prescriber.
4. APhA supports permitting pharmacists to lawfully dispense and/or administer legend drugs without an order from a licensed prescriber during disaster situations.

[Am Pharm. NS19(7):68; June 1979] [Reviewed 2002] [Reviewed 2006] [Revised 2007] [Reviewed 2012] [Reviewed 2012] [Reviewed 2017]

**1979**

### **Out-of-State Prescription Orders**

APhA supports the repeal of state laws that prohibit the dispensing of an otherwise legal prescription order issued by a prescriber licensed in another state.

[Am Pharm. NS19(7):67; June 1979] [Reviewed 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

# DRUG ABUSE, CONTROL, AND EDUCATION

2020

## Increasing Access to and Advocacy for Medications for Opioid Use Disorder (MOUD)

1. APhA supports the use of evidence-based medicine as first-line treatment for opioid use disorder for patients, including health care professionals in and out of the workplace, for as long as needed to treat their disease.
2. APhA encourages pharmacies to maintain an inventory of medications of public health importance, particularly medications for opioid use disorder (MOUD), to ensure access for patients.
3. APhA encourages pharmacists and payers to ensure patients have equitable access to, and coverage for, at least one medication from each class of medications used in the treatment of opioid use disorder.

[JAPhA. 2020;60(5):e11]

2020, 2015

## Integrated Nationwide Prescription Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards that include pharmacists to coordinate collaborative efforts for
  - (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud;
  - (b) providing focused provider education and patient referral to treatment programs; and
  - (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

[JAPhA. N55(4):364; July/August 2015] [JAPhA. 2020;60(5):e10]

2020

## Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill

APhA supports regulations that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

[JAPhA. 2020;60(5):e10]

2019, 2016

## Substance Use Disorder

1. APhA supports legislative, regulatory, and private sector efforts that include pharmacists' input and that will balance patient/consumers' need for access to medications for legitimate medical purposes with the need to prevent the diversion, misuse, and abuse of medications.
2. APhA supports consumer sales limits of nonprescription drug products, such as methamphetamine precursors, that may be illegally converted into drugs for illicit use.
3. APhA encourages education of all personnel involved in the distribution chain of nonprescription products so they understand the potential for certain products, such as methamphetamine precursors, to be illegally converted into drugs for illicit use. APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.
4. APhA supports public and private initiatives to fund treatment and prevention of substance use disorders.
5. APhA supports stringent enforcement of criminal laws against individuals who engage in drug trafficking.

[JAPhA. 56(4):369; July/August 2016] [JAPhA. 59(4):e28; July/August 2019]

2017

### **Drug Disposal Program Involvement**

APhA urges pharmacists to expand patient access to secure, convenient, and ecologically responsible drug disposal options, in accordance with the Secure and Responsible Drug Disposal Act of 2010, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in an effort to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

[JAPhA. 57(4):441; July/August 2017]

2016

### **Medication-Assisted Treatment**

APhA supports expanding access to medication-assisted treatment (MAT), including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

[JAPhA. 56(4):370; July/August 2016]

2016

### **Opioid Overdose Prevention**

1. APhA supports access to third-party (nonpatient-recipient) prescriptions for opioid reversal agents that are furnished by pharmacists.
2. APhA affirms that third-party (nonpatient-recipient) prescriptions should be reimbursed by public and private payers.

[JAPhA. 56(4):370; July/August 2016] (Reviewed 2020)

2014

### **Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents**

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in overdose, drug diversion, and substance-related and addictive disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse, abuse, and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse, abuse, and/or diversion.
4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish opioid reversal agents to prevent opioid-related deaths due to overdose.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent opioid-related deaths due to overdose.

[JAPhA. 54(4) July/August 2014] (Reviewed 2015) (Reviewed 2018)

2011, 2005, 2002

### **Funding for Pharmacist Recovery Programs**

APhA supports and encourages a cooperative effort among state and national pharmacy associations, state boards of pharmacy, and state legislative bodies to authorize, develop, implement, and maintain mechanisms for the comprehensive funding of state recovery programs for pharmacists, student pharmacists, and pharmacy technicians.

[JAPhA. NS42(5)(suppl 1):S61; September/October 2002] [JAPhA. NS45(5):559; September/October 2005] (Reviewed 2006) (Reviewed 2010) [JAPhA. NS51(4)483; July/August 2011] (Reviewed 2016)

2005, 2003, 1982

### **Pharmacists with Impairments That Affect Practice**

1. APhA advocates that pharmacists should not practice while subject to physical or mental impairment due to the influence of drugs, – including alcohol – or other causes that might adversely affect their abilities to function properly in their professional capacities.
2. APhA supports establishment of counseling, treatment, prevention, and rehabilitation programs for pharmacists and student pharmacists who are subject to physical or mental impairment due to the influence of drugs – including alcohol – or other causes, when such impairment has potential for adversely affecting their abilities to function in their professional capacities.

[Am Pharm. NS22(7):32; July 1982] [JAPhA. NS43(5)(suppl 1):S58; September/October 2003] [JAPhA. NS45(5):559; September/October 2005] (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

2003, 1971

### **Security: Pharmacists' Responsibility**

APhA encourages pharmacists to voluntarily remove all proprietary drug products with potential for abuse or adverse drug interactions from general sales areas and to make their dispensing the personal responsibility of the pharmacist.

[JAPhA. NS11:267 May 1971] [JAPhA. NS43(5)[suppl 1]:S58; September/October 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

2003, 1983

### **The Use of Controlled Substances in the Treatment of Intractable Pain**

1. APhA supports the continued classification of heroin as a Schedule I controlled substance.
2. APhA supports research by qualified investigators under the Investigational New Drug (IND) process to explore the potential medicinal uses of Schedule I controlled substances and their analogues.
3. APhA supports comprehensive education to maximize the proper use of approved analgesic drugs for treating patients with chronic pain.
4. APhA recognizes that pharmacists receiving controlled substance prescription orders used for analgesia have a responsibility to ensure that the medication has been prescribed for a legitimate medical use and that patients achieve the intended therapeutic outcomes
5. APhA advocates that pharmacists play an important role on the patient care team providing pain control and management.

[Am Pharm. NS23(6):52; June 1983] [JAPhA. NS43(5)[suppl 1]:S58; September/October 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2012] [Reviewed 2013] [Reviewed 2015]

1997

### **Drug Enforcement Agency Employment Waiver**

APhA urges the Drug Enforcement Administration, in processing employment waiver requests, to defer to the decisions of state boards of pharmacy related to the licensure of pharmacists suffering from alcohol and other chemical dependencies.

[JAPhA. NS37(4):459; July/August 1997] [Reviewed 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

1990

### **Drug Testing in the Workplace**

APhA endorses the concept of the “Drug-Free Workplace” and recommends that, where drug testing is performed in the workplace, it be conducted in conjunction with an employee assistance program.

[Am Pharm. NS30(6):45; June 1990] [Reviewed 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

1982

### **Innovative Approaches to Combating Pharmacy Crime**

1. APhA encourages federal government agencies to provide mechanisms for supporting experimental, drug dependence, treatment programs based on principles of maintenance and/or detoxification.
2. APhA supports the development of a comprehensive educational program on drug use and misuse, starting with children in primary grades (kindergarten–grade 5).

[Am Pharm. NS22(7):32; July 1982] [Reviewed 2003] [Reviewed 2006] [Reviewed 2010] [Reviewed 2015]

## *Hallucinogens*

1981

### **Removal of Hallucinogenic Solvents from Paints, Sprays, and Glues**

APhA supports the denaturing of abused products containing hallucinogens by appropriate means, such as the addition of harmless chemicals with obnoxious scents or with the ability to produce nausea when the products are abused, but not when used as directed.

[Am Pharm. NS21(5):40 May 1981] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

## *Marijuana*

2015

### **Role of the Pharmacist in the Care of Patients Using Cannabis**

1. APhA supports regulatory changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.

2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in furnishing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to furnish them.
5. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.

[JAPhA. N55(4):365; July/August 2015]

**1980**

### **Medicinal Use of Marijuana**

1. APhA supports research by properly qualified investigators operating under the investigational new drug (IND) process to explore fully the potential medicinal uses of marijuana and its constituents or derivatives.
2. APhA opposes state by state, marijuana specific, or other drug specific legislation intended to circumvent the federal laws and regulations pertaining to
  - (a) marketing approval of new drugs based on demonstrated safety and efficacy, or
  - (b) controlling restrictions relating to those substances having a recognized hazard of abuse.

[Am Pharm. NS20(7):71; July 1980] [Reviewed 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2015]

### *Methodone*

**2003, 1972**

### **Methadone Used as Analgesic and Antitussive**

APhA encourages developers of methadone programs to place pharmacists in charge of their drug distribution and control systems.

[JAPhA. NS12:308; June 1972] [JAPhA. NS43(5)[suppl 1]:S58; September/October 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

### *Performance-Enhancing Drugs*

**1986**

### **Use of Performance-Enhancing Drugs by Athletes**

1. APhA is opposed to the use of performance-enhancing drugs by athletes.
2. APhA should educate the public on the dangers of the use of performance-enhancing drugs by athletes.
3. APhA encourages enforcement of laws related to the use of performance-enhancing drugs by athletes.

[Am Pharm. NS26(6):420; June 1986] [Reviewed 2003] [Reviewed 2006] [Reviewed 2015]

### *State Drug Laws and Legalization Issues*

**2019**

### **Patient-Centered Care of People Who Inject Nonmedically Sanctioned Psychotropic or Psychotropic Substances**

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with injection drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and postexposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.

5. APhA urges pharmacists to refer people who inject nonmedically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.

[JAPhA. 59(4):e17; July/August 2019]

**2016, 1990**

### **Legalization or Decriminalization of Illicit Drugs**

1. APhA opposes legalization of the possession, sale, distribution, or use of illicit drug substances for nonmedical uses.
2. APhA supports the use of drug courts or other evidence-based mechanisms—when appropriate as determined by the courts—to provide alternate pathways within the criminal justice system for the treatment and rehabilitation of individuals who are charged with drug-related offenses and who have substance use or other related medical disorders.
3. APhA supports criminal penalties for persons convicted of drug-related crimes, including but not limited to drug trafficking, drug manufacturing, and drug diversion, whenever alternate pathways are inappropriate as determined by the courts.

[Am Pharm. NS30(6):46; June 1990] [Reviewed 2003] [Reviewed 2006] [Reviewed 2011] [(JAPhA. 56(4):369; July/August 2016)]

**2012**

### **Controlled Substances Regulation and Patient Care**

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
  - (a) the burdens on health care providers,
  - (b) the cost of health care delivery, and
  - (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2015]

**2010**

### **Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities That Include Pharmacies**

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2015]

**1999**

### **Sale of Sterile Syringes**

APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

[JAPhA. 39(4):447; July/August 1999] [Reviewed 2003] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019] [Reviewed 2020]

# DRUG CLASSIFICATION

- 2020**  
**Nonexecution-Related Use of Pharmaceuticals in Correctional Facilities**
1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of inmates.
  2. APhA advocates for inmates to have an opportunity, equal to that of noninmates, to access medications that correctional health care providers deem medically necessary for appropriate and humane health care treatment.
  3. APhA advocates for correctional health care providers to have opportunity, equal to that of noncorrectional health care providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of inmates.
- [JAPhA. 2020;60(5):e11]

- 2018, 2013**  
**Revisions to the Medication Classification System**
1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
  2. APhA supports the implementation or modification of state laws and regulations to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
  3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
  4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
  5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
  6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
  7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
  8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.
- [JAPhA. 53(4):365; July/August 2013] [JAPhA. 58(4):356; July/August 2018]

- 2016**  
**Biologic, Biosimilar, and Interchangeable Biologic Drug Products**
1. APhA urges the development of programs and policies that facilitate patient access to and affordability of biologic products.
  2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.
  3. APhA recognizes the Food and Drug Administration's (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.
  4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.
  5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.
- [JAPhA. 56(4):369; July/August 2016]

- 2006**  
**Drug Classification System**
1. APhA supports restructuring the current drug classification system and drug approval process. Evidence should drive the restructuring beyond the current prescription and nonprescription classes to ensure appropriate access to medications and pharmacist services and improve medication use and outcomes.
  2. APhA encourages pharmacists to exercise their professional judgment to manage access to nonprescription medications and dietary supplements to facilitate patient/caregiver interaction with their pharmacist.
- [JAPhA. NS46(5):561; September/October 2006] [Reviewed 2011] [Reviewed 2013] [Reviewed 2017]

# DRUG PRICING AND DISTRIBUTION

2020

## Coordination of the Pharmacy and Medical Benefit

APhA supports coordination of patients' comprehensive pharmacy and medical benefits that allows for provision of and compensation for pharmacists' patient care services; aligns incentives to optimize patient outcomes; streamlines administrative processes; reduces overall health care costs and preserves patients' right to choose providers under their pharmacy and medical benefits.

[JAPhA. 2020;60(5):e10]

2020

## Nonexecution-Related Use of Pharmaceuticals in Correctional Facilities

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of inmates.
2. APhA advocates for inmates to have an opportunity, equal to that of noninmates, to access medications that correctional health care providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional health care providers to have opportunity, equal to that of noncorrectional health care providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of inmates.

[JAPhA. 2020;60(5):e11]

2020

## Pharmaceutical Safety and Access During Emergencies

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

[JAPhA. 2020;60(5):e11]

2020

## Protecting Pharmaceuticals as a Strategic Asset

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for regulatory and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

[JAPhA. 2020;60(5):e9]

2020

### **Specialty Pharmacy and Specialized Pharmacy Services**

1. APhA recognizes that certain complex medications require more specialized care and resources. Further, APhA asserts that delineation of medications as specialty versus nonspecialty, and associated payer and manufacturer practices, may introduce continuity of care disruption, patient access issues, and financial inequities.
2. APhA supports pharmacists and pharmacies choosing to specialize or incorporate specialty pharmacy services into their practice to optimize patient outcomes.
3. APhA opposes payer policies and practices that limit patient choice of pharmacy providers, disrupt continuity of care, or compromise patient safety through the creation of specialty drug lists, and restrictive specialty pharmacy networks
4. APhA opposes manufacturer distribution and related business practices that restrict patient or pharmacy access to medications, medical products, and patient care services.
5. APhA advocates for the adoption of pharmacy profession-developed, harmonized practice standards for specialized pharmacy practices, and specialty pharmacy services and products.
6. APhA encourages increased availability and use of data integration, patient financial assistance, and other resources to inform clinical practice and support the provision of specialized pharmacy practices and specialty pharmacy services.
7. APhA supports the availability of education and training for pharmacists and student pharmacists related to specialized pharmacy practices and specialty pharmacy services.

[JAPhA. 2020;60(5):e10]

2016

### **Biologic, Biosimilar, and Interchangeable Biologic Drug Products**

1. APhA urges the development of programs and policies that facilitate patient access to and affordability of biologic products.
2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.
3. APhA recognizes the Food and Drug Administration's (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.
4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.
5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.

[JAPhA. 56(4):369; July/August 2016]

2016

### **Opioid Overdose Prevention**

1. APhA supports access to third-party (nonpatient-recipient) prescriptions for opioid reversal agents that are furnished by pharmacists.
2. APhA affirms that third-party (nonpatient-recipient) prescriptions should be reimbursed by public and private payers.

[JAPhA. 56(4):370; July/August 2016] (Reviewed 2020)

2012

### **Drug Supply Shortages and Patient Care**

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.
2. APhA supports revising current laws and regulations that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.
3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.
4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.

5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by:
  - (a) creating a practice site drug shortage plan as well as policies and procedures,
  - (b) using reputable drug shortage management and information resources in decision making,
  - (c) communicating with patients and coordinating with other health care providers,
  - (d) avoiding excessive ordering and stockpiling of drugs,
  - (e) acquiring drugs from reputable distributors, and
  - (f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.
6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

[JAPhA. NS52(4):457; July/August 2012] (Reviewed 2017)

**2010**

### **Transfer Incentives**

APhA advocates the elimination of coupons, rebates, discounts, and other incentives provided to patients that promote the transfer of prescriptions between competitors.

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2015)

**2004, 1966**

### **Distribution Programs: Circumvention of the Pharmacist**

APhA opposes distribution programs and policies by manufacturers, governmental agencies, and voluntary health groups that circumvent the pharmacist and promote the dispensing of prescription, legend drugs by nonpharmacists. These programs and policies should, in the public interest, be eliminated.

[JAPhA. NS6:293; June 1966] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

**2004, 1968**

### **Manufacturers' Pricing Policies**

APhA supports pharmaceutical industry adoption of a “transparent pricing” system that would eliminate hidden discounts, free goods, and other subtle economic devices.

[JAPhA. NS8:362; July 1968] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2018)

**2004**

### **Protecting the Integrity of the Medication Supply**

1. APhA encourages pharmacists to enhance their role in protecting the integrity of the medication supply, including careful consideration of the source and distribution pathways of the medications they dispense.
2. APhA recommends that all individuals and entities of the pharmaceutical supply system, including manufacturers, wholesalers, pharmacies, pharmacists, and others, adopt appropriate technology, tracking mechanisms, business practices, and other initiatives to protect the integrity of the drug supply.
3. APhA supports public education about the risk of using medications whose production, distribution, or sale does not comply with U.S. federal and state laws and regulations.
4. APhA urges pharmacists and other health care professionals to report suspected counterfeit products to the Food and Drug Administration.

[JAPhA. NS44(5):551; September/October 2004] (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018)

**1994**

### **Product Licensing Agreements and Restricted Distribution**

APhA opposes any manufacturer–provider relationship that involves product licensing agreements and/or restricted distribution arrangements that infringe on pharmacists’ rights to provide pharmaceuticals and pharmaceutical care to their patients.

[Am Pharm. NS34(6):55; June 1994] (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

1989

### **Impact of Drug Distribution Systems on Integrity and Stability of Drug Products**

APhA encourages the development and use of quality-control procedures by all persons or entities involved in the distribution and dispensing of drug products. Such procedures should ensure drug product integrity and stability in accordance with official compendia standards.

[Am Pharm. NS29(7):464; July 1989] [Reviewed 2004] [Reviewed 2006] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

1985

### **Pharmaceutical Pricing**

APhA supports a system of equal opportunity with the same terms, conditions, and prices available for all pharmacies.

[Am Pharm. NS25(5):52 May 1985] [Reviewed 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

1978

### **Postmarketing Requirements (Restricted Distribution)**

APhA opposes any legislation that would grant FDA authority to restrict the channels of drug distribution for any prescription drug as a condition for approval for marketing the drug under approved labeling.

[Am Pharm. NS18(8):30; July 1978] [Reviewed 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

## **DRUG PRODUCT PACKAGING**

2019, 2006, 2003

### **Unit-of-Use Packaging**

1. APhA supports development, distribution, and use of unit-of-use packaging as the pharmaceutical industry standard to enhance patient safety, patient adherence, drug distribution efficiencies, and Drug Supply Chain Security Act (DSCSA) regulations.
2. APhA encourages collaboration with the pharmaceutical industry, repackagers, third-party payers, and appropriate federal agencies to effect the changes necessary for the adoption of unit-of-use packaging as the industry standard.
3. APhA supports the enactment of legislation and regulations to permit pharmacists to modify prescribed quantities to correspond with commercially available unit-of-use packages.

[JAPhA. NS43(5)(suppl 1):S57; September/October 2003] [JAPhA. NS46(5):562; September/October 2006] [Reviewed 2007] [Reviewed 2012] [Reviewed 2013] [Reviewed 2018] [JAPhA. 59(4):e17; July/August 2019] [Reviewed 2020]

2012, 2004, 1992

### **Drug Product Packaging**

1. APhA supports the role of the pharmacist to select appropriate drug product packaging.
2. APhA supports the pharmaceutical industry's performance of compatibility and stability testing of drug products in officially defined containers to assist pharmacist selection of appropriate drug product packaging.
3. APhA supports the value of unit-of-use packaging to enhance patient care but recognizes that product and patient needs may preclude its use.
4. APhA encourages the pharmaceutical industry to ensure that all unit-of-use packaging will accommodate a standard pharmacy label.

[Am Pharm. NS32(6):515; June 1992] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2006] [Reviewed 2007] [JAPhA. NS52(4):458; July/August 2012] [Reviewed 2013] [Reviewed 2017] [Reviewed 2020]

2012

### **Drug Product Packaging**

APhA supports the use of tamper-evident packaging on pharmaceutical products throughout the supply chain before dispensing to reduce the potential of counterfeit and/or adulterated medications reaching patients.

[JAPhA. N552(4):458; July/August 2012] [Reviewed 2018]

2012

### **Medication Verification**

APhA encourages including a description of a medication's appearance on the pharmacy label or receipt as a means of reducing medication errors and distribution of counterfeit medications.

[JAPhA. NS52(4):458; July/August 2012] [Reviewed 2017] [Reviewed 2018]

2004, 1971

### **Single-Dose Containers for Parenteral Use**

APhA supports packaging all drugs intended for parenteral use in humans in single-dose containers, except where clearly not feasible.

[JAPhA. NS11:270 May 1971] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

## **DRUG PRODUCT SELECTION**

2018, 2013

### **Revisions to the Medication Classification System**

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws and regulations to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

[JAPhA. 53(4):365; July/August 2013] [JAPhA. 58(4):356; July/August 2018]

2017

### **Patient Access to Pharmacist-Prescribed Medications**

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

[JAPhA. 57(4):441; July/August 2017] [Reviewed 2019] [Reviewed 2020]

2011

### **Potential Conflicts of Interest in Pharmacy Practice**

1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.

3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

[JAPhA. NS51(4):482 July/August 2011] (Reviewed 2016)

**2009**

### **Non-FDA-Approved Drugs and Patient Safety**

1. APhA calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackaged marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing regulatory and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/ medical education programs and drug information compendia.

[JAPhA. NS49(4):492; July/August 2009] (Reviewed 2014) [Reviewed 2019]

**2005, 1997**

### **Complementary/Alternative Medications and Integrative Health**

1. APhA supports pharmacists using professional judgment to make informed decisions regarding the appropriateness of use or the sale of complementary and alternative medicines.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety, and possible interactions.

[JAPhA. NS37(4): ; July/August 1997] (Reviewed 2002) [JAPhA. NS45(5):556–557; September/October 2005] (Reviewed 2009) [Reviewed 2014] [Reviewed 2019]

**2004, 1970**

### **Licensure/Registration of Drug Manufacturers**

APhA supports the requirements that all drug manufacturers must obtain a federal license or registration, conditioned upon an inspection of the manufacturer’s facilities, before manufacturing is begun.

[JAPhA. NS10:347; June 1970] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2006) [Reviewed 2010] [Reviewed 2015]

**2001, 1989**

### **Uniform Designation for Drug Product Selection Authority**

APhA supports a uniform procedure nationwide for designating on a prescription order that drug product selection by the pharmacist is precluded by the prescriber.

[Am Pharm. NS29(1):67 January 1989] [JAPhA. NS41(5)[suppl 1]:58;September/October 2001] (Reviewed 2004) [Reviewed 2006] [Reviewed 2011] [Reviewed 2012] [Reviewed 2017]

## *Antisubstitution Laws*

**2004, 1971**

### **Antisubstitution Laws: Pharmacists’ Responsibility**

APhA supports state substitution laws that emphasize pharmacists’ professional responsibility for determining, on the basis of available evidence, including professional literature, clinical studies, drug recalls, manufacturer reputation, and other pertinent factors, that the drug products they dispense are therapeutically effective.

[JAPhA. NS11:260 May 1971] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2006) [Reviewed 2011] [Reviewed 2016] [Reviewed 2017]

## Therapeutic Equivalence

2017, 1982

### Legislative Restrictions on Clinical Judgment

APhA opposes the enactment of legislation that would act to restrict the clinical judgments of medical practitioners and other health professionals.

[Am Pharm. NS22(7):32; July 1982] [Reviewed 2004] [Reviewed 2006] [Reviewed 2007] [Reviewed 2012] [JAPhA. 57(4):441; July/August 2017]

2016

### Biologic, Biosimilar, and Interchangeable Biologic Drug Products

1. APhA urges the development of programs and policies that facilitate patient access to and affordability of biologic products.
2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.
3. APhA recognizes the Food and Drug Administration's (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.
4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.
5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.

[JAPhA. 56(4):369; July/August 2016]

2012, 2007

### Biologic Drug Products

APhA should initiate educational programs for pharmacists and other health care professionals concerning the determination of therapeutic equivalence of generic/biosimilar versions of biologic drug products.

[JAPhA. NS45(5):580 September–October 2007] [JAPhA. NS52(4):457; July/August 2012] [Reviewed 2016] [Reviewed 2017]

1987

### Therapeutic Equivalence

1. APhA encourages continuing dialogue with other health care organizations on the pharmacist's role in therapeutic interchange, including the formation of a task force to include representatives of pharmacy, industry, government, and medicine for the purpose of adoption of uniform terminology and definitions related to chemical, biological, and therapeutic equivalence.
2. APhA supports the concept of therapeutic interchange of various drug products by pharmacists under arrangements in which pharmacists and authorized prescribers interrelate on behalf of the care of patients.

[JAPhA. NS27:424; June 1987] [Reviewed 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2012] [Reviewed 2017]

1983

### Pharmaceutical Alternates

APhA supports recognition of the pharmacist's role in the selection of pharmaceutical alternates (i.e., drug products containing the same therapeutic moiety, but differing in salt, ester, or comparable physical/chemical form or differing in dosage form).

[Am Pharm. NS23(6):52; June 1983] [Reviewed 2004] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

## DRUG RECALLS

2011, 2004, 1995

### Product Recall Policy

1. APhA supports
  - (a) the use of contemporary communications technologies to enhance communication of recall information to all relevant parties;
  - (b) developing and promoting strategies to identify and communicate with patients who may have received recalled products, when appropriate;
  - (c) identifying compensation mechanisms for resources expended in responding to recalls; and
  - (d) maintaining the FDA recall program, which ensures that appropriate promptness of action can be taken based on the depth and severity of the recall.

[Am Pharm. NS35(6):38;; June 1995] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2006] [JAPhA NS51(4):483; July/August 2011] [Reviewed 2016]

# EDUCATION, CURRICULUM, AND COMPETENCE FOR PHARMACY

## 2014 **Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents**

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in overdose, drug diversion, and substance-related and addictive disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse, abuse, and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse, abuse, and/or diversion.
4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish opioid reversal agents to prevent opioid-related deaths due to overdose.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent opioid-related deaths due to overdose.

[JAPhA. 54(4); July/August 2014] (Reviewed 2015) (Reviewed 2018)

### *Competency and Training in Specific Areas*

## 2020 **Community-Based Pharmacists as Providers of Care**

2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists.
3. APhA advocates for laws and regulations that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community-based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

[JAPhA. 2020;60(5):e10]

## 2020 **Digital Health Integration in Pharmacy**

1. APhA supports education about digital health technologies and integration in pharmacy practice, in pharmacy school curricula, and for the pharmacy workforce.
2. APhA supports inclusion of pharmacists in the design and development of digital health technologies.
3. APhA supports that digital health technologies be interoperable with and integrated into pharmacy management systems and electronic health records.
4. APhA supports pharmacists applying digital health technologies to optimize patient care outcomes.

[JAPhA. 2020;60(5):e11]

## 2019 **Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians**

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are victims of firearm-related violence to seek the help of counselors and other trained mental health professionals.

[JAPhA. 59(4):e17; July/August 2019]

2019, 2018

### **Gluten Content and Labeling in Medications**

1. APhA supports labeling of all prescription and nonprescription products, as well as dietary supplement products, to indicate the presence of gluten.
2. APhA encourages manufacturers to formulate drug products without use of wheat, barley, rye, or their derivatives whenever possible.
3. APhA supports additional research on the effects of gluten intolerance and celiac malabsorption, particularly as it relates to medication absorption.
4. APhA supports pharmacist education regarding celiac disease and nonceliac gluten sensitivity.
5. APhA encourages the development of analytical methods that can accurately detect lower levels of gluten than the current standard (20 ppm) and for the establishment of evidence-based gluten-free standards for the labeling of foods, excipients, dietary supplements, and prescription and nonprescription products.

[JAPhA. 58(4):356; July/August 2018] [JAPhA. 59(4):e16; July/August 2019] (Reviewed 2020)

2019

### **Pharmacist and Pharmacy Personnel Safety and Well-Being**

1. APhA calls for employers to develop policies and resources to support pharmacy personnel's ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.

[JAPhA. 59(4):e17; July/August 2019]

2019

### **Pharmacists' Role in Mental Health and Emotional Well-Being**

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for, or currently experiencing, a mental health crisis.
2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for all pharmacy personnel to engage and assist individuals regarding mental health and emotional well-being.
3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.

[JAPhA. 59(4):e16; July/August 2019]

2018

### **Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases**

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

[JAPhA. 58(4):356; July/August 2018]

2018

### **Use of Genomic Data Within Pharmacy Practice**

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.

6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct to consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

**2017, 2012**

### **Contemporary Pharmacy Practice**

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

[JAPhA. NS52(4):457; July/August 2012] (Reviewed 2016) [JAPhA. 57(4):441; July/August 2017] (Reviewed 2019)

**2012, 1981**

### **Pharmacist Training in Nutrition**

1. APhA advocates that all pharmacists become knowledgeable about the subject of nutrition.
2. APhA encourages schools and colleges of pharmacy as well as providers of continuing pharmacy education to offer education and training on the subject of nutrition.

[Am Pharm. NS21(5):40 May 1981] (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) [JAPhA. NS52(4):458; July/August 2012] (Reviewed 2017)

**2012, 1981**

### **Pharmacist Training in Physical Assessments**

APhA supports education and training by schools and colleges of pharmacy, as well as providers of continuing pharmacy education, to prepare pharmacists to perform physical assessments of patients.

[Am Pharm. NS21(5):40 May 1981] (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) [JAPhA. NS52(4):458; July/August 2012] (Reviewed 2017)

**2009**

### **Non-FDA-Approved Drugs and Patient Safety**

1. The American Pharmacists Association calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackaged marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing regulatory and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/medical education programs and drug information compendia.

[JAPhA. NS49(4):492; July/August 2009] (Reviewed 2014) (Reviewed 2019)

**2005, 1997**

### **Complementary/Alternative Medications and Integrative Health**

1. APhA supports pharmacists using professional judgment to make informed decisions regarding the appropriateness of use or the sale of complementary and alternative medicines.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety, and possible interactions.

[JAPhA. NS37(4): July/August 1997] (Reviewed 2002) [JAPhA. NS45(5):556–557; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2005, 1988**

### **Pharmaceutical Biotechnology Products**

APhA recognizes the urgent need for education and training of pharmacists and student pharmacists relative to the therapeutic and diagnostic use of pharmaceutical biotechnology products. APhA, therefore, supports the continuing development and implementation of such education and training.

[Am Pharm. NS28(6):394; June 1988] [JAPhA. NS45(5):559; September/October 2005] (Reviewed 2006) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Reviewed 2017)

**2001**

### **Credentialing and Pharmaceutical Care**

1. APhA should continue to assist in the unification of the profession and the development of a national strategy by its continued support of the Council on Credentialing in Pharmacy as the body responsible for the leadership, standards, public information, and coordination of the professions voluntary credentialing programs.
2. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should provide competence-based material and testing via technology, such as the APhA website and state association websites, to further the profession's self-assessment.
3. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should develop the necessary products and programs to educate the public, insurers, and health professionals on credentialing and make them available to state associations at cost.
4. APhA supports the development, on a continuing basis, of programs such as Project IMPACT, that provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.

[JAPhA. NS41(5)[suppl 1]:S8; September/October 2001] (Reviewed 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**1987**

### **Drug Product Equivalence**

APhA shall continue to support educational programs for pharmacists on issues regarding generic drugs.

[Am Pharm. NS27(6):424; June 1987] (Reviewed 2003) (Reviewed 2006) (Reviewed 2007) (Reviewed 2012)

**1981**

### **Pharmacist Training in Medical Technology**

1. APhA supports the education and training of pharmacists in the ordering and interpretation of laboratory tests as they may relate to the usage, dosing, and administration of drugs.
2. APhA opposes requiring certification of pharmacists as medical technologists for the practice of pharmacy.

[Am Pharm. NS21(5):40 May 1981] (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2017)

## *Continuing Education*

**2020, 2015**

### **Integrated Nationwide Prescription Drug Monitoring Program**

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.

3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for
  - (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud;
  - (b) providing focused provider education and patient referral to treatment programs; and
  - (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

[JAPhA. N55(4):364; July/August 2015] [JAPhA. 2020;60(5):e10]

## 2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and nonpunitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

[JAPhA. N55(4):364; July/August 2015] [Reviewed 2019]

## 2014 The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air regulations for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

[JAPhA. 54(4):358; July/August 2014] [Reviewed 2019]

2009

### **Health Information Technology**

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the definition, development, and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, the certification of systems, and the integration of medication use systems with health information technology.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2010] [Reviewed 2013] [Reviewed 2014] [Reviewed 2015] [Reviewed 2019]

2009

### **Pharmacist's Role in Patient Safety**

1. It is APhA's position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and postmarketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized, and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, nonpunitive, easily accessible, and user friendly for all providers within the health care system.
6. APhA supports the elimination of handwritten prescriptions or medication orders.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2010] [Reviewed 2015] [Reviewed 2019]

2005

### **Continuing Professional Development**

1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to life-long learning, to support pharmacist's efforts to maintain professional competence in their practice.
2. APhA should work with appropriate organizations to provide self-assessment and plan development tools. APhA shall help identify and facilitate access to quality educational programs.
3. Employers should foster and support pharmacist participation in continuing professional development.
4. Continuing professional development is a learning process that requires full participation to achieve desired individual outcomes. To facilitate that participation, each pharmacist controls disclosure of their individual assessments and outcomes.

[JAPhA. NS45(5):554; September/October 2005] [Reviewed 2006] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

2005, 1992

### **Cross-Discipline Accreditation of Continuing Education**

1. APhA supports the acceptance, for pharmacy continuing education credit of relevant, quality programs offered by other health-related continuing education providers.
2. APhA supports the acceptance of relevant programs offered by the Accreditation Council for Pharmacy Education (ACPE)-accredited providers to meet continuing education requirements in other health disciplines.

[Am Pharm. NS32(6):515; June 1992] [Reviewed 2003] [JAPhA. NS45(5):560; September/October 2005] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

2003, 1997

### **Continued Competence Assessment Examination**

1. APhA should develop, in cooperation with other state and national associations, a voluntary process for self-assessing pharmaceutical care competence.
2. APhA opposes regulatory bodies utilizing continuing competence examinations as a requirement for renewal of a pharmacist's license.
3. APhA supports programs that measure and evaluate pharmacist competence based on established valid standards.

[JAPhA. NS37(4):460; July/August 1997] [JAPhA. NS43(5);Suppl.1:S58; September/October 2003] (Reviewed 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2011) (Reviewed 2016)

2003, 1974

### **Continuing Education**

APhA strongly endorses continuing education for pharmacists.

[JAPhA. NS14:494 September 1974] [JAPhA. NS43(5);Suppl.1:S58; September/October 2003] (Reviewed 2005) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

1982

### **Use of Academic and Continuing Education Credit**

1. APhA supports the award of continuing education credit for the successful completion of academic credit courses within the scope of pharmacy practice under circumstances that preserve the integrity of both the academic and the continuing education credit.
2. APhA endorses the development and implementation by colleges of pharmacy and other appropriate organizations, of standards and mechanisms by which academic credit can be awarded for successful completion of continuing education courses under circumstances that preserve the integrity of the academic credit.

[Am Pharm. NS22(7):33; July 1982] (Reviewed 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

1975

### **Pharmacists' Responsibility for Continuing Competence**

APhA advocates that pharmacists maintain their professional competence throughout their professional careers.

[JAPhA. NS15:336. June 1975] (Reviewed 2001) (Reviewed 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

## *Degree/Designation*

2011, 2003

### **Distance Education in First Professional Pharmacy Degree Programs**

1. Distance education components of first professional pharmacy degree programs must be constructed in a way to ensure socialization into the profession and understanding the ethos and essence of the profession, as such development is primarily derived through practical experience and interaction with faculty, colleagues, and patients.
2. APhA expects the Accreditation Council for Pharmacy Education to develop, maintain, and enforce applicable standards to ensure students trained in distance education programs achieve the same educational and professional competencies as students in onsite programs.

[JAPhA. NS43(5)(suppl 1):S56; September/October 2003] (Reviewed 2006) [JAPhA. NS51(4) 482; July/August 2011] (Reviewed 2016)

1991

### **Doctor of Pharmacy Attainment through Nontraditional Mechanisms**

1. APhA encourages schools and colleges of pharmacy to consider, in their strategic planning process, offering nontraditional postbaccalaureate Doctor of Pharmacy degree programs. Issues to be considered in such planning should include at least the following:
  - (a) entry requirements,
  - (b) educational and financial resources, and
  - (c) competency evaluation for course credit.
2. APhA recommends that nontraditional Doctor of Pharmacy degree programs have competency outcomes for graduates equal to those in traditional programs.

[Am Pharm. NS31(6):28; June 1991] (Reviewed 2003) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

**2013, 2008**

### **Pharmacy Practice–Based Research Networks**

1. APhA supports establishment of pharmacy practice–based research networks (PBRNs) to strengthen the evidence base in support of pharmacists' patient care services.
2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional, and nationwide networks for performing pharmacy practice–based research.
3. APhA encourages pharmacy residency programs to actively participate in pharmacy PBRNs (practice-based research networks).

[JAPhA. NS48(4):471; July/August 2008] [JAPhA. 53(4) 366; July/August 2013] [Reviewed 2018]

**2013, 2008**

### **Residency Training for Pharmacists**

1. APhA urges continued growth in the number of accredited pharmacy residency positions in all practice settings to better meet the future health care needs of the nation.
2. APhA encourages active involvement of schools and colleges of pharmacy in the development and advancement of accredited pharmacy practice residency programs.
3. APhA advocates for the allocation of adequate funding for accredited pharmacy residencies in all practice settings by governmental and other entities.
4. APhA supports postgraduate training for new PharmD graduates.
5. APhA supports accreditation of all pharmacy residency programs by federally recognized accrediting bodies to ensure quality training experiences.

[JAPhA. NS48(4):470; July/August 2008] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2018]

**2010**

### **Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities That Include Pharmacies**

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2015]

**2010**

### **Introductory Pharmacy Practice Experience**

APhA supports a collaborative effort amongst stakeholders (e.g., professional pharmacy organizations, deans, faculty, preceptors, and student pharmacists) to develop and implement a nationally defined set of competencies to assess the successful completion of introductory pharmacy practice experiences (IPPEs). APhA believes that these competencies should reflect the professional knowledge, attitudes, and skills necessary for entry into advanced pharmacy practice experiences (APPEs).

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2015]

**2008**

### **Experiential Education**

2. APhA encourages the American Association of Colleges of Pharmacy (AACCP), in collaboration with state boards of pharmacy, practitioner organizations, and other stakeholders, to develop national standardization among schools and colleges of pharmacy to improve the quality of student pharmacists' experiential education. This standardization should be adopted by all schools and colleges of pharmacy and should include
  - (a) a preceptor training program;
  - (b) a model instrument for preceptors to evaluate student pharmacist performance in required pharmacy practice experiences;

- (c) a set of quality indicators for each required pharmacy practice experience; and
  - (d) a report of quality indicator outcomes made available to all schools and colleges of pharmacy, faculty, and current and prospective students.
3. APhA urges schools and colleges of pharmacy to dedicate adequate and equitable financial and human resources to experiential education.

[JAPhA. NS48(4):470; July/August 2008] [Reviewed 2013] [Reviewed 2018]

**2005**

### **Regulation of Student Pharmacists' Practice Experience**

1. APhA encourages state boards of pharmacy to use the title “student pharmacist” to identify all students enrolled in their professional years of pharmacy education in an Accreditation Council for Pharmacy Education (ACPE) accredited program.
2. APhA encourages state boards of pharmacy to permit a student pharmacist to perform the duties of a pharmacist within the applicable state’s scope of practice under a pharmacist’s supervision. Preceptors shall consider the experience and education of student pharmacists when providing pharmacy practice opportunities.

[JAPhA. NS45(5):554; September/October 2005] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009] [Reviewed 2013] [Reviewed 2018]

## *Pharmacy School Curriculum*

**2019**

### **Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians**

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are victims of firearm-related violence to seek the help of counselors and other trained mental health professionals.

[JAPhA. 59(4):e17; July/August 2019]

**2019**

### **Patient-Centered Care of People Who Inject Nonmedically Sanctioned Psychotropic or Psychoactive Substances**

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with injection drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists’ roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and postexposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who inject nonmedically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.

[JAPhA. 59(4):e17; July/August 2019]

2018

### **Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases**

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

[JAPhA. 58(4):356; July/August 2018]

2018, 2005, 1990

### **Pharmacy Schools' Curriculum and Contemporary Pharmacy Needs**

1. APhA supports adopting and maintaining continuous quality improvement processes at the national school/college level to identify differences between contemporary pharmacy practice and curriculum offerings, and to provide information and resources to encourage up-to-date curricula.
2. APhA encourages pharmacists to cooperate with schools and colleges of pharmacy by participating as preceptors and permitting their practices to be used as experiential sites.

[Am Pharm. NS30(6):45; June 1990] [Reviewed 2001] [Reviewed 2003] [JAPhA. NS45(5):560; September/October 2005] [Reviewed 2006] [Reviewed 2008] [Reviewed 2013] [JAPhA. 58(4):356; July/August 2018]

2018

### **Use of Genomic Data within Pharmacy Practice**

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct to consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

2016, 2005, 1995

### **Professional Development of Student Pharmacists**

1. APhA believes that it is essential to integrate professionalism throughout a student pharmacist's educational experience.
2. APhA will assist schools and colleges of pharmacy to develop and utilize recruitment materials that emphasize the professional role and responsibilities associated with the provision of pharmaceutical care.
3. APhA supports schools and colleges of pharmacy interviewing candidates during the admissions process to assess their characteristics for the potential for development of professional attitudes and behaviors.

4. APhA recommends that schools and colleges of pharmacy administer the model pledge of professionalism, as developed by the APhA-ASP/American Association of Colleges of Pharmacy Council of Deans Task Force on Professionalism, to all student pharmacists.
5. APhA encourages schools and colleges of pharmacy and the American Association of Colleges of Pharmacy to develop and implement ongoing programs for faculty, staff, preceptors, and other mentors to enhance their ability to serve as role models and teach professionalism.
6. APhA supports the continuation of a forum for faculty, students, preceptors, and others to establish and foster mentor relationships.

[Am Pharm. NS35(6):36; June 1995] (Reviewed 2003) [JAPhA. NS45(5):554; September/October 2005] (Reviewed 2006) (Reviewed 2011) [JAPhA. 56(4):379; July/August 2016]

## **2015 Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care**

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download, and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and nonpunitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

[JAPhA. N55(4):364; July/August 2015] (Reviewed 2019)

## **2014 Use of Social Media**

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2010

### **Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities That Include Pharmacies**

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2015)

2010

### **Introductory Pharmacy Practice Experience**

APhA supports a collaborative effort amongst stakeholders (e.g., professional pharmacy organizations, deans, faculty, preceptors, and student pharmacists) to develop and implement a nationally defined set of competencies to assess the successful completion of introductory pharmacy practice experiences (IPPEs). APhA believes that these competencies should reflect the professional knowledge, attitudes, and skills necessary for entry into advanced pharmacy practice experiences (APPEs).

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2015)

2009

### **Health Information Technology**

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the definition, development, and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, the certification of systems, and the integration of medication use systems with health information technology.

[JAPhA. NS49(4):492; July/August 2009] (Reviewed 2010) (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (Reviewed 2019)

2009

### **Pharmacist's Role in Patient Safety**

1. It is APhA's position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and postmarketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized, and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, nonpunitive, easily accessible, and user friendly for all providers within the health care system.
6. APhA supports the elimination of handwritten prescriptions or medication orders.

[JAPhA. NS49(4):492; July/August 2009] (Reviewed 2010) (Reviewed 2015) (Reviewed 2019)

2005

### **Regulation of Student Pharmacists' Practice Experience**

1. APhA encourages state boards of pharmacy to use the title “student pharmacist” to identify all students enrolled in their professional years of pharmacy education in an Accreditation Council for Pharmacy Education (ACPE) accredited program.
2. APhA encourages state boards of pharmacy to permit a student pharmacist to perform the duties of a pharmacist within the applicable state’s scope of practice under a pharmacist’s supervision. Preceptors shall consider the experience and education of student pharmacists when providing pharmacy practice opportunities.

[JAPhA. NS45(5):554; September/October 2005] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009] [Reviewed 2013] [Reviewed 2018]

1993

### **Payment System Reform Curriculum**

APhA encourages the colleges and schools of pharmacy to incorporate the concept of payment system reform throughout the curricula for all professional programs and should work with pharmacy organizations to ensure the integration of these concepts into practitioners’ continuing development.

[Am Pharm. NS33(7):54; July 1993] [Reviewed 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

1988

### **Professional Ethics in Educational Curricula and Practice**

APhA supports the incorporation of professional ethics instruction in pharmacy curricula and postgraduate continuing education and training.

[Am Pharm. NS28(6):394; June 1988] [Reviewed 2003] [Reviewed 2005] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

1984

### **Primary and Secondary Education in Science, Mathematics, and English**

APhA supports efforts to improve education at the primary and secondary school levels, particularly in the areas of science, mathematics, and English.

[Am Pharm. NS24(7):60; July 1984] [Reviewed 2003] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

## **EMPLOYER/EMPLOYEE RELATIONS**

### *Other Employment Issues*

2019

### **Qualification Standards for Pharmacists**

APhA adamantly opposes the basic education requirement within the Office of Personnel Management’s Classification and Qualifications – General Schedule Qualification Standard – Pharmacy Series, 0660, requiring a Doctor of Pharmacy degree as the minimum qualifications to practice pharmacy that are inconsistent with pharmacist licensure requirements by state boards of pharmacy.

[JAPhA. 59(4):e17; July/August 2019]

2017, 2012, 1989

### **Equal Rights and Opportunities for Pharmacy Personnel**

APhA reaffirms its unequivocal support of equal opportunities for employment and advancement, compensation, and organizational leadership positions. APhA opposes discrimination based on sex, gender identity or expression, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.

[Am Pharm. NS 29(7):464; July 1989] [Reviewed 2001] [Reviewed 2007] [JAPhA. NS52(4):459; July/August 2012] [JAPhA. 57(4):441; July/August 2017]

2013, 2009

### **Independent Practice of Pharmacists**

1. APhA recommends that health plans and payers contract with and appropriately compensate individual pharmacist providers for the level of care rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to the independent practice of pharmacists when those laws and rules are consistent with APhA policy.

3. APhA, recognizing the positive impact that pharmacists can have in meeting unmet needs and managing medical conditions, supports the adoption of laws and regulations and the creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services, including prescribing, as part of the health care team.  
[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2012] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2018]

**2012, 2001, 1969**

### **Pharmacist Workforce Census**

1. APhA recognizes the need for an ongoing census of pharmacists to establish and track changes in workforce demographics and practice characteristics.
2. APhA urges the federal government or other stakeholders to establish funding mechanisms to conduct an ongoing census of pharmacists to establish and track changes in workforce demographics and practice characteristics.

[JAPhA. NS9:361; July 1969] [JAPhA. NS41(5);Suppl.1:S9; September/October 2001] [Reviewed 2007] [JAPhA. NS52(4):458; July/August 2012] [Reviewed 2017]

**2011**

### **Requiring Influenza Vaccination for All Pharmacy Personnel**

APhA supports an annual influenza vaccination as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination).

[JAPhA. NS51(4):482 July/August 2011] [Reviewed 2012] [Reviewed 2017]

**2008**

### **Internet Access by Pharmacists**

APhA supports ready access to Internet resources by pharmacists at their practice sites to facilitate delivery of patient care and to support professional development.

[JAPhA. NS 48(4):471; July/August 2008] [Reviewed 2013] [Reviewed 2018]

**2007**

### **Pharmacy Personnel Immunization Rates**

1. APhA supports efforts to increase immunization rates of health care professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for health care workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (e.g., physicians, nurses, police) and prioritize pharmacists to receive medications and immunizations.

[JAPhA. NS45(5):580; September/October 2007] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

**2001**

### **Employee Benefits**

2. APhA encourages employers to offer benefit packages that provide dependent-care benefits, including, but not limited to, flexible spending accounts, voucher systems, referral services, onsite dependent care, and negotiated discounts for use of day care facilities, to improve workforce conditions.

[JAPhA. NS(5);Suppl.1:S10; September/October 2001] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017] [Reviewed 2019]

**1979**

### **Consideration of the Equal Rights Amendment**

APhA supports efforts to ensure equal rights of all persons.

[Am Pharm. NS19(7):60; June 1979] [Reviewed 2009] [Reviewed 2014] [Reviewed 2018]

## *Productivity Requirements*

**2018**

### **Pharmacist Workplace Environment and Patient Safety**

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.

3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment policies that support the safe provision of medications and delivery of effective patient care.
  4. APhA urges pharmacy practice employers to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
  5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negative impact patient safety.
  6. APhA opposes retaliation against pharmacy staff for reporting workplace issues that may negatively impact patient safety.
- [JAPhA. 58(4):355; July/August 2018] [Reviewed 2020]

**1999, 1970**

### **Unionization of Pharmacists: State Participation in Employer/Employee Relations**

The committee endorses the recommendations in the Provisional Policy Statement on Employment Standards submitted by the Board of Trustees at the special meeting of the House of Delegates in November 1969. The committee recommends that any change in this statement to provide that APhA function as a collective bargaining unit be rejected.

[JAPhA. NS10:353; June 1970] [JAPhA. 39(4):447; July/August 1999] [Reviewed 2001] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

## *Unionization*

**2012, 1999**

### **Collective Bargaining/Unionization**

1. APhA supports pharmacists' participation in organizations that promote the discretion or professional prerogatives exercised by pharmacists in their practice, including the provision of patient care.
2. APhA supports the rights of pharmacists to negotiate with their respective employers for working conditions that will foster compliance with the standards of patient care as established by the profession.

[JAPhA. 39(4):447; July/August 1999] [Reviewed 2001] [Reviewed 2007] [JAPhA. NS52(4):458; July/August 2012] [Reviewed 2017] [Reviewed 2019] [Reviewed 2020]

**1999, 1971**

### **Unionization of Pharmacists**

1. The committee recommends that no change be made in the present policy of APhA with regard to becoming a collective bargaining unit.
2. The committee recommends that APhA continue its educational efforts concerning the mutual responsibilities of the employer and employee pharmacist inherent in the employment relationship.
3. The committee recommends that APhA continue to urge state associations to develop employee/employer relations committees to
  - (a) Study all aspects of both the professional and employment relationships that exist between the employer and the employee;
  - (b) Develop and recommend guidelines to provide direction and guidance to both the employed pharmacist and the employer in developing a mutually acceptable relationship;
  - (c) Conduct necessary surveys designed to provide information on salaries, benefits, and specific problems with attention given to possible regional variations in the data obtained; and
  - (d) Consider the establishment of an employment standards committee where feasible in each appropriate area of the state to act in an advisory and/or arbitrating capacity on matters pertaining to employment standards and employment grievances.
4. The committee recommends that colleges of pharmacy include the subject of employer/ employee relations within an appropriate course of the curriculum.

[JAPhA. NS11:273 May 1971] [JAPhA. 39(4):447; July/August 1999] [Reviewed 2001] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

2020

### **Protecting Pharmacy Personnel During Public Health Crisis**

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as “frontline providers” who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

[JAPhA. 2020;60(5):e11]

2019

### **Pharmacist and Pharmacy Personnel Safety and Well-Being**

1. APhA calls for employers to develop policies and resources to support pharmacy personnel’s ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.

[JAPhA. 59(4):e17; ; July/August 2019]

2019

### **Pharmacists’ Role in Mental Health and Emotional Well-Being**

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for, or currently experiencing, a mental health crisis.
2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for all pharmacy personnel to engage and assist individuals regarding mental health and emotional well-being.
3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.

[JAPhA. 59(4):e16;; July/August 2019]

2018

### **Pharmacist Workplace Environment and Patient Safety**

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy practice employers to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may have a negatively impact patient safety.
6. APhA opposes retaliation against pharmacy staff for reporting workplace issues that may negatively impact patient safety.

[JAPhA. 58(4):355; July/August 2018] (Reviewed 2020)

2012, 2007, 1970

### **Employment Standards Policy Statement**

The employment relationship between pharmacists and their employers must start with the principle that pharmacists have a professional, inherent right to practice in a manner that will engender self-respect in pursuit of their professional and economic objectives.

It is the policy of APhA to further the following basic employment standards:

1. Employers are obligated to respect the professional status, privileges, and responsibilities of employed pharmacists.
2. Employers are obligated to provide working conditions that enhance the ability of employed pharmacists to utilize their full professional capacity in providing patient care service to the public.

3. Employers are obligated to provide employed pharmacists opportunities to increase their professional knowledge and experience.
4. Employers are obligated to fairly compensate employed pharmacists commensurate with their duties and performances. Such compensation should include benefits generally available to other professionals including, but not limited to, vacation, sick leave, insurance plans, and retirement programs.
5. Employed pharmacists are obligated to use their best efforts to further the services offered to the public by their employers.
6. Employed pharmacists are obligated to unhesitatingly bring to the attention of their employers all matters that will assist the employers in maintaining professional standards and successful practices.
7. Employed pharmacists are obligated, when negotiating compensation, to consider not only prevailing economic conditions in their community, but also their economic position relative to other health care professionals.
8. Employed pharmacists are obligated to recognize that their responsibility includes not depriving the public of their patient care services by striking in support of their economic demands or those of others.
9. Both employers and employed pharmacists are obligated to reach and maintain definite understandings with regards to their respective economic rights and duties by resolving employment issues fairly, promptly, and in good faith.

It is the policy of APhA to support these basic employment standards by:

1. Encouraging and assisting state pharmacists associations and national specialty associations to establish broadly representative bodies to study the subject of professional and economic relations and to establish locally responsive guidelines to assist employers and employed pharmacists in developing satisfactory employment relationships.
2. Encouraging and assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues that may arise.
3. Assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues that may arise.
4. Assisting state pharmacists associations and national specialty associations to develop procedures for mediation or arbitration of disputes that may arise between employers and employed pharmacists so that pharmacists can call on their profession for such assistance when required.
5. Increasing its activities directed towards educating the profession about the mutual employment responsibilities of employers and employed pharmacists.
6. Developing benefits programs wherever possible to assist employers in providing employed pharmacists with economic security.
7. Continuously reminding pharmacists that the future development and status of pharmacy as a health profession rests in their willingness and ability to maintain control of their profession.

[JAPhA. NS10:363; June 1970] (Reviewed 2001) [JAPhA. NS45(5):580 September/October 2007] [JAPhA. NS52(4):458; July/August 2012] (Reviewed 2017) (Reviewed 2018) (Reviewed 2020)

**2004, 1977**

### **Pharmacy Practice: Professional Judgment**

1. APhA supports a pharmacist's right, regardless of place or style of practice, to exercise individual professional judgment and complete authority for those individual professional responsibilities assumed.
2. APhA supports decision-making processes that ensure the opportunity for input by all pharmacists affected by the decisions.

[JAPhA. NS17:463; July 1977] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

**2004, 1994**

### **Sexual Harassment in the Workplace**

1. APhA supports the principle that all work environments and educational settings be free of sexual harassment.
2. APhA recommends all pharmacy practice environments and educational settings have a written policy on sexual harassment prevention and grievance procedures.
3. APhA recommends that every owner/employer in facilities where pharmacists work institute a sexual harassment awareness education and training program for all employees.
4. APhA supports the wide distribution of the model guidelines on "Sexual Harassment Prevention and Grievance Procedures".

[Am Pharm. NS34(6):55; June 1994] (Reviewed 2001) [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2010) (Reviewed 2015)

**2001**

### **Stress and Conflict in the Workplace**

APhA encourages employers to provide pharmacists with the tools required to manage stress and conflict within the workplace.

[JAPhA. NS41(5)[suppl 1]:S9; September/October 2001] (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2019)

# ENVIRONMENTAL CONCERNS

2017

## Drug Disposal Program Involvement

APhA urges pharmacists to expand patient access to secure, convenient, and ecologically responsible drug disposal options, in accordance with the Secure and Responsible Drug Disposal Act of 2010, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in an effort to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

[JAPhA. 57(4):441; July/August 2017]

2014

## The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air regulations for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

[JAPhA. 54(4):358; July/August 2014] (Reviewed 2019)

2013

## Medication Take-Back/Disposal Programs

1. APhA encourages pharmacist involvement in the planning and coordination of medication take-back programs for the purpose of disposal.
2. APhA supports increasing public awareness regarding medication take-back programs for the purpose of disposal.
3. APhA urges public and private stakeholders, including local, state, and federal agencies, to coordinate and create uniform, standardized regulations, including issues related to liability and sustainable funding sources, for the proper and safe disposal of unused medications.
4. APhA recommends ongoing medication take-back and disposal programs.

[JAPhA. 53(4):365; July/August 2013] (Reviewed 2018)

2009

## Medication Disposal

1. APhA encourages appropriate public and private partnerships to accept responsibility for the costs of implementing safe medication disposal programs for consumers. Furthermore, APhA urges DEA to permit the safe disposal of controlled substances by consumers or on their behalf.
2. APhA encourages provision of patient-appropriate quantities of medication supplies to minimize unused medications and unnecessary medication disposal.

[JAPhA. NS49(4):493; July/August 2009] (Reviewed 2012) (Reviewed 2013) (2018)

2007

## Redistribution of Previously Dispensed Medications

1. As a matter of patient safety, APhA opposes the redispensing of a previously dispensed medication once it has been out of the control of a health care professional.
2. APhA supports a public awareness program to explain why the redispensing of a previously dispensed medication once it is out of the control of the health care professional is a public health safety concern.

[JAPhA. NS45(5):580; September/October 2007] (Reviewed 2012) (Reviewed 2017)

2007, 1992

## Recycling of Pharmaceutical Packaging

APhA supports aggressive research and development by pharmacists, pharmaceutical manufacturers, waste product managers, and other appropriate parties of mechanisms to increase recycling of nonhazardous, pharmaceutical, packaging materials, to reduce unnecessary waste in pharmaceutical product packaging, and to minimize the opportunity for counterfeiters to use discarded packaging.

[Am Pharm. NS32(6):516; June 1992] (Reviewed 2004) [JAPhA. NS45(5):580 September/October 2007] (Reviewed 2012) (Reviewed 2017)

2001

### **Syringe Disposal**

APhA supports collaboration with other interested health care organizations, public and environmental health groups, waste management groups, syringe manufacturers, health insurers, and patient advocacy groups to develop and promote safer systems and procedures for the disposal of used needles and syringes by patients outside of health care facilities.

[JAPhA. NS41(5):Suppl.1:S9; September/October 2001] (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

1990

### **Proper Handling and Disposal of Hazardous Pharmaceuticals and Associated Supplies and Materials**

1. APhA supports the proper handling and disposal of hazardous, pharmaceutical products and associated supplies and materials by health professionals and by patients to whom such products, supplies, and materials are provided.
2. APhA supports involvement with representatives from other health professional organizations, industry, and government to develop recommendations for the proper handling and disposal of hazardous pharmaceuticals and associated supplies and materials.
3. APhA supports the development of educational programs for health professionals and patients on the proper handling and disposal of hazardous pharmaceuticals and associated supplies and materials.

[Am Pharm. NS30(6):45; June 1990] (Reviewed 2004) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2018)

## **ETHICAL ISSUES**

2020

### **Nonexecution-Related Use of Pharmaceuticals in Correctional Facilities**

1. APhA opposes drug manufacturer's refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of inmates.
2. APhA advocates for inmates to have an opportunity, equal to that of noninmates, to access medications that correctional health care providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional health care providers to have opportunity, equal to noncorrectional health care providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of inmates.

[JAPhA. 2020;60(5):e11]

2019

### **Referral System for the Pharmacy Profession**

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

[JAPhA. 59(4):e16; July/August 2019]

2015

### **Pharmacist Participation in Executions**

The American Pharmacists Association discourages pharmacist participation in executions on the basis that such activities are fundamentally contrary to the role of pharmacists as providers of health care.

[JAPhA. 55(4):365; July/August 2015]

2011

### **Potential Conflicts of Interest in Pharmacy Practice**

1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

[JAPhA. NS51(4):482;; July/August 2011] (Reviewed 2016)

2004, 1998

### **Pharmacist Conscience Clause**

1. APhA recognizes the individual pharmacist's right to exercise conscientious refusal and supports the establishment of systems to ensure patient's access to legally prescribed therapy without compromising the pharmacist's right of conscientious refusal.
2. APhA shall appoint a council on an as needed basis to serve as a resource for the profession in addressing and understanding ethical issues.

[JAPhA. 38(4):417; July/August 1998] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2010) (Reviewed 2015)

2004, 1985

### **Pharmacist Involvement in Execution by Lethal Injection**

1. APhA opposes the use of the term "drug" for chemicals when used in lethal injections.
2. APhA opposes laws and regulations that mandate or prohibit the participation of pharmacists in the process of execution by lethal injection.

[Am Pharm. NS25(5):51 May 1985] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2010) (Reviewed 2015)

2004, 1997

### **Physician-Assisted Suicide**

1. APhA supports informed decision-making based upon the professional judgment of pharmacists, rather than endorsing a particular moral stance on the issue of physician-assisted suicide.
2. APhA opposes laws and regulations that mandate or prohibit the participation of pharmacists in physician-assisted suicide.

[JAPhA. NS37(4):459; July/August 1997] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2010) (Reviewed 2015)

1994

### **Code of Ethics for Pharmacists**

The Code of Ethics for Pharmacists was adopted by the membership of the American Pharmacist Association (then the American Pharmaceutical Association) on October 27, 1994.

#### **Preamble**

Pharmacists are health professionals who assist individuals in making the best use of medications. This Code, prepared and supported by pharmacists, is intended to state publicly the principles that form the fundamental basis of the roles and responsibilities of pharmacists. These principles, based on moral obligations and virtues, are established to guide pharmacists in relationships with patients, health professionals, and society.

#### **I. A pharmacist respects the covenant relationship between the patient and pharmacist.**

Considering the patient-pharmacist relationship as a covenant means that a pharmacist has moral obligations in response to the gift of trust received from society. In return for this gift, a pharmacist promises to help individuals achieve optimum benefit from their medications, to be committed to their welfare, and to maintain their trust.

#### **II. A pharmacist promotes the good of every patient in a caring, compassionate, and confidential manner.**

A pharmacist places concern for the well-being of the patient at the center of professional practice. In doing so, a pharmacist considers needs stated by the patient as well as those defined by health science. A pharmacist is dedicated to protecting the dignity of the patient. With a caring attitude and a compassionate spirit, a pharmacist focuses on serving the patient in a private and confidential manner.

- III. **A pharmacist respects the autonomy and dignity of each patient.**  
A pharmacist promotes the right of self-determination and recognizes individual self-worth by encouraging patients to participate in decisions about their health. A pharmacist communicates with patients in terms that are understandable. In all cases, a pharmacist respects personal and cultural differences among patients.
- IV. **A pharmacist acts with honesty and integrity in professional relationships.**  
A pharmacist has a duty to tell the truth and to act with conviction of conscience. A pharmacist avoids discriminatory practices, behavior or work conditions that impair professional judgment, and actions that compromise dedication to the best interests of patients.
- V. **A pharmacist maintains professional competence.**  
A pharmacist has a duty to maintain knowledge and abilities as new medications, devices, and technologies become available and as health information advances.
- VI. **A pharmacist respects the values and abilities of colleagues and other health professionals.**  
When appropriate, a pharmacist asks for the consultation of colleagues or other health professionals or refers the patient. A pharmacist acknowledges that colleagues and other health professionals may differ in the beliefs and values they apply to the care of the patient.
- VII. **A pharmacist serves individual, community, and societal needs.**  
The primary obligation of a pharmacist is to individual patients. However, the obligations of a pharmacist may at times extend beyond the individual to the community and society. In these situations, the pharmacist recognizes the responsibilities that accompany these obligations and acts accordingly.
- VIII. **A pharmacist seeks justice in the distribution of health resources.**  
When health resources are allocated, a pharmacist is fair and equitable, balancing the needs of patients and society.

[Adopted October 27, 1994]

1991

### **Biotechnology**

APhA encourages the development of appropriate educational materials and guidelines to assist pharmacists in addressing the ethical issues associated with the appropriate use of biotechnology-based products.

[Am Pharm. NS31(6):29; June 1991] (Reviewed 2004) (Reviewed 2007) (Reviewed 2010) (Reviewed 2015) (Reviewed 2016) (Reviewed 2017)

1989

### **Ethics and Technology**

APhA, in recognition of pharmacists' professional and ethical responsibility to society, endorses the consideration of ethical principles in the design, conduct, and application of scientific research.

[Am Pharm. NS29(1):76; January 1989] (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

## **FEDERAL PROGRAMS AND POLICIES**

2020, 2015

### **Integrated Nationwide Prescription Drug Monitoring Program**

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).

6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for
  - (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud;
  - (b) providing focused provider education and patient referral to treatment programs; and
  - (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

[JAPhA. N55(4):364; July/August 2015] [JAPhA. 2020;60(5):e10]

**2020**

### **Nonexecution-Related Use of Pharmaceuticals in Correctional Facilities**

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of inmates.
2. APhA advocates for inmates to have an opportunity, equal to that of noninmates, to access medications that correctional health care providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional health care providers to have opportunity, equal to noncorrectional health care providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of inmates.

[JAPhA. 2020;60(5):e11]

**2020**

### **Protecting Pharmaceuticals as a Strategic Asset**

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for regulatory and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.
8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

[JAPhA. 2020;60(5):e9]

**2019**

### **Consolidation Within Health Care**

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
  - Enhance patient experience and safety,
  - Improve population health,
  - Reduce health care costs, and
  - Improve the work life of health care providers.

3. APhA asserts that the scope of review by federal agencies must have a focus on the impact of health care mergers and acquisitions on patient access and the provision of care to ensure optimal patient outcomes. Therefore, APhA calls for
  - Reform of the pre–health care mergers and acquisitions process,
  - Implementation of an ongoing post–health care mergers and acquisitions evaluation process to preserve patient choice and access to established patient–pharmacist relationships, and
  - Continuous transparent dialogue among stakeholders throughout the process.
4. APhA calls for the Federal Trade Commission (FTC) to develop a task force to monitor health care mergers and acquisitions activity.

[JAPhA. 59(4):e16; July/August 2019]

## 2019

### **Qualification Standards for Pharmacists**

APhA adamantly opposes the basic education requirement within the Office of Personnel Management’s Classification and Qualifications – General Schedule Qualification Standard – Pharmacy Series, 0660, requiring a Doctor of Pharmacy degree as the minimum qualifications to practice pharmacy that are inconsistent with pharmacist licensure requirements by state boards of pharmacy.

[JAPhA. 59(4):e17; July/August 2019]

## 2018, 2013

### **Revisions to the Medication Classification System**

1. APhA supports the Food and Drug Administration’s (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients’ relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws and regulations to facilitate pharmacists’ implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA’s approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists’ input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA’s defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA’s approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA’s defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA’s defined conditions of safe use programs.

[JAPhA. 53(4):365; July/August 2013] [JAPhA. 58(4):356; July/August 2018]

## 2016

### **Biologic, Biosimilar, and Interchangeable Biologic Drug Products**

1. APhA urges the development of programs and policies that facilitate patient access to and affordability of biologic products.
2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.
3. APhA recognizes the Food and Drug Administration’s (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.
4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.
5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.

[JAPhA. 56(4):369; July/August 2016]

2016, 2011

## **Pharmacists as Providers Under the Social Security Act**

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services.

[JAPhA. NS51(4):482;; July/August 2011] [JAPhA. 56(4):379;; July/August 2016]

2013

## **Ensuring Access to Pharmacists' Services**

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.

[JAPhA. 53(4):365; July/August 2013] (Reviewed 2018) (Reviewed 2019)

2013

## **Pharmacists Providing Primary Care Services**

APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.

[JAPhA. 53(4):365; July/August 2013] (Reviewing 2018) (Reviewed 2019) (Reviewed 2020)

2012

## **Controlled Substances Regulation and Patient Care**

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
  - (a) the burdens on health care providers,
  - (b) the cost of health care delivery, and
  - (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

[JAPhA. NS52(4):457;; July/August 2012] (Reviewed 2015)

2012

## **Drug Supply Shortages and Patient Care**

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.
2. APhA supports revising current laws and regulations that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.
3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.

4. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.
5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by:
  - (a) creating a practice site drug shortage plan as well as policies and procedures,
  - (b) using reputable drug shortage management and information resources in decision making,
  - (c) communicating with patients and coordinating with other health care providers,
  - (d) avoiding excessive ordering and stockpiling of drugs,
  - (e) acquiring drugs from reputable distributors, and
  - (f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.
6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

[JAPhA. NS52(4):457; July/August 2012] (Reviewed 2017)

## **2010 Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities That Include Pharmacies**

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2015)

## **2004, 1980 IRS Drug Deduction**

APhA supports amendment of the federal and state personal income tax laws to permit all personal expenditures for medicines and drugs to be totally deductible and exempt from any exclusionary limits.

[Am Pharm. NS20(7):61; July 1980] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2010) (Reviewed 2015)

## **2004, 1994 Small Business Set-Asides**

APhA encourages all federal agencies (such as the Office of Personnel Management) to eliminate inconsistencies in federal contracts that in any way affect community pharmacies operating as small businesses.

[Am Pharm. NS34(6):60; June 1994] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2010) (Reviewed 2015)

## **1985 Reduction of Federal Laws and Regulations (Paperwork Burden)**

APhA supports the reduction and simplification of laws, regulations, and record-keeping requirements that affect pharmacy practice and are not beneficial in protecting the public welfare.

[Am Pharm. NS25(5):51 May 1985] (Reviewed 2001) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

# FREEDOM OF ACCESS (FREEDOM OF CHOICE)

2020

## **Nonexecution-Related Use of Pharmaceuticals in Correctional Facilities**

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of inmates.
2. APhA advocates for inmates to have an opportunity, equal to that of noninmates, to access medications that correctional health care providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional health care providers to have opportunity, equal to noncorrectional health care providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of inmates.

[JAPhA. 2020;60(5):e11]

2004, 1990

## **Freedom to Choose**

1. APhA supports the patient's freedom to choose a provider of health care services and a provider's right to be offered participation in governmental or other third-party programs under equal terms and conditions.
2. APhA opposes government or other third-party programs that impose financial disincentives or penalties that inhibit the patient's freedom to choose a provider or health care services.
3. APhA supports that patients who must rely upon governmentally financed or administered programs are entitled to the same high quality of pharmaceutical services as are provided to the population as a whole.

[Am Pharm. NS30(6):45; June 1990] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015] [Reviewed 2018]

# HEALTH CARE REFORM

2020

## **Coordination of the Pharmacy and Medical Benefit**

APhA supports coordination of patients' comprehensive pharmacy and medical benefits that allows for provision of and compensation for pharmacists' patient care services; aligns incentives to optimize patient outcomes; streamlines administrative processes; reduces overall health care costs and preserves patients' right to choose providers under their pharmacy and medical benefits.

[JAPhA. 2020;60(5):e10]

2020

## **Providing Affordable and Comprehensive Pharmacy Services to the Underserved**

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower health care costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable law.

[JAPhA. 2020;60(5):e11]

2016, 1994

## **Pharmacy Services Benefits in Health Care Reform**

APhA supports reform of the U.S. health care system and believes that any reform at the state or national level must provide for the following:

1. Universal coverage for pharmacy service benefits that include both medications and pharmacists' services;
2. Specific provisions for the access to and payment for pharmacists' patient care services.
3. A single set of pricing rules, eliminating class-of-trade distinctions, for medications, medication delivery systems, and other equipment so that no payer, patient, or provider is disadvantaged by cost shifting;
4. The right for every American to choose his/her own provider of medications and pharmacists' services and for all pharmacists to participate in the health plans of their choice under equally applied terms and conditions;
5. Quality assurance mechanisms to improve and substantiate the effectiveness of medications and health services;
6. Information and administrative systems designed to enhance patient care, eliminate needless bureaucracy, and provide patients and providers price and quality information needed to make informed patient care decisions;

7. Relief from antitrust laws and regulations to enable pharmacists to establish systems that balance provider needs relative to corporate and governmental interests;
8. Reform in the professional liability system, including caps on noneconomic damages, attorneys' fees, and other measures;
9. Representation on the controlling board of each plan by an active health care practitioner from each discipline within the scope of the plan; and
10. Recognition of the pharmacist's role in delivering primary health care services.

[Am Pharm. NS34(6):58; June 1994] [Reviewed 2004] [Reviewed 2010] [Reviewed 2011] [JAPhA. 56(4):379; July/August 2016] [Reviewed 2018]

**2011**

### **Pharmacist's Role in Health Care Reform**

1. APhA affirms that pharmacists are the medication experts whose accessibility uniquely positions them to increase access to and improve quality of health care while decreasing overall costs.
2. APhA asserts that pharmacists must be recognized as the essential and accountable patient care provider on the health care team responsible for optimizing outcomes through medication therapy management (MTM).
3. APhA asserts the following:
  - (a) Medication Therapy Management Services: Definition and Program Criteria is the standard definition of MTM that must be recognized by all stakeholders.
  - (b) Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, as adopted by the profession of pharmacy, shall serve as the foundational MTM service model.
4. APhA asserts that pharmacists must be included as essential patient care provider and compensated as such in every health care model, including but not limited to, the medical home and accountable care organizations.
5. APhA actively promotes the outcomes-based studies, pilot programs, demonstration projects, and other activities that document and reconfirm pharmacists' impact on patient health and well-being, process of care delivery, and overall health care costs.

[JAPhA. NS51(4):482 July/August 2011] [Reviewed 2016]

**1994**

### **The Scientific Implications of Health Care Reform**

1. APhA advocates that the public and private sectors maintain or increase their level of commitment to ensure adequate resources for both basic and applied research within a reformed health care system.
2. APhA encourages the public and private research communities to preferentially expend resources for the discovery and development of new drugs and technologies that provide substantive, innovative therapeutic advances.
3. APhA advocates an increased emphasis on outcomes research in all areas of health services, including drug and disease-specific research encompassing clinical, economic, and humanistic dimensions (e.g., quality of life, patient satisfaction, ethics) and advocates for action related to conclusions for such research.
4. APhA encourages interdisciplinary collaboration in research efforts within and between the public and private research communities.

[Am Pharm. NS34(6):55; June 1994] [Reviewed 2004] [Reviewed 2005] [Reviewed 2010] [Reviewed 2011] [Reviewed 2016]

## **INTERNET PHARMACY**

**2005, 2004, 1999**

### **Telemedicine/Telehealth/Telepharmacy**

1. APhA supports the pharmacist as the only appropriate provider of telepharmacy services, a component of telehealth, for which compensation should be provided. Telepharmacy is defined as the provision of pharmaceutical care to patients through the use of telecommunications and information technologies.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about telepharmacy and telehealth.
3. APhA shall participate in the ongoing development of the telehealth infrastructure, including but not limited to regulations, standards development, security guidelines, information systems, and compensation.
4. APhA acknowledges that state boards of pharmacy are primarily responsible for the regulation of the practice of telepharmacy, encourages appropriate regulatory action that facilitates the practice of telepharmacy and maintains appropriate guidelines to protect the public health and patient confidentiality.

[JAPhA. 39(4):447; July/August 1999] [JAPhA. NS44(5):551; September/October 2004] [JAPhA. NS45(5):559; September/October 2005] [Reviewed 2009] [Reviewed 2012] [Reviewed 2014] [Reviewed 2019]

# INTERPROFESSIONAL RELATIONS

2020

## Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

[JAPhA. 2020;60(5):e9]

2020

## Pharmaceutical Safety and Access During Emergencies

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

[JAPhA. 2020;60(5):e11]

### *Consumer*

2004, 1970

## Consumer Organizations

APhA, as well as state and local pharmacy organizations, shall continue to establish liaisons with the growing number of consumer groups, attend their meetings, and seek to be included on their programs.

[JAPhA. NS10:350; June 1970] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

### *General Health Care Organizations*

2004, 1975

## Other Health Care Professional Organizations

APhA supports continuing joint action with other health care and professional organizations.

[JAPhA. NS15:331–333; June 1975] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2011] [Reviewed 2016]

1989

## The Joint Commission

1. APhA supports increased interaction with The Joint Commission regarding accreditation standards and procedures pertaining to pharmacy and therapeutics.
2. APhA supports pharmacy representation on appropriate The Joint Commission professional and technical advisory committees.

[Am Pharm. NS29(7):464; July 1989] [Reviewed 2004] [Reviewed 2009] [Modified 2010] [Reviewed 2011] [Reviewed 2016]

## *Mental Health*

2018

### **Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases**

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

[JAPhA. 58(4):356; July/August 2018]

## *Physicians*

2019, 1997

### **Collaborative Practice Agreements**

1. APhA supports the establishment of collaborative practice agreements between pharmacists and other health care professionals designed to optimize patient care outcomes.
2. APhA supports the establishment of collaborative practice agreements between one or multiple pharmacists and one or multiple prescribers or entities.
3. APhA supports state laws that do not require a referral or a prior provider–patient relationship as a prerequisite to access services provided under a collaborative practice agreement.
4. APhA opposes state laws that limit collaborative practice agreements to specific patients.
5. APhA supports state laws that allow for pharmacists’ prescriptive authority.
6. APhA supports state collaborative practice laws that allow all licensed pharmacists, in all practice settings, to establish collaborative practice agreements with other health care professionals or entities.
7. APhA shall promote the establishment and dissemination of guidelines and information to pharmacists and other health care professionals to facilitate the development of collaborative practice agreements.

[JAPhA. NS37(4):459; July/August 1997] [Reviewed 2003] [Reviewed 2007] [Reviewed 2009] [Reviewed 2011] [Reviewed 2012] [Reviewed 2017] [JAPhA. 59(4):e17; July/August 2019] [Reviewed 2020]

2017, 2012

### **Contemporary Pharmacy Practice**

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists’ roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2016] [JAPhA. 57(4):441; July/August 2017] [Reviewed 2019]

2015

### **Antimicrobial Stewardship**

1. APhA supports the role of pharmacists in antimicrobial stewardship in all practice settings.
2. APhA supports pharmacists working in collaboration with others to lead the development and implementation of antimicrobial stewardship programs and initiatives.
3. APhA supports pharmacists advising prescribers and educating patients on the appropriate use of antimicrobials.

[JAPhA. N55(4):365; July/August 2015]

2014

### **Care Transitions**

2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
3. APhA strongly encourages collaboration and shared accountability among patients, family members, caregivers, pharmacists, and other health care providers during care transitions.
4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
6. APhA supports financially viable payment models that recognize the value of pharmacists' services, including, but not limited to, those provided during care transitions.
7. APhA strongly urges the development and implementation of multidisciplinary, interprofessional, and team-based training for health care professionals and students to improve the quality and consistency of care transition services.
8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.

[JAPhA. 54(4):357; July/August 2014] [Reviewed 2019]

2011, 2004, 1963

### **Pharmacists and Other Health Practitioners: Relationships and Compensation Among Health Care Practitioners**

APhA opposes any method that provides an inappropriate sharing of compensation between the prescriber and dispenser.

[JAPhA. NS3:298; June 1963] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [JAPhA. NS51(4):484;; July/August 2011] [Reviewed 2016]

2004, 1965

### **Guidelines for Physician Ownership**

APhA supports efforts to develop guidelines on physician ownership of pharmacies due to the inherent conflict of interest.

[JAPhA. NS5:276; May 1965] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2011] [Reviewed 2016]

## *Public Health*

2011

### **Role and Contributions of the Pharmacist in Public Health**

In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.

[JAPhA. NS51(4) 482; July/August 2011] [Reviewed 2012] [Reviewed 2016] [Reviewed 2020]

2004, 1964

### **Community Health Councils**

APhA encourages pharmacists' active participation in health care organizations within their communities to assist in the public health efforts of community health and foster better community understanding of the profession of pharmacy.

[JAPhA. NS4:428; August 1964] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

1967

## **State and Local Boards of Health**

Because of the broad implications of the pharmacist's role in public health, the committee recommends that pharmacists and pharmacy associations seek to have the state laws amended to require that a pharmacist serve on the state and local boards of health. One part of this effort should be an increased interest on the part of the pharmacist in his local health boards and commissions.

[JAPhA. NS7:324; June 1967] (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

### *Referral Programs*

2019

## **Patient-Centered Care of People Who Inject Nonmedically Sanctioned Psychotropic or Psychoactive Substances**

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with injection drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and postexposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who inject nonmedically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.

[JAPhA. 59(4):e17;; July/August 2019]

2019

## **Referral System for the Pharmacy Profession**

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

[JAPhA. 59(4):e16; July/August 2019]

### *Veterinary Medicine*

2004, 1988

## **Pharmacists' Relationship to Veterinarians**

APhA encourages pharmacists and student pharmacists to become more knowledgeable about veterinary drugs and their usage.

[Am Pharm. NS28(6):395; June 1988] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2010) (Reviewed 2015)

# LABELING

2017

## Indication on Prescription Labels and Medication Safety

APhA supports pharmacists' authority to include a medication's purpose on prescription labels, on the basis of professional knowledge, judgment, and patient preference, using vocabulary that is appropriate for their unique practice sites and that addresses the needs of their specific patient populations.

[JAPhA. 57(4):442; July/August 2017]

2016

## Labeling and Measurement of Oral Liquid Medications

1. APhA supports the use of the milliliter (mL) as the standard unit of measure for oral liquid medications.
2. APhA encourages the mandatory use of leading zeros before the decimal point for amounts of less than one on prescription-container labels for oral liquid medications.
3. APhA discourages the use of trailing zeros after the decimal point for amounts greater than one on prescription-container labels for oral liquid medications.
4. APhA supports access to and universal availability of dosing devices with numeric graduations that correspond to the unit of measure that is on the container's label for oral liquid medications.

[JAPhA. 56(4):369; July/August 2016]

### *Expiration Dating and Drug Storage Instructions*

2012

## Drug Supply Shortages and Patient Care

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.
2. APhA supports revising current laws and regulations that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.
3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.
3. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.
5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by:
  - (a) creating a practice site drug shortage plan as well as policies and procedures,
  - (b) using reputable drug shortage management and information resources in decision making,
  - (c) communicating with patients and coordinating with other health care providers,
  - (d) avoiding excessive ordering and stockpiling of drugs,
  - (e) acquiring drugs from reputable distributors, and
  - (f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.
6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2017]

2004, 1989

## "Beyond-Use Dating" by Pharmacists

APhA recommends that all pharmacists place a "beyond-use date" on the labeling of all medications dispensed to patients as recommended by the U. S. Pharmacopeia–National Formulary or manufacturer.

[Am Pharm. NS29(7):465; July 1989] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

2004, 1971

### **Expiration Dating**

APhA supports manufacturers of prescription and nonprescription drugs including on the package label adequate information regarding storage requirements and a date after which the product should not be used.

[JAPhA. NS11:271; May 1971] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

## *Identification of Drug and Manufacturer*

2012

### **Medication Verification**

APhA encourages including a description of a medication's appearance on the pharmacy label or receipt as a means of reducing medication errors and distribution of counterfeit medications.

[JAPhA. NS52(4):458; July/August 2012] [Reviewed 2017] [Reviewed 2018]

2004, 1980

### **Identification of Prescription Drug Products**

APhA supports a federal legislative or regulatory requirement that a name, trademark, number, or code be included on the drug dosage form.

[Am Pharm. NS20(7):62; July 1980] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

2004, 1969

### **Manufacturer's Name Included on Labels**

APhA supports legislation that would require the name of the actual manufacturer of the dosage forms on all drug products.

[JAPhA. NS9:361; July 1969] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

2004, 1975

### **National Drug Code: Uniform Identification Numbers**

APhA supports modification of the National Drug Code system to provide uniform identification numbers for the same drug entity, dosage form, strength, and quantity in addition to a manufacturer's identification number.

[JAPhA. NS15:332; June 1975] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

2004, 1968

### **Standardized Manufacturers' Control Numbers**

1. APhA encourages manufacturers to adopt a standardized system of control numbers that meets the following guidelines:

- (a) The number should be legible.
- (b) The numbers should be placed in a standard position on the label.
- (c) The date of manufacture should be obvious from the control number.
- (d) The number should be on both the carton and the original container.

[JAPhA. NS8:380; July 1968] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

## *Ingredients*

2019, 2018

### **Gluten Content and Labeling in Medications**

1. APhA supports labeling of all prescription and nonprescription products, as well as dietary supplement products, to indicate the presence of gluten.
2. APhA encourages manufacturers to formulate drug products without use of wheat, barley, rye, or their derivatives whenever possible.
3. APhA supports additional research on the effects of gluten intolerance and celiac malabsorption, particularly as it relates to medication absorption.
4. APhA supports pharmacist education regarding celiac disease and nonceliac gluten sensitivity.
5. APhA encourages the development of analytical methods that can accurately detect lower levels of gluten than the current standard (20 ppm) and for the establishment of evidence-based gluten-free standards for the labeling of foods, excipients, dietary supplements, and prescription and nonprescription products.

[JAPhA. 58(4):356; July/August 2018] [JAPhA. 59(4):e16; July/August 2019] [Reviewed 2020]

2004, 1970

### **Disclosure of Ingredients in Drug Products**

APhA supports legislation or regulation to require a full disclosure of therapeutically inactive as well as active ingredients of all drug products.

[JAPhA. NS10:357; June 1970] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015] [Reviewed 2019]

2000

### **Regulation of Dietary Supplements**

1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other legislation to require that dietary supplement manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.
2. APhA supports the establishment and implementation of clear and effective enforcement policies to remove promptly unsafe or ineffective dietary supplement products from the marketplace.
3. APhA shall work with the FDA to improve dietary supplement product labeling to ensure full disclosure of all product components and their source with associated strengths and recommendations for use in specific patient populations.
4. APhA supports the development and enforcement of dietary supplement good manufacturing practices (GMPs) and compliance with USP/NF standards to ensure quality, safe, contaminant-free products.
5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.

[JAPhA. NS1(9):40; September/October 2000] [Reviewed 2005] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

## **LICENSURE, REGISTRATION, AND REGULATION**

2007

### **Privacy of Pharmacists' Personal Information**

1. APhA supports protecting pharmacist, student pharmacist, and pharmacy technician personal information (e.g. home address, telephone, and personal email address).
2. APhA opposes legislative or regulatory requirements that mandate the publication of pharmacist, student pharmacist and pharmacy technician personal information (e.g., home address, telephone, and personal email address).
3. APhA encourages state boards of pharmacy to remove from their websites personal addresses, phone numbers, email, and other nonbusiness contact information of pharmacists, student pharmacists, and pharmacy technicians.

[JAPhA. NS45(5):580 September/October 2007] [Reviewed 2012] [Reviewed 2017]

### *Composition of State Boards of Pharmacy*

1972

### **Boards of Pharmacy: Consumer Representation**

APhA encourages state pharmaceutical associations to actively seek appointment of lay representation of the public to their respective boards of pharmacy and other health profession licensing and regulatory agencies.

[JAPhA. NS12:281; June 1972] [Reviewed 2004] [Reviewed 2010] [Reviewed 2015]

### *Licensure and Registration of Personnel*

2019

### **Expanding Technician Roles**

1. APhA encourages state boards of pharmacy to develop regulations allowing expanded pharmacy technician roles that allow both technicians and pharmacists to practice at the top of their training and license or certification.
2. APhA supports state board of pharmacy regulations that standardize and set minimum didactic and experiential standards for technicians to allow for functioning in expanded roles.

[JAPhA. 59(4):e17; July/August 2019]

2017

## **Pharmacy Technician Education, Training, and Development**

1. APhA supports the following minimum requirements for all new pharmacy technicians:
  - (a) Successful completion of an accredited or state-approved education and training program.
  - (b) Certification by the Pharmacy Technician Certification Board (PTCB).
2. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, certification, and recertification. APhA encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians. APhA also encourages boards of pharmacy to delineate between pharmacy technicians and student pharmacists for the purposes of education, training, certification, and recertification.
3. APhA recognizes the important contribution and role of pharmacy technicians in assisting pharmacists and student pharmacists with the delivery of patient care.
4. APhA supports the development of resources and programs that promote the recruitment and retention of qualified pharmacy technicians.
5. APhA supports the development of continuing pharmacy education programs that enhance and support the continued professional development of pharmacy technicians.
6. APhA encourages the development of compensation models for pharmacy technicians that promote sustainable career opportunities.

[JAPhA. 57(4):442; July/August 2017]

2004, 1996

## **Technician Licensure and Registration**

APhA recognizes the following definitions with regards to technician licensure and registration:

- (a) Licensure: The process by which an agency of government grants permission an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Within pharmacy, a pharmacist is licensed by a State Board of Pharmacy.
- (b) Registration: The process of making a list or being enrolled in an existing list.

[JAPhA. NS36(6):396; June 1996] [Reviewed 2001] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2008] [Reviewed 2010] [Reviewed 2015] [Reviewed 2018]

2003, 1997

## **Continued Competence Assessment Examination**

1. APhA should develop, in cooperation with other state and national associations, a voluntary process for self-assessing pharmaceutical care competence.
2. APhA opposes regulatory bodies utilizing continuing competence examinations as a requirement for renewal of a pharmacist's license.
3. APhA supports programs that measure and evaluate pharmacist competence based on established valid standards.

[JAPhA. NS37(4):460; July/August 1997] [JAPhA. NS43(5);Suppl.1:S58; September/October 2003] [Reviewed 2005] [Reviewed 2006] [Reviewed 2008] [Reviewed 2011] [Reviewed 2016]

1980

## **Reciprocity**

APhA supports systems of reciprocity that recognize a current license issued by any state and eliminate the requirement for pharmacists to maintain active practice licenses in the states of initial licensure.

[Am Pharm. NS20(7):76; July 1980] [Reviewed 2004] [Reviewed 2010] [Reviewed 2015]

### *Licensure, Registration, and Inspection of Facilities*

2012

## **Controlled Substances Regulation and Patient Care**

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.

4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
  - (a) the burdens on health care providers,
  - (b) the cost of health care delivery, and
  - (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2015]

## 2012

### Registration of Facilities

APhA supports state and federal laws and regulations that require registration with the state boards of pharmacy of all facilities involved in the storage, wholesale distribution, and issuance of legend drugs to patients, provided that such registration does not restrict the pharmacists from providing professional services independent of a facility.

[JAPhA. NS52(4):458; July/August 2012] [Reviewed 2017]

## 2011

### Pharmacy Practice Accreditation

1. APhA should lead the creation of consensus-based, pharmacy profession-developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.
2. APhA urges that accrediting bodies use profession-developed standards for pharmacy.
3. APhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, and affordable, while avoiding duplication and barriers to patient care.
4. APhA opposes mandatory pharmacy accreditation.
5. APhA shall assume the leadership role among stakeholders on the design and implementation of an appropriate process for any new pharmacy accrediting program.
6. APhA supports the appropriate use of data gathered from pharmacy practice monitoring processes to facilitate the advancement of pharmacy practice and quality of patient care.

[JAPhA. NS51(4):482;; July/August 2011] [Reviewed 2016]

## 2010

### Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities That Include Pharmacies

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2015]

## 2008

### Pharmacy Compounding Accreditation

1. APhA reaffirms the 1992 Compounding Activities of Pharmacists policy, which states that APhA affirms that compounding pursuant to or in anticipation of a prescription or diagnostic preparation order is an essential part of health care that is the prerogative of the pharmacist.
2. APhA supports compounding as defined by the Pharmacy Compounding Accreditation Board (PCAB) as a means to meet patient drug therapy needs.
3. APhA opposes compounding when identical medications are commercially and readily available in strength and dosage form to meet patient drug therapy needs.
4. APhA asserts that compounding is subject to regulations and oversight from state boards of pharmacy. APhA urges state boards of pharmacy to identify and take appropriate action against entities who are illegally manufacturing medications under the guise of compounding.

5. APhA supports accreditation of compounding sites by PCAB to ensure patient safety. APhA encourages state boards of pharmacy to recommend accreditation for those sites that engage in more than basic nonsterile compounding as defined by PCAB.
6. APhA supports the development of education, training and recognition programs that enhance pharmacist and student pharmacist knowledge and skills to engage in compounding beyond basic, nonsterile preparations as defined by PCAB.
7. APhA encourages the exploration of a specialty certification in the area of compounding through the Board of Pharmaceutical Specialties (BPS).

[JAPhA. NS48(4):470; July/August 2008] (Reviewed 2009) (Reviewed 2011) (Reviewed 2016)

**2008, 2001**

### **Regulatory Compliance/Regulatory Burden**

APhA supports measures that protect the patient, public, and employees from pharmacy conditions that pose a threat to health.

[JAPhA. NS41(5)[suppl 1]:S9; September/October 2001] [JAPhA. NS48(4):470; July/August 2008] (Reviewed 2013) (Reviewed 2018)

**2004, 1977**

### **Licensing Boards: Inspection of Pharmacies**

1. APhA supports that all noncriminal inspections of pharmacies shall be under the direct control of each state board of pharmacy.
2. APhA recommends that state boards of pharmacy require that all pharmacy inspectors be licensed pharmacists who regularly update their knowledge of pharmacy practice.
3. APhA encourages NABP to develop and maintain uniform guidelines and standards for noncriminal inspections of pharmacies.

[JAPhA. NS17:456; July 1977] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

**2004, 1970**

### **Licensure/Registration of Drug Manufacturers**

APhA supports the requirements that all drug manufacturers must obtain a federal license or registration, conditioned upon an inspection of the manufacturer's facilities before manufacturing is begun.

[JAPhA. NS10:347; June 1970] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2006) (Reviewed 2010) (Reviewed 2015)

**2004, 1978**

### **State Boards of Pharmacy/Inspections**

1. APhA supports inspections of pharmacies and peer review of pharmacists that promote high-quality pharmaceutical service and thereby serve to improve public health.
2. APhA opposes the use of criminal investigative techniques during routine noncriminal pharmacy inspections.
3. APhA supports regulation and inspection by boards of pharmacy of all facilities within a state at which drugs are dispensed, stored, or offered for sale in the same manner as pharmacies.

[Am Pharm. NS18(8):36; July 1978] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2008) (Reviewed 2013) (Reviewed 2018)

**1985**

### **Registration of Facilities Involved in the Storage and Issuing of Legend Drugs to Patients**

APhA supports enactment of state and federal laws and regulations that would require registration with the state boards of pharmacy of all facilities involved in the storage and issuing of legend drugs to patients, provided that such registration does not restrict the pharmacist from providing professional services independent of a facility.

[Am Pharm. NS25(5):51 May 1985] (Reviewed 2004) (Reviewed 2010) (Reviewed 2012) (Reviewed 2013) (Reviewed 2018)

**1985**

### **Regulation of Mobile Facilities**

APhA supports enactment of state and federal laws and regulations that would govern the dispensing and issuing of legend drugs from mobile facilities.

[Am Pharm. NS25(5):51 May 1985] (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

**2017, 2012**

### **Contemporary Pharmacy Practice**

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2016] [JAPhA. 57(4):441; July/August 2017] [Reviewed 2019]

**2012**

### **Controlled Substances Regulation and Patient Care**

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
  - (a) the burdens on health care providers,
  - (b) the cost of health care delivery, and
  - (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2015]

**2004,1991**

### **Updating of State Pharmacy Practice Acts**

1. APhA recommends and supports enactment of state pharmacy practice act revisions enabling pharmacists to achieve the full scope of APhA's Mission Statement for the Pharmacy Profession.
2. APhA supports standards of pharmacy practice reflecting the APhA Mission Statement for the Pharmacy Profession.

[Am Pharm. NS31(6):28; June 1991] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

**2002**

### **National Framework for Practice Regulation**

1. APhA supports state-based systems to regulate pharmacy and pharmacist practice.
2. APhA encourages states to provide pharmacy boards with the following:
  - (a) adequate resources,
  - (b) independent authority, including autonomy from other agencies, and
  - (c) assistance in meeting their mission to protect the public health and safety of consumers.
3. APhA supports efforts of state boards of pharmacy to adopt uniform standards and definitions of pharmacy and pharmacist practice.
4. APhA encourages state boards of pharmacy to recognize and facilitate innovations in pharmacy and pharmacist practice.

[JAPhA. NS2(5)[suppl 1]: 563 ; September/October 2002] [Reviewed 2007] [Reviewed 2008] [Reviewed 2013] [Reviewed 2015] [Reviewed 2020]

2002

### **Professional Practice Regulation**

1. APhA encourages the revision of pharmacy laws to assign the responsibility and accountability to the pharmacy license holder for the operations of the pharmacy, including but not limited to quality improvement, staffing, inventory, and financial activities. Further, APhA supports the responsibility and accountability of the pharmacist for dispensing of the pharmaceutical product and for the provision of pharmaceutical care services.
2. APhA encourages the pharmacy license holder to provide adequate resources and support for pharmacists to meet their professional responsibilities, and for pharmacists to utilize the resources and support appropriately and efficiently. APhA encourages state boards of pharmacy to hold pharmacy license holders accountable for failure to provide such adequate resources and support.

[JAPhA. NS42(5)(suppl 1):S60; September/October 2002] (Reviewed 2007) (Reviewed 2008) (Reviewed 2011) (Reviewed 2016)

## **MAIL SERVICE PRESCRIPTIONS**

2012, 1992

### **Patient Care and Medication Distribution System**

APhA encourages those responsible for practice environments without direct patient/pharmacist contact to use methods to enhance communication, face-to-face interaction, and patient care.

[Am Pharm. NS32(6):515; June 1992] (Reviewed 2001) (Reviewed 2007) [JAPhA. NS52(4) 459; July/August 2012] (Reviewed 2017)

## **MEDICAL AND PHARMACEUTICAL EQUIPMENT AND PRODUCTS**

2020

### **Digital Health Integration in Pharmacy**

1. APhA supports education about digital health technologies and integration in pharmacy practice, in pharmacy school curricula, and for the pharmacy workforce.
2. APhA supports inclusion of pharmacists in the design and development of digital health technologies.
3. APhA supports that digital health technologies be interoperable with and integrated into pharmacy management systems and electronic health records.
4. APhA supports pharmacists applying digital health technologies to optimize patient care outcomes.

[JAPhA. 2020;60(5):e111]

2017

### **Support for Clinically Validated Blood Pressure Measurement Devices**

1. APhA supports the use of manual and automated blood pressure measurement devices that are clinically validated initially and then undergo routine calibration to ensure accurate results.
2. APhA supports regulations and peer-reviewed clinical validation testing for automated blood pressure measurement devices.
3. APhA promotes public awareness of accuracy of automated blood pressure measurement devices.

[JAPhA. 57(4):442; July/August 2017]

2016

### **Labeling and Measurement of Oral Liquid Medications**

1. APhA supports the use of the milliliter (mL) as the standard unit of measure for oral liquid medications.
2. APhA encourages the mandatory use of leading zeros before the decimal point for amounts of less than one on prescription-container labels for oral liquid medications.
3. APhA discourages the use of trailing zeros after the decimal point for amounts greater than one on prescription-container labels for oral liquid medications.
4. APhA supports access to and universal availability of dosing devices with numeric graduations that correspond to the unit of measure that is on the container's label for oral liquid medications.

[JAPhA. 56(4):369; July/August 2016]

2016

### **Point-of-Care Testing**

1. APhA recognizes the value of pharmacist-provided point-of-care testing and related clinical services and promotes the provision of those tests and services in accordance with the Joint Commission of Pharmacy Practitioners Pharmacists' Patient Care Process.
2. APhA advocates for laws, regulations, and policies that enable pharmacist-provided point-of-care testing and related clinical services that are consistent with the pharmacists' role in team-based care.
3. APhA opposes laws, regulations, and policies that create barriers to the tests that have been waived by the Clinical Laboratory Improvement Amendments (CLIA) and that are administered and interpreted by pharmacists.
4. APhA encourages use of educational programming and resources to facilitate practice implementation of pharmacist-provided point-of-care testing and related clinical services.
5. APhA supports patients taking active roles in the management of their health, including their ability to request and obtain pharmacist-provided point-of-care tests and related clinical services.
6. APhA advocates for access to, coverage of, and payment for both pharmacist-provided point-of-care tests and any related clinical services.

[JAPhA. 56(4):369; July/August 2016] [Reviewed 2018] [Reviewed 2019] [Reviewed 2020]

2013, 2008

### **Reuse of Devices Intended for "Single Use"**

APhA opposes the reuse of devices intended for "single use" in the screening and management of patients, consistent with the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines.

[JAPhA. NS48(4):471; July/August 2008] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2018]

2013, 2008, 1987

### **Sale of Home-Use Diagnostic and Monitoring Products**

1. APhA supports the need to protect the health of the American people through proper instruction in the safe and effective use of the more complex home-use diagnostic and monitoring products.
2. APhA supports the promotion of the pharmacist as a widely available and qualified health care professional to advise patients in the use of home-use diagnostic and monitoring products.

[Am Pharm. NS27(6):424; June 1987] [Reviewed 2003] [JAPhA. NS48(4):470; July/August 2008] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2016] [Reviewed 2017]

2001

### **Pharmacist Counseling on Administration Devices**

APhA encourages patient and caregiver education by a pharmacist on the appropriate use of drug administration devices.

[JAPhA. NS41(5)[suppl 1]:S9; September/October 2001] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

2001

### **Syringe Disposal**

APhA supports collaboration with other interested health care organizations, public and environmental health groups, waste management groups, syringe manufacturers, health insurers, and patient advocacy groups to develop and promote safer systems and procedures for the disposal of used needles and syringes by patients outside of health care facilities.

[JAPhA. NS41(5)[suppl 1]:S9; September/October 2001] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017] [Reviewed 2020]

1999

### **Sale of Sterile Syringes**

APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

[JAPhA. 39(4):447; July/August 1999] [Reviewed 2003] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019] [Reviewed 2020]

## MINORITIES IN PHARMACY

2017, 2012, 1989

### Equal Rights and Opportunities for Pharmacy Personnel

APhA reaffirms its unequivocal support of equal opportunities for employment and advancement, compensation, and organizational leadership positions. APhA opposes discrimination based on sex, gender identity or expression, race, color, religion, national origin, age, disability, genetic information, sexual orientation, or any other category protected by federal or state law.

[Am Pharm. NS 29(7):464; July 1989] [Reviewed 2001] [Reviewed 2007] [JAPhA. NS52(4) 459; July/August 2012] [JAPhA. 57(4): 441; July/August 2017]

2012, 1991

### Recruitment of a Diverse Population into Pharmacy

1. APhA supports a vigorous long-term program for the recruitment of a diverse population of student pharmacists into the pharmacy profession.
2. APhA encourages the development and regular updating of comprehensive recruitment materials, directed toward diversity and inclusion, that address such issues as pharmacy career opportunities, financial aid, and educational prerequisites, and that highlight professional diverse role models.
3. APhA encourages national, state, and local association; schools; students; and industry to create a network of pharmacists who would serve as role models for a diverse population of student pharmacists.
4. APhA supports the development of guidelines that assist schools of pharmacy in implementing diversity and inclusion initiatives into student pharmacist recruitment programs.

[Am Pharm. NS31(6):28; June 1991] [Reviewed 2001] [Reviewed 2007] [JAPhA. NS52(4) 459; July/August 2012] [Reviewed 2017] [Reviewed 2018]

1979

### Consideration of the Equal Rights Amendment

APhA supports efforts to ensure equal rights of all persons.

[AmPharm. NS19(7):60; June 1979] [Reviewed 2009] [Reviewed 2014] [Reviewed 2018]

## MISCELLANEOUS POLICIES

2004, 1984

### Center for Human Organ Acquisition

1. APhA supports activities that would increase voluntary human organ donations.
2. APhA encourages all pharmacists to consider becoming organ donors themselves, and to inform and encourage their patients to participate in organ donor programs.
3. APhA strongly urges all pharmacists, especially those in emergency room and intensive/critical care settings, to sensitize the other health care team members to the basic need for asking if a patient is an organ donor as part of the admission.

[Am Pharm. NS24(7):61; July 1984] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

2004, 1986

### Rationing of Expensive Health Care Services

1. APhA supports programs that will actively market the cost-effective benefits of comprehensive pharmacy services to patients and payers.
2. APhA supports the utilization of management tools to assist the pharmacist in maximizing available revenues in an environment of expensive and/or scarce health services and funding.

[Am Pharm. NS26(6):420; June 1986] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

1979

### Child Abuse Reporting

APhA urges pharmacists to report all suspected cases of child abuse to proper authorities.

[Am Pharm. NS19(7):69; June 1979] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

# NEW DRUG APPLICATIONS AND INVESTIGATIONAL NEW DRUGS

## *Investigational New Drugs*

2010

### **Pharmacogenomics/Personalized Medicine**

1. APhA supports evidence-based personalized medicine, defined as the use of a person's clinical, genetic, genomic, and environmental information to select a medication or its dose, to choose a therapy, or to recommend preventive measures, as a means to improve patient safety and optimize health outcomes.
2. APhA promotes pharmacists as health care providers in the collection, use, interpretation, and application of pharmacogenomic data to optimize health outcomes.
3. APhA supports the development and implementation of programs, tools, and clinical guidelines that facilitate the translation and application of pharmacogenomic data into clinical practice.
4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.

[JPhA. NS50(4):471; July/August 2010] [Reviewed 2015] [Reviewed 2019]

2004, 1980

### **Therapeutic Orphans**

APhA supports the adoption of policies in the new drug application (NDA) process that, beyond the premarket clinical testing, would result in postmarketing clinical testing of the drug for important new clinical uses or population groups. Postmarketing studies may also be preferable for other indications where circumstances may require a lengthy gathering of data due to limitations in numbers of clinical cases, and for which initial marketing approval for the major indication(s) or population groups should not be delayed.

[Am Pharm. NS20(7):73; July 1980] [JPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

1990

### **Reimbursement of Pharmacy Services Associated with Drugs Undergoing Assessment**

1. APhA recognizes that investigational new drugs (IND) play a significant role in the delivery of innovative drug therapy approaches and as adjunctive aids in various diagnostics testing modalities.
2. APhA supports coverage by government and other third-party payers for pharmacy services associated with the use of drugs undergoing assessment.

[Am Pharm. NS30(6):46; June 1990] [Reviewed 2004] [Reviewed 2009] [Reviewed 2010] [Reviewed 2015]

1981

### **Investigational New Drug (IND) Studies**

APhA encourages investigators and sponsors who are conducting IND studies to utilize the professional services of pharmacists in carrying out such studies.

[Am Pharm. NS2(5):40; July 1981] [Reviewed 2004] [Reviewed 2009] [Reviewed 2010] [Reviewed 2015]

## **OFF-LABEL INDICATIONS**

1994

### **Off-Label Use of FDA-Approved Products**

1. APhA advocates the collaboration of pharmacists, other health care professionals, industry, and the FDA in developing procedures to evaluate off-label use of FDA-approved products.
2. APhA encourages industry and government cooperation to streamline approval of beneficial off-label therapeutic or diagnostic use of FDA-approved products.
3. APhA advocates removal of restrictions on reimbursement of pharmaceutical services and FDA-approved products when, in the judgment of the pharmacist, those products are for medically acceptable, off-label uses.

[Am Pharm. NS34(6):56; June 1994] [Reviewed 2004] [Reviewed 2010] [Reviewed 2015]

# ORPHAN DRUGS

2004, 1981

## Needed Drugs of Limited Commercial Value (Orphan Drugs)

1. APhA supports incentives to manufacturers, private foundations, academic and public institutions, and others for the development, manufacture, and distribution of needed drugs (including biological) and drug dosage forms of limited commercial value.
2. APhA supports the federal government bearing the responsibility to make orphan drugs and drug dosage forms available when incentives alone fail to achieve the availability of needed drugs (including biologicals) of limited commercial value.

[Am Pharm. NS21(5):41; May 1981] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

# PATIENT/PHARMACIST RELATIONSHIPS

2018

## Use of Genomic Data Within Pharmacy Practice

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct to consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

2016

## Point-of-Care Testing

1. APhA recognizes the value of pharmacist-provided point-of-care testing and related clinical services and promotes the provision of those tests and services in accordance with the Joint Commission of Pharmacy Practitioners Pharmacists' Patient Care Process.
2. APhA advocates for laws, regulations, and policies that enable pharmacist-provided point-of-care testing and related clinical services that are consistent with the pharmacists' role in team-based care.
3. APhA opposes laws, regulations, and policies that create barriers to the tests that have been waived by the Clinical Laboratory Improvement Amendments (CLIA) and that are administered and interpreted by pharmacists.
4. APhA encourages use of educational programming and resources to facilitate practice implementation of pharmacist-provided point-of-care testing and related clinical services.
5. APhA supports patients taking active roles in the management of their health, including their ability to request and obtain pharmacist-provided point-of-care tests and related clinical services.
6. APhA advocates for access to, coverage of, and payment for both pharmacist-provided point-of-care tests and any related clinical services.

[JAPhA. 56(4):369; July/August 2016] [Reviewed 2018] [Reviewed 2019] [Reviewed 2020]

2014

## Care Transitions

1. APhA supports pharmacists leading medication management activities during care transitions to ensure safe and effective medication use.
2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
3. APhA strongly encourages collaboration and shared accountability among patients, family members, caregivers, pharmacists, and other health care providers during care transitions.
4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
6. APhA supports financially viable payment models that recognize the value of pharmacists' services, including, but not limited to, those provided during care transitions.
7. APhA strongly urges the development and implementation of multidisciplinary, interprofessional, and team-based training for health care professionals and students to improve the quality and consistency of care transition services.
8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2014

## Use of Social Media

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2010

## Transfer Incentives

APhA advocates the elimination of coupons, rebates, discounts, and other incentives provided to patients that promote the transfer of prescriptions between competitors.

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2015)

2009

## Disparities in Health care

APhA supports elimination of disparities in health care delivery.

[JAPhA. NS49(4):493; July/August 2009] (Reviewed 2013) (Reviewed 2018) (Reviewed 2020)

2006

## Cultural Health Beliefs and Medication Use

1. APhA supports culturally sensitive outreach efforts to increase mutual understanding of the risks and other issues of using prescription medications without a prescription order or using unapproved products.
2. APhA supports expanding culturally competent health care services in all communities.

[JAPhA. NS46(5):561; September/October 2006] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005

## **Cultural Competence**

1. Recognizing the diverse patient population served by our profession and the impact of cultural diversity on patient safety and medication use outcomes, APhA encourages pharmacists to continually strive to achieve and develop cultural awareness, sensitivity, and cultural competence.
2. APhA shall facilitate access to resources that assist pharmacists and student pharmacists in achieving and maintaining cultural competence relevant to their practice.

[JAPhA. NS45(5):554; September/October 2005] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

2005, 2002

## **Health Literacy**

1. APhA encourages pharmacists and student pharmacists to increase their awareness of health literacy. Health literacy is the degree to which people can obtain, process, and understand basic health information and services they need to make appropriate health decisions.
2. APhA encourages pharmacists and student pharmacists to assess patients' health literacy and then implement appropriate communications and education.
3. APhA encourages the review of all patient information for health literacy appropriateness.

[JAPhA. NS42(5)(suppl 1):S60 ; September/October 2002] [JAPhA. NS45(5):556; September/October 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

2005

## **Patient Safety**

1. Patient safety is influenced by patients, caregivers, health care providers, and health care systems. APhA recognizes that improving patient safety requires a comprehensive, continuous, and collaborative approach to health care.
2. APhA should promote public and provider awareness of and encourage participation in patient safety initiatives.
3. APhA supports research on a more effective, proactive, and integrated health care system focused on improving patient safety. APhA encourages implementation of appropriate recommendations from that research.

[JAPhA. NS45(5):554; September/October 2005] [Reviewed 2009] [Reviewed 2011] [Reviewed 2016] [Reviewed 2019] [Reviewed 2020]

2003

## **Prior Authorization**

1. APhA opposes prior authorization programs that create barriers to patient care.
2. Patients, prescribers, and pharmacists should have ready access to the coverage conditions for medications or devices requiring prior authorization.
3. Prescription drug benefit plan sponsors and administrators should actively seek and integrate the input of network pharmacists in the design and operation of prior authorization programs.
4. APhA supports prior authorization programs that allow pharmacists to provide the necessary information to determine appropriate patient care.
5. APhA expects prescription drug benefit plan sponsors to compensate pharmacy providers who complete third-party payer authorization procedures. Compensation should be in addition to dispensing fee arrangements.
6. APhA should work with relevant groups to improve prior authorization design and decrease prescription processing inefficiencies.

[JAPhA. NS43(5)(suppl 1):S58; September/October 2003] [Reviewed 2008] [Reviewed 2013] [Reviewed 2015]

2002, 1991, 1977

## **Pharmacist/Patient Communication**

1. APhA acknowledges the following:
  - (a) Patients have the right to be informed participants in decisions related to their personal health care.
  - (b) Pharmacists have a professional obligation to contribute to the education of patients to help achieve optimal drug therapy.
  - (c) Pharmacists should provide drug-related information to their patients (or patients' agent) by face-to-face oral consultation, supplemented by written or printed material, or any other means or combination of means that is best suited to an individual patient's needs for specific information.
2. APhA acknowledges that the pharmacist is responsible for initiating pharmacist/patient dialogue and assessing the patient's ability to comprehend and communicate so as to optimize the patient's understanding of and compliance with drug therapy.

3. APhA encourages the research and development of ancillary communication aids and techniques to maximize patient understanding of medication and its proper use.

[JAPhA. NS17:464; July 1977] [Am Pharm. NS3(16):28; June 1991] [JAPhA. NS2(5)[suppl 1]:563 ; September/October 2002] (Reviewed 2006) (Reviewed 2010) (Reviewed 2015) (Reviewed 2019)

**2001**

### **Administrative Contributions to Medication Errors**

1. APhA encourages implementation of a standard prescription drug card to improve the dispensing process and encourages the use of technology in this implementation.
2. APhA supports the use of technology to facilitate record-keeping of patient prescription information for third-party audit purposes and regulatory compliance.
3. APhA supports education of the public regarding the responsibility to be informed consumers of their pharmacy benefits provided through third-party plans.
4. APhA encourages third-party plans to provide pharmacies all information necessary for benefits administration in a timely organized manner or to provide access to the information through the Internet or similar technologies at no cost to the pharmacy.
5. APhA supports the distinction of plan management messages (e.g., days' supply limitations or formulary management) from drug utilization review messages (e.g., drug-drug interactions). APhA supports the communication of all plan management options available (e.g., approved formulary alternatives) from the claims processor to the pharmacist.
6. APhA supports the development and use of systems to communicate in-pharmacy drug utilization review messages with online claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of preadjudication drug utilization review messages (i.e., drug utilization review communication between the prescriber and claims processor) to the pharmacist.
8. APhA supports efforts to
  - (a) improve online drug utilization review messages by the establishment of evidence-based criteria to prevent drug-related conflicts that have the potential for causing serious harm, and
  - (b) eliminate drug utilization review messages that have questionable or inconsequential impact on patient outcomes.

[JAPhA. NS4(5)[suppl 1]:57; September/October 2001] (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2000**

### **Medication Errors**

1. APhA, as the national professional society of pharmacists, will work to ensure that pharmacy is the profession responsible for providing leadership in developing a safe, error-free medication use process.
2. APhA supports continuation and expansion of medication error reporting programs.
3. Medication error reporting programs should be nonpunitive and allow appropriate anonymity to facilitate error reporting and development of solutions to eliminate error.
4. APhA supports identifying the system-based causes of errors and building systems to support safe medication practice.

[JAPhA. NS(9):40; September/October 2000] (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**1995**

### **Continuum of Patient Care**

1. APhA advocates and will facilitate pharmacists' participation in the continuum of patient care. The continuum of patient care is characterized by the interdisciplinary care provided a patient through a series of organized, connected events or activities independent of time and practice site, in order to optimize desired therapeutic outcomes.
2. APhA will facilitate pharmacists' participation in the continuum of patient care by
  - (a) Achieving recognition for the pharmacist as a primary care provider;
  - (b) Securing access for pharmacists to patient information systems, including creation of the necessary software for the purpose of record maintenance of cognitive services provided by pharmacists; and
  - (c) Developing means and methods to establish and enable pharmacists' direct participation in the continuum of patient care.

[Am Pharm. NS35(6):36; June 1995] (Reviewed 2004) (Reviewed 2006) (Reviewed 2011) (Reviewed 2016) (Reviewed 2019)

1991

## **Biotechnology**

APhA encourages the development of appropriate educational materials and guidelines to assist pharmacists in addressing the ethical issues associated with the appropriate use of biotechnology-based products.

[Am Pharm. NS31(6):29; June 1991] [Reviewed 2004] [Reviewed 2007] [Reviewed 2010] [Reviewed 2015] [Reviewed 2016] [Reviewed 2017]

1987

## **Cost-Effectiveness of Drug Products and Pharmacy Services**

APhA supports the development of programs that educate pharmacy's several publics about the cost-effectiveness of drug products and related comprehensive pharmacist services.

[Am Pharm. NS27(6):422; June 1987] [Reviewed 2004] [Reviewed 2010] [Reviewed 2011] [Reviewed 2016]

1971

## **Communications with Patients: Drug Delivery Practice**

APhA supports the Academy of General Practice of Pharmacy statement on drug delivery practice that reads as follows: "When requested by a patient or a prescriber to deliver medication to the home of a patient, the pharmacist will communicate directly with the patient, or his representative, instructions and warnings concerning the medication and ascertain that a responsible individual will receive the medication or determine that the medication will be left in a safe place."

[JAPhA. NS11:272; May 1971] [Reviewed 2001] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

# **PHARMACEUTICAL CARE**

2020

## **Accountability of Pharmacists**

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

[JAPhA. 2020;60(5):e9]

2016

## **Point-of-Care Testing**

1. APhA recognizes the value of pharmacist-provided point-of-care testing and related clinical services and promotes the provision of those tests and services in accordance with the Joint Commission of Pharmacy Practitioners Pharmacists' Patient Care Process.
2. APhA advocates for laws, regulations, and policies that enable pharmacist-provided point-of-care testing and related clinical services that are consistent with the pharmacists' role in team-based care.
3. APhA opposes laws, regulations, and policies that create barriers to the tests that have been waived by the Clinical Laboratory Improvement Amendments (CLIA) and that are administered and interpreted by pharmacists.
4. APhA encourages use of educational programming and resources to facilitate practice implementation of pharmacist-provided point-of-care testing and related clinical services.
5. APhA supports patients taking active roles in the management of their health, including their ability to request and obtain pharmacist-provided point-of-care tests and related clinical services.
6. APhA advocates for access to, coverage of, and payment for both pharmacist-provided point-of-care tests and any related clinical services.

[JAPhA. 56(4):369; July/August 2016] [Reviewed 2018] [Reviewed 2019] [Reviewed 2020]

2013

### **Ensuring Access to Pharmacists' Services**

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.

[JAPhA. 53(4):365; July/August 2013] [Reviewed 2018] [Reviewed 2019]

2013, 2008

### **Pharmacy Practice–Based Research Networks**

1. APhA supports establishment of pharmacy practice–based research networks (PBRNs) to strengthen the evidence base in support of pharmacists' patient care services.
2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional, and nationwide networks for performing pharmacy practice–based research.
3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice–based research networks (PBRNs). [JAPhA. NS48(4):471; July/August 2008] [JAPhA. 53(4) 366; July/August 2013] [Reviewed 2018]

2012, 2003

### **The Pharmacist's Role in Laboratory Monitoring and Health Screening**

1. APhA supports pharmacist involvement in appropriate laboratory testing and health screening, including pharmacists directly conducting the activity, supervising such activity, ordering and interpreting such tests, and communicating such tests results.
2. APhA supports revision of relevant laws and regulations to facilitate pharmacist involvement in appropriate laboratory testing and health screening as essential components of patient care
3. APhA encourages research to further demonstrate the value of pharmacist involvement in laboratory testing and health screening services.
4. APhA supports public and private sector compensation for pharmacist involvement in laboratory testing and health screening services.
5. APhA supports training and education of pharmacists and student pharmacists to direct, perform, and interpret appropriate laboratory testing and health screening services. Such education and training should include proficiency testing, quality control, and quality assurance.
6. APhA encourages collaboration and research with other health care providers to ensure appropriate interpretation and use of laboratory monitoring and health screening results.

[JAPhA. NS43(5)[suppl 1]:S58; September/October 2003] [Reviewed 2007] [Reviewed 2009] [Reviewed 2010] [JAPhA. NS52(4):460; July/August 2012] [Reviewed 2013] [Reviewing 2016] [Reviewed 2017]

2011

### **Pharmacist's Role in Health Care Reform**

1. APhA affirms that pharmacists are the medication experts whose accessibility uniquely positions them to increase access to and improve quality of health care while decreasing overall costs.
2. APhA asserts that pharmacists must be recognized as the essential and accountable patient care provider on the health care team responsible for optimizing outcomes through medication therapy management (MTM).
3. APhA asserts the following:
  - (a) Medication Therapy Management Services: Definition and Program Criteria is the standard definition of MTM that must be recognized by all stakeholders.
  - (b) Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, as adopted by the profession of pharmacy, shall serve as the foundational MTM service model.

4. APhA asserts that pharmacists must be included as essential patient care provider and compensated as such in every health care model, including but not limited to, the medical home and accountable care organizations.
5. APhA actively promotes the outcomes-based studies, pilot programs, demonstration projects, and other activities that document and reconfirm pharmacists' impact on patient health and well-being, process of care delivery, and overall health care costs.

[JAPhA. NS51(4):482; July/August 2011] (Reviewed 2016)

**2010**

### **Pharmacogenomics/Personalized Medicine**

1. APhA supports evidence-based personalized medicine, defined as the use of a person's clinical, genetic, genomic, and environmental information to select a medication or its dose, to choose a therapy, or to recommend preventive measures, as a means to improve patient safety and optimize health outcomes.
2. APhA promotes pharmacists as health care providers in the collection, use, interpretation, and application of pharmacogenomic data to optimize health outcomes.
3. APhA supports the development and implementation of programs, tools, and clinical guidelines that facilitate the translation and application of pharmacogenomic data into clinical practice.
4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.

[JAPhA. NS50(4):471; July/August 2010] (Reviewed 2015) (Reviewed 2019)

**2008**

### **Billing and Documentation of Medication Therapy Management (MTM) Services**

1. APhA encourages the development and use of a system for billing of medication therapy management (MTM) services that
  - (a) includes a standardized data set for transmission of billing claims,
  - (b) utilizes a standardized process that is consistent with claim billing by other health care providers,
  - (c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC).

[JAPhA. NS48(4):471; July/August 2008] (Reviewed 2010) (Reviewed 2015) (Reviewed 2016)

**2003, 1992**

### **The Pharmacist's Role in Therapeutic Outcomes**

1. APhA affirms that achieving optimal therapeutic outcomes for each patient is a shared responsibility of the health care team.
2. APhA recognizes that a primary responsibility of the pharmacist in achieving optimal therapeutic outcomes is to take an active role in the development and implementation of a therapeutic plan and in the appropriate monitoring of each patient.

[Am Pharm. NS32(6):515; June 1992] [JAPhA. NS43(5)[suppl 1]:S57; September/October 2003] (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016) (Reviewed 2016)

**1989**

### **Pharmacy-Based Screening and Monitoring Services**

APhA supports projects that demonstrate and evaluate various pharmacy-based screening and monitoring services.

[Am Pharm. NS29(7):463; July 1989] (Reviewed 2006) (Reviewed 2007) (Reviewed 2012) (Reviewed 2013) (Reviewed 2017)

# PHARMACY CRIME AND SECURITY

2019

## **Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians**

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are victims of firearm-related violence to seek the help of counselors and other trained mental health professionals.

[JAPhA. 59(4):e17; July/August 2019]

2019

## **Pharmacist and Pharmacy Personnel Safety and Well-Being**

1. APhA calls for employers to develop policies and resources to support pharmacy personnel's ability to retreat or withdraw, without retaliation, from interactions that threaten their safety and well-being.
2. APhA encourages the development or utilization of educational programs and resources by the Association, employers, and other institutions to prepare pharmacy personnel to respond to situations that threaten their safety and well-being.

[JAPhA. 59(4):e17; July/August 2019]

2007

## **Privacy of Pharmacists' Personal Information**

1. APhA supports protecting pharmacist, student pharmacist, and pharmacy technician personal information (e.g., home address, telephone, and personal email address).
2. APhA opposes legislative or regulatory requirements that mandate the publication of pharmacist, student pharmacist, and pharmacy technician personal information (e.g., home address, telephone, and personal email address).
3. APhA encourages state boards of pharmacy to remove from their websites personal addresses, phone numbers, email, and other nonbusiness contact information of pharmacists, student pharmacists, and pharmacy technicians.

[JAPhA. NS45(5):580; September/October 2007] (Reviewed 2012) (Reviewed 2017)

2003, 1971

## **Security: Pharmacists' Responsibility**

APhA encourages pharmacists to voluntarily remove all proprietary drug products with potential for abuse or adverse drug interactions from general sales areas and to make their dispensing the personal responsibility of the pharmacist.

[JAPhA. NS11:267; May 1971] [JAPhA. NS43(5)[suppl 1]:S58 ; September/October 2003] (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

1982

## **Innovative Approaches to Combating Pharmacy Crime**

APhA encourages pharmaceutical associations to work with state legislators in an effort to provide mandatory imprisonment for the theft of controlled substances and the restriction of bail for such crimes.

[Am Pharm. NS22(7):32; July 1982] (Reviewed 2003) (Reviewed 2004) (Reviewed 2010)

1971

## **Prescription Department Security**

The committee recommends that APhA support state legislation to require that a prescription department must be secured whenever the pharmacist or persons authorized by the pharmacist are not present.

[JAPhA. NS11:267; May 1971] (Reviewed 2006) (Reviewed 2011) (Reviewed 2016)

# PHARMACY PRACTICE

2020

## Accountability of Pharmacists

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

[JAPhA. 2020;60(5):e9]

2020

## Community-Based Pharmacists as Providers of Care

1. APhA advocates for the identification of medical conditions that may be safely and effectively treated by community-based pharmacists.
2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists.
3. APhA advocates for laws and regulations that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community-based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

[JAPhA. 2020;60(5):e10]

2020, 2010

## E-prescribing Standardization

1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.
2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce, in order to improve health information technology systems and, ultimately, patient care.
3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.
4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.
5. APhA supports laws and regulations that require e-prescribing of controlled substances to reduce fraudulent prescriptions.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2012] [Reviewed 2014] [Reviewed 2015] [JAPhA. 2020;60(5):e10]

2020, 2015

## Integrated Nationwide Prescription Drug Monitoring Program

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.

4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for
  - (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud;
  - (b) providing focused provider education and patient referral to treatment programs; and
  - (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

[JAPhA. N55(4):364; July/August 2015] [JAPhA. 2020;60(5):e10]

**2020**

### **Nonexecution-Related Use of Pharmaceuticals in Correctional Facilities**

1. APhA opposes drug manufacturers' refusal to supply certain drugs to correctional health services units necessary to provide medical treatment of inmates.
2. APhA advocates for inmates to have an opportunity, equal to that of noninmates, to access medications that correctional health care providers deem medically necessary for appropriate and humane health care treatment.
3. APhA advocates for correctional health care providers to have opportunity, equal to noncorrectional health care providers, to access, prescribe, and procure pharmaceuticals deemed necessary for medical treatment of inmates.

[JAPhA. 2020;60(5):e11]

**2020**

### **Protecting Pharmacy Personnel During Public Health Crisis**

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as "frontline providers" who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

[JAPhA. 2020;60(5):e11]

**2020**

### **Providing Affordable and Comprehensive Pharmacy Services to the Underserved**

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower health care costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable law.

[JAPhA. 2020;60(5):e11]

**2020**

### **Specialty Pharmacy and Specialized Pharmacy Services**

1. APhA recognizes that certain complex medications require more specialized care and resources. Further, APhA asserts that delineation of medications as specialty versus nonspecialty, and associated payer and manufacturer practices, may introduce continuity of care disruption, patient access issues, and financial inequities.
2. APhA supports pharmacists and pharmacies choosing to specialize or incorporate specialty pharmacy services into their practice to optimize patient outcomes.
3. APhA opposes payer policies and practices that limit patient choice of pharmacy providers, disrupt continuity of care, or compromise patient safety through the creation of specialty drug lists, and restrictive specialty pharmacy networks
4. APhA opposes manufacturer distribution and related business practices that restrict patient or pharmacy access to medications, medical products, and patient care services.
5. APhA advocates for the adoption of pharmacy profession-developed, harmonized practice standards for specialized pharmacy practices, and specialty pharmacy services and products.

6. APhA encourages increased availability and use of data integration, patient financial assistance, and other resources to inform clinical practice and support the provision of specialized pharmacy practices and specialty pharmacy services.
7. APhA supports the availability of education and training for pharmacists and student pharmacists related to specialized pharmacy practices and specialty pharmacy services.

[JAPhA. 2020;60(5):e10]

**2020**

### **Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill**

APhA supports regulations that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

[JAPhA. 2020;60(5):e10]

**2019, 1997**

### **Collaborative Practice Agreements**

1. APhA supports the establishment of collaborative practice agreements between pharmacists and other health care professionals designed to optimize patient care outcomes.
2. APhA supports the establishment of collaborative practice agreements between one or multiple pharmacists and one or multiple prescribers or entities.
3. APhA supports state laws that do not require a referral or a prior provider–patient relationship as a prerequisite to access services provided under a collaborative practice agreement.
4. APhA opposes state laws that limit collaborative practice agreements to specific patients.
5. APhA supports state laws that allow for pharmacists’ prescriptive authority.
6. APhA supports state collaborative practice laws that allow all licensed pharmacists, in all practice settings, to establish collaborative practice agreements with other health care professionals or entities.
7. APhA shall promote the establishment and dissemination of guidelines and information to pharmacists and other health care professionals to facilitate the development of collaborative practice agreements.

[JAPhA. NS37(4):459; July/August 1997] (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) (Reviewed 2017) [JAPhA. 59(4):e17; July/August 2019] (Reviewed 2020)

**2019**

### **Consolidation Within Health Care**

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
  - Enhance patient experience and safety, in order to:
  - Improve population health,
  - Reduce health care costs, and
  - Improve the work life of health care providers.
3. APhA asserts that the scope of review by federal agencies must have a focus on the impact of health care mergers and acquisitions on patient access and the provision of care to ensure optimal patient outcomes. Therefore, APhA calls for:
  - Reform of the pre–health care mergers and acquisitions process,
  - Implementation of an ongoing post–health care mergers and acquisitions evaluation process to preserve patient choice and access to established patient–pharmacist relationships, and
  - Continuous transparent dialogue among stakeholders throughout the process.
4. APhA calls for the Federal Trade Commission (FTC) to develop a task force to monitor health care mergers and acquisitions activity.

[JAPhA. 59(4):e16; July/August 2019]

## 2019

### **Patient-Centered Care of People Who Inject Nonmedically Sanctioned Psychotropic or Psychotropic Substances**

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with injection drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and postexposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who inject nonmedically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.

[JAPhA. 59(4):e17; July/August 2019]

## 2019

### **Pharmacists' Role in Mental Health and Emotional Well-Being**

1. APhA encourages all health care personnel to receive training and provide services to identify, assist, and refer people at risk for, or currently experiencing, a mental health crisis.
2. APhA encourages employers and policy makers to provide the support, resources, culture, and authority necessary for all pharmacy personnel to engage and assist individuals regarding mental health and emotional well-being.
3. APhA supports integration of a mental health assessment as a vital component of pharmacist-provided patient care services.

[JAPhA. 59(4):e16; July/August 2019]

## 2019

### **Referral System for the Pharmacy Profession**

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

[JAPhA. 59(4):e16; July/August 2019]

## 2018

### **Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases**

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

[JAPhA. 58(4):356; July/August 2018]

2018

## **Proactive Immunization Assessment and Immunization Information Systems**

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

[JAPhA. 58(4):355; July/August 2018]

2018, 2013

## **Revisions to the Medication Classification System**

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws and regulations to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.
7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

[JAPhA. 53(4):365; July/August 2013] [JAPhA. 58(4):356; July/August 2018]

2018

## **Use of Genomic Data Within Pharmacy Practice**

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.

8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct-to-consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

**2017**

### **Patient Access to Pharmacist-Prescribed Medications**

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

[JAPhA. 57(4):441; July/August 2017] [Reviewed 2019] [Reviewed 2020]

**2017**

### **Pharmacists' Role Within Value-based Payment Models**

1. APhA supports value-based payment models that include pharmacists as essential health care team members and that promote coordinated care, improved health outcomes, and lower total costs of health care.
2. APhA encourages the development and implementation of meaningful, consistent, process-based and outcomes-based quality measures that allow attribution of pharmacist impact within value-based payment models.
3. APhA advocates for mechanisms that recognize and compensate pharmacists for their contributions toward meeting goals of quality and total costs of care in value-based payment models, separate and distinct from the full product and dispensing cost reimbursement.
4. APhA advocates that pharmacists must have real-time access to and exchange of electronic health record data within value-based payment models in order to achieve optimal health and medication-related outcomes.
5. APhA supports education, training, and resources that help pharmacists transform and integrate their practices with value-based payment models and programs.

[JAPhA. 57(4):441; July/August 2017]

**2017**

### **Pharmacy Performance Networks**

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.
2. APhA urges collaboration between pharmacists and payers to develop distinct, transparent, fair, and equitable payment strategies for achieving performance measures associated with providing pharmacists' patient care services that are separate from the reimbursement methods used for product fulfillment.
3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Furthermore, updates on provider and practice performance against these measures should be provided in a timely and regular manner.
4. APhA supports pharmacists' professional autonomy to determine processes that improve performance on evidence-based quality measures.

[JAPhA. 57(4):441; July/August 2017] [Reviewed 2019]

2016

### **Labeling and Measurement of Oral Liquid Medications**

1. APhA supports the use of the milliliter (mL) as the standard unit of measure for oral liquid medications.
2. APhA encourages the mandatory use of leading zeros before the decimal point for amounts of less than one on prescription-container labels for oral liquid medications.
3. APhA discourages the use of trailing zeros after the decimal point for amounts greater than one on prescription-container labels for oral liquid medications.
4. APhA supports access to and universal availability of dosing devices with numeric graduations that correspond to the unit of measure that is on the container's label for oral liquid medications.

[JAPhA. 56(4):369; July/August 2016]

2016

### **Medication-Assisted Treatment**

APhA supports expanding access to medication assisted treatment (MAT), including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

[JAPhA. 56(4):370; July/August 2016]

2016, 2011

### **Pharmacists as Providers Under the Social Security Act**

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services.

[JAPhA. NS51(4):482;; July/August 2011] [JAPhA. 56(4):379;; July/August 2016]

2016

### **Point-of-Care Testing**

1. APhA recognizes the value of pharmacist-provided point-of-care testing and related clinical services and promotes the provision of those tests and services in accordance with the Joint Commission of Pharmacy Practitioners Pharmacists' Patient Care Process.
2. APhA advocates for laws, regulations, and policies that enable pharmacist-provided point-of-care testing and related clinical services that are consistent with the pharmacists' role in team-based care.
3. APhA opposes laws, regulations, and policies that create barriers to the tests that have been waived by the Clinical Laboratory Improvement Amendments (CLIA) and that are administered and interpreted by pharmacists.
4. APhA encourages use of educational programming and resources to facilitate practice implementation of pharmacist-provided point-of-care testing and related clinical services.
5. APhA supports patients taking active roles in the management of their health, including their ability to request and obtain pharmacist-provided point-of-care tests and related clinical services.
6. APhA advocates for access to, coverage of, and payment for both pharmacist-provided point-of-care tests and any related clinical services.

[JAPhA. 56(4):369; July/August 2016] [Reviewed 2018] [Reviewed 2019] [Reviewed 2020]

2015

### **Antimicrobial Stewardship**

1. APhA supports the role of pharmacists in antimicrobial stewardship in all practice settings.
2. APhA supports pharmacists working in collaboration with others to lead the development and implementation of antimicrobial stewardship programs and initiatives.
3. APhA supports pharmacists advising prescribers and educating patients on the appropriate use of antimicrobials.

[JAPhA. N55(4):365; July/August 2015]

2015

### **Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care**

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a

timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.

4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.
8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and nonpunitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

[JAPhA. N55(4):364; July/August 2015] (Reviewed 2019)

**2015**

### **Pharmacist's Role in Promoting Medication Adherence**

1. APhA supports pharmacists leading the process of assessing and improving patient medication adherence in collaboration with the health care team.
2. APhA advocates for pharmacists taking leadership roles in working with administrators, health care professionals, payers, patients, and other stakeholders to design processes, systems, and technology that promote interoperability and care coordination across settings to improve medication adherence.
3. APhA advocates for the profession of pharmacy to continually study, evaluate, and disseminate evidence-based methods to improve medication adherence.
4. APhA advocates for raising awareness about the issue of medication nonadherence and the importance of engaging patients in their treatment.
5. APhA supports education of the public, employee benefit managers, third-party payers, and other health care decision makers regarding the value and cost-effectiveness of the role of the pharmacist in improving medication adherence.

[JAPhA. N55(4):365; July/August 2015]

**2015**

### **Role of the Pharmacist in the Care of Patients Using Cannabis**

1. APhA supports regulatory changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in furnishing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to furnish them.
5. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.

[JAPhA. N55(4):365; July/August 2015]

2014

### **Audits of Health Care Practices**

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2014

### **Care Transitions**

1. APhA supports pharmacists leading medication management activities during care transitions to ensure safe and effective medication use.
2. APhA supports the integral role of pharmacists during care transitions for improving quality of patient-centered care and reducing overall costs to the health care system.
3. APhA strongly encourages collaboration and shared accountability among patients, family members, caregivers, pharmacists, and other health care providers during care transitions.
4. APhA supports the development and utilization of standardized processes that facilitate real-time, bidirectional communication of protected health information during care transitions.
5. APhA supports that documentation of health outcomes is an essential component of any care transition program to demonstrate value and ensure continuous quality improvement.
6. APhA supports financially viable payment models that recognize the value of pharmacists' services, including, but not limited to, those provided during care transitions.
7. APhA strongly urges the development and implementation of multidisciplinary, interprofessional, and team-based training for health care professionals and students to improve the quality and consistency of care transition services.
8. APhA urges the collaboration and partnership of community pharmacies with health care systems, institutions, and other entities involved in care transitions.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2014

### **Controlled Substances and Other Medications with the Potential for Abuse and Use of Opioid Reversal Agents**

1. APhA supports education for pharmacists and student pharmacists to address issues of pain management, palliative care, appropriate use of opioid reversal agents in overdose, drug diversion, and substance-related and addictive disorders.
2. APhA supports recognition of pharmacists as the health care providers who must exercise professional judgment in the assessment of a patient's conditions to fulfill corresponding responsibility for the use of controlled substances and other medications with the potential for misuse, abuse, and/or diversion.
3. APhA supports pharmacists' access to and use of prescription monitoring programs to identify and prevent drug misuse, abuse, and/or diversion.
4. APhA supports the development and implementation of state and federal laws and regulations that permit pharmacists to furnish opioid reversal agents to prevent opioid-related deaths due to overdose.
5. APhA supports the pharmacist's role in selecting appropriate therapy and dosing and initiating and providing education about the proper use of opioid reversal agents to prevent opioid-related deaths due to overdose.

[JAPhA. 54(4); July/August 2014] (Reviewed 2015) (Reviewed 2018)

2014

### **The Use and Sale of Electronic Cigarettes (e-cigarettes)**

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air regulations for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

[JAPhA. 54(4):358; July/August 2014] (Reviewed 2019)

2014

### **Use of Social Media**

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2013

### **Ensuring Access to Pharmacists' Services**

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.

[JAPhA. 53(4):365; July/August 2013] (Reviewed 2018) (Reviewed 2019)

2013, 2009

### **Independent Practice of Pharmacists**

1. APhA recommends that health plans and payers contract with and appropriately compensate individual pharmacist providers for the level of care rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to the independent practice of pharmacists when those laws and rules are consistent with APhA policy.
3. APhA, recognizing the positive impact that pharmacists can have in meeting unmet needs and managing medical conditions, supports the adoption of laws and regulations and the creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services, including prescribing, as part of the health care team.

[JAPhA. NS 49(4):492; July/August 2009] (Reviewed 2012) [JAPhA. 53(4):366; July/August 2013] (Reviewed 2018)

2013

### **Medication Take-Back/Disposal Programs**

1. APhA encourages pharmacist involvement in the planning and coordination of medication take-back programs for the purpose of disposal.
2. APhA supports increasing public awareness regarding medication take-back programs for the purpose of disposal.
3. APhA urges public and private stakeholders, including local, state, and federal agencies, to coordinate and create uniform, standardized regulations, including issues related to liability and sustainable funding sources, for the proper and safe disposal of unused medications.
4. APhA recommends ongoing medication take-back and disposal programs.

[JAPhA. 53(4):365; July/August 2013] [Reviewed 2018]

2013, 1978

### **Pharmacists Providing Health Care Services**

APhA supports the study and development of new methods and procedures whereby pharmacists can increase their ability and expand their opportunities to provide health care services to patients.

[Am Pharm. NS18(8):47; July 1978] [Reviewed 2007] [Reviewed 2008] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2016]

2013

### **Pharmacists Providing Primary Care Services**

APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.

[JAPhA. 53(4):365; July/August 2013] [Reviewing 2018] [Reviewed 2019] [Reviewed 2020]

2013, 1995

### **Pharmacists' Role in the Development and Implementation of Evidence-Based Clinical Guidelines**

1. APhA advocates direct involvement of pharmacists in the development, evaluation, and implementation of evidence-based clinical guidelines. Well-designed guidelines promote an interdisciplinary team approach to patient care that utilizes pharmacists' expertise in optimizing patient outcomes.
2. APhA believes that evidence-based clinical guidelines should promote optimal patient care built on the best available scientific data. These guidelines should be developed using an interdisciplinary approach and should be evaluated regularly to ensure that they reflect current practice standards.
3. APhA should promote educational programs, products, and services that facilitate the participation of pharmacists in the development, evaluation, and implementation of evidence-based practice guidelines in all practice settings.
4. APhA advocates the use by pharmacists, in all practice settings, of evidence-based practice guidelines for pharmaceutical care built on the best scientific data to optimize patient outcomes. These guidelines should be developed using an interdisciplinary approach and should be evaluated regularly to ensure that they reflect current practice standards.

[Am Pharm. NS35(6):37; June 1995] [Reviewed 2003] [Reviewed 2008] [JAPhA53(4):366; July/August2013] [Reviewed 2018]

2013, 2008

### **Pharmacy Practice–Based Research Networks**

1. APhA supports establishment of pharmacy practice–based research networks (PBRNs) to strengthen the evidence base in support of pharmacists' patient care services.
2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional, and nationwide networks for performing pharmacy practice–based research.
3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice–based research networks (PBRNs).

[JAPhA. NS48(4):471; July/August 2008] [JAPhA. 53(4) 366; July/August 2013] [Reviewed 2018]

2013, 2008

### **Reuse of Devices Intended for “Single Use”**

APhA opposes the reuse of devices intended for “single use” in the screening and management of patients, consistent with the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines.

[JAPhA. NS48(4):471; July/August 2008] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2018]

2012

### **Controlled Substances Regulation and Patient Care**

1. APhA encourages the Drug Enforcement Administration (DEA) and other regulatory agencies to recognize pharmacists as partners that are committed to ensuring that patients in legitimate need of controlled substances are able to receive the medications.
2. APhA supports efforts to modernize and harmonize state and federal controlled substance laws.
3. APhA urges DEA and other regulatory agencies to balance patient care and regulatory issues when developing, interpreting, and enforcing laws and regulations.
4. APhA encourages DEA and other regulatory agencies to recognize the changes occurring in health care delivery and to establish a transparent and inclusive process for the timely updating of laws and regulations.
5. APhA encourages the U.S. Department of Justice to collaborate with professional organizations to identify and reduce
  - (a) the burdens on health care providers,
  - (b) the cost of health care delivery, and
  - (c) the barriers to patient care in the establishment and enforcement of controlled substance laws.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2015]

2012

### **Drug Supply Shortages and Patient Care**

1. APhA supports the immediate reporting by manufacturers to the U.S. Food and Drug Administration (FDA) of disruptions that may impact the market supply of medically necessary drug products to prevent, mitigate, or resolve drug shortage issues and supports the authority for FDA to impose penalties for failing to report.
2. APhA supports revising current laws and regulations that restrict the FDA's ability to provide timely communication to pharmacists, other health care providers, health systems, and professional associations regarding potential or real drug shortages.
3. APhA encourages the FDA, the Drug Enforcement Administration (DEA), and other stakeholders to collaborate in order to minimize barriers (e.g., aggregate production quotas, annual assessment of needs, unapproved drug initiatives) that contribute to or exacerbate drug shortages.
3. APhA should actively support legislation to hasten the development of an efficient regulatory process to approve therapeutically equivalent generic versions of biologic drug products.
5. APhA encourages pharmacists and other health care providers to assist in maintaining continuity of care during drug shortage situations by:
  - (a) creating a practice site drug shortage plan as well as policies and procedures,
  - (b) using reputable drug shortage management and information resources in decision making,
  - (c) communicating with patients and coordinating with other health care providers,
  - (d) avoiding excessive ordering and stockpiling of drugs,
  - (e) acquiring drugs from reputable distributors, and
  - (f) heightening their awareness of the potential for counterfeit or adulterated drugs entering the drug distribution system.
6. APhA encourages accrediting and regulatory agencies and the pharmaceutical science and manufacturing communities to evaluate policies/procedures related to the establishment and use of drug expiration dates and any impact those policies/procedures may have on drug shortages.
7. APhA encourages the active investigation and appropriate prosecution of entities that engage in price gouging and profiteering of medically necessary drug products in response to drug shortages.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2017]

2011

### **Pharmacist's Role in Health Care Reform**

1. APhA affirms that pharmacists are the medication experts whose accessibility uniquely positions them to increase access to and improve quality of health care while decreasing overall costs.
2. APhA asserts that pharmacists must be recognized as the essential and accountable patient care provider on the health care team responsible for optimizing outcomes through medication therapy management (MTM).
3. APhA asserts the following:
  - (a) Medication Therapy Management Services: Definition and Program Criteria is the standard definition of MTM that must be recognized by all stakeholders.

(b) Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, as adopted by the profession of pharmacy, shall serve as the foundational MTM service model.

4. APhA asserts that pharmacists must be included as essential patient care provider and compensated as such in every health care model, including but not limited to, the medical home and accountable care organizations.
5. APhA actively promotes the outcomes-based studies, pilot programs, demonstration projects, and other activities that document and reconfirm pharmacists' impact on patient health and well-being, process of care delivery, and overall health care costs.

[JAPhA. NS51(4):482 July/August 2011] (Reviewed 2016)

2011

### **Pharmacy Practice Accreditation**

1. APhA should lead the creation of consensus-based, pharmacy profession–developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.
2. APhA urges that accrediting bodies use profession-developed standards for pharmacy.
3. APhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, and affordable, while avoiding duplication and barriers to patient care.
4. APhA opposes mandatory pharmacy accreditation.
5. APhA shall assume the leadership role among stakeholders on the design and implementation of an appropriate process for any new pharmacy accrediting program.
6. APhA supports the appropriate use of data gathered from pharmacy practice monitoring processes to facilitate the advancement of pharmacy practice and quality of patient care.

[JAPhA. NS51(4):482;; July/August 2011] (Reviewed 2016)

2011

### **Potential Conflicts of Interest in Pharmacy Practice**

1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

[JAPhA. NS51(4):482;; July/August 2011] (Reviewed 2016)

2011

### **The Role and Contributions of the Pharmacist in Public Health**

In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.

[JAPhA. NS51(4):482;; July/August 2011] (Reviewed 2012) (Reviewed 2016) (Reviewed 2020)

2010

### **Personal Health Records**

1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.
2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.
3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.
4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (reviewed 2019)

2010

### **Pharmacogenomics/Personalized Medicine**

1. APhA supports evidence-based personalized medicine, defined as the use of a person's clinical, genetic, genomic, and environmental information to select a medication or its dose, to choose a therapy, or to recommend preventive measures, as a means to improve patient safety and optimize health outcomes.
2. APhA promotes pharmacists as health care providers in the collection, use, interpretation, and application of pharmacogenomic data to optimize health outcomes.
3. APhA supports the development and implementation of programs, tools, and clinical guidelines that facilitate the translation and application of pharmacogenomic data into clinical practice.
4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.

[JAPhA. NS50(4):471; July/August 2010] [Reviewed 2015] [Reviewed 2019]

2009

### **Health Information Technology**

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.
3. APhA encourages inclusion of pharmacists in the definition, development, and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, the certification of systems, and the integration of medication use systems with health information technology.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2010] [Reviewed 2013] [Reviewed 2014] [Reviewed 2015] [Reviewed 2019]

2009

### **Non-FDA-Approved Drugs and Patient Safety**

1. The American Pharmacists Association calls for education and collaboration among health professional organizations, federal agencies, and other stakeholders to ensure that all manufacturer, distributor, and repackaged marketed prescription drugs used in patient care have been FDA-approved as safe and effective.
2. APhA supports initiatives aimed at closing regulatory and distribution-system loopholes that facilitate market entry of new prescription drugs products without FDA approval.
3. APhA encourages health professionals to consider FDA approval status of prescription drug products when making decisions about prescribing, dispensing, substitution, purchasing, formulary development, and in the development of pharmacy/medical education programs and drug information compendia.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2014] [Reviewed 2019]

2009

### **Pharmacist's Role in Patient Safety**

1. It is APhA's position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and postmarketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized, and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, nonpunitive, easily accessible, and user friendly for all providers within the health care system.
6. APhA supports the elimination of handwritten prescriptions or medication orders.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2010] [Reviewed 2015] [Reviewed 2019]

2008

### **Billing and Documentation of Medication Therapy Management (MTM) Services**

1. APhA encourages the development and use of a system for billing of medication therapy management (MTM) services that
  - (a) includes a standardized data set for transmission of billing claims,
  - (b) utilizes a standardized process that is consistent with claim billing by other health care providers, and
  - (c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC).

[JAPhA. NS48(4):471; July/August 2008] [Reviewed 2010] [Reviewed 2015] [Reviewed 2016]

2008

### **Pharmacy Compounding Accreditation**

1. APhA reaffirms the 1992 Compounding Activities of Pharmacists policy, which states that APhA affirms that compounding pursuant to or in anticipation of a prescription or diagnostic preparation order is an essential part of health care that is the prerogative of the pharmacist.
2. APhA supports compounding as defined by the Pharmacy Compounding Accreditation Board (PCAB) as a means to meet patient drug therapy needs.
3. APhA opposes compounding when identical medications are commercially and readily available in strength and dosage form to meet patient drug therapy needs.
4. APhA asserts that compounding is subject to regulations and oversight from state boards of pharmacy. APhA urges state boards of pharmacy to identify and take appropriate action against entities who are illegally manufacturing medications under the guise of compounding.
5. APhA supports accreditation of compounding sites by PCAB to ensure patient safety. APhA encourages state boards of pharmacy to recommend accreditation for those sites that engage in more than basic nonsterile compounding as defined by PCAB.
6. APhA supports the development of education, training and recognition programs that enhance pharmacist and student pharmacist knowledge and skills to engage in compounding beyond basic, nonsterile preparations as defined by PCAB.
7. APhA encourages the exploration of a specialty certification in compounding through the Board of Pharmaceutical Specialties (BPS).

[JAPhA. NS48(4):470; July/August 2008] [Reviewed 2009] [Reviewed 2011] [Reviewed 2016]

2008, 2001

### **Regulatory Compliance/Regulatory Burden**

APhA supports measures that protect the patient, public, and employees from pharmacy conditions that pose a threat to health.

[JAPhA. NS41(5)[suppl 1]:S9; September/October 2001] [JAPhA. NS48(4):470; July/August 2008] [Reviewed 2013] [Reviewed 2018]

2007

### **Redistribution of Previously Dispensed Medications**

1. As a matter of patient safety, APhA opposes the redispensing of a previously dispensed medication once it has been out of the control of a health care professional.
2. APhA supports a public awareness program to explain why the redispensing of a previously dispensed medication once it is out of the control of the health care professional is a public health safety concern.

[JAPhA. NS45(5):580; September/October 2007] [Reviewed 2012] [Reviewed 2017]

- 2006**  
**Continuity of Care**
1. APhA supports the pharmacist as the most appropriate member of the health care team responsible for reconciling medication use when patients move between practice settings within the continuum of care.
  2. APhA supports the development and use, in practice, of a standardized, portable, accessible, HIPAA compliant, and secure electronic health record (EHR) to facilitate continuity of care across all practice settings. The EHR shall include the clinical data elements necessary to support the performance of medication reconciliation.
  3. APhA supports patient access to pharmacists with specialized skills and expertise. The patient's pharmacist should make patient referrals where appropriate.
- [JAPhA. NS46(5):561; September/October 2006] (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2014) (Reviewed 2019)

- 2005**  
**Compounding with Multicomponent Vehicles**
1. APhA encourages companies that offer multicomponent vehicles for compounding to list all ingredients and to restrict claims about the vehicles to the structure and function of the ingredients in those vehicles unless clinical evidence exists to support more specific claims.
  2. When claims are made by companies for systemic delivery of active ingredients in multicomponent vehicles, APhA encourages pharmacists to secure bioavailability data in support of such claims.
- [JAPhA. NS45(5):555; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

- 2005, 2003, 1996**  
**Pharmacist's Role in Immunizations**
1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through
    - (a) advocacy,
    - (b) contracting with other health care professionals, or
    - (c) administering vaccines to vulnerable patients.
  2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
  3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
  4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.
- [JAPhA. NS36(6):395; June 1996] [JAPhA. NS43(5)[suppl 1]:S57; September/October 2003] [JAPhA. NS45(5):556; September/October 2005] (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

- 2004, 1980**  
**Development of the Cost-Effectiveness of Clinical Pharmacy Services**
- APhA encourages development and maintenance of programs, tools, and data useful in assessing the cost-effective nature and benefits of patient-oriented services within all areas of pharmacy practice.
- [Am Pharm. NS20(7):77; July 1980] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)

- 2004, 1978**  
**Drug Information**
- APhA supports the profession of pharmacy having the primary responsibility to foster the development of an organized system for the accumulation and dissemination of drug information and knowledge.
- [Am Pharm. NS18(8):42; July 1978] [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2007) (Reviewed 2010) (Reviewed 2015)

- 2004, 1979**  
**Drug Regimen Review (DRR) by Pharmacists**
- APhA endorses adequate compensation for pharmacists by the patient, the government, and/or all other third-party programs for performing drug regimen review in all settings where drug therapy is used.
- [Am Pharm. NS19(7):61; June 1979] [JAPhA NS44(5):551; September/October 2004] (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

2004, 1971

### **Drug Storage and Return Goods Policy**

1. APhA recommends that all practitioners and wholesalers provide controlled, room temperature, storage conditions as defined in the official compendia to adequately store drug products.
2. APhA recommends that manufacturers adopt return goods policies that allow the return of drug products even if the expiration date has not yet occurred.
3. APhA shall continue to study the problem of drug storage at all levels of distribution including in transit, in the pharmacy, and in the home and provide guidance for the profession and public in these areas.

[JAPhA. NS11:271; May 1971] [JAPhA. NS44(5):551; September/October 2004 ] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

2004, 1989

### **Drug Use Control by Pharmacists for All Prescription Drugs**

1. APhA supports the authority and responsibility of pharmacists in the management and control of all approved and investigational drug products.
2. APhA encourages corporate, government, and health-care organizations to recognize and utilize the unique expertise of the pharmacist in the management and control of all approved and investigational drug products.

[Am Pharm. NS29(1):66; January 1989] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

2004, 1978

### **Roles in Health Care for Pharmacists**

1. APhA shall develop and maintain new methods and procedures whereby pharmacists can increase their ability and expand their opportunities to provide health care services.
2. APhA supports legislative and judicial action that confirms pharmacists' professional rights to perform those functions consistent with APhA's definition of pharmacy practice and that are necessary to fulfill pharmacists' professional responsibilities to patients they serve.

[Am Pharm. NS18(8):42; July 1978] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2007] [Reviewed 2011] [Reviewed 2012] [Reviewed 2013] [Reviewed 2018] [Reviewed 2020]

2003, 1993

### **The Pharmacist's Role with Diagnostic Drugs in Therapeutic Outcomes**

APhA recognizes that it is a responsibility of the pharmacists to take an active role in the selection and use of diagnostic drugs as an integral component in the development and implementation of a patient's therapeutic plan.

[Am Pharm. NS33(7):56; July 1993] [JAPhA. NS43(5):[suppl 1]:S57 ; September/October 2003] [Reviewed 2007] [Reviewed 2009] [Reviewed 2010] [Reviewed 2011] [Reviewed 2016]

2001

### **Administrative Contributions to Medication Errors**

1. APhA encourages implementation of a standard prescription drug card to improve the dispensing process and encourages the use of technology in this implementation.
2. APhA supports the use of technology to facilitate record-keeping of patient prescription information for third-party audit purposes and regulatory compliance.
3. APhA supports education of the public regarding the responsibility to be informed consumers of their pharmacy benefits provided through third-party plans.
4. APhA encourages third-party plans to provide pharmacies all information necessary for benefits administration in a timely organized manner or to provide access to the information through the Internet or similar technologies at no cost to the pharmacy.
5. APhA supports the distinction of plan management messages (e.g., days' supply limitations or formulary management) from drug utilization review messages (e.g., drug-drug interactions). APhA supports the communication of all plan management options available (e.g., approved formulary alternatives) from the claims processor to the pharmacist.
6. APhA supports the development and use of systems to communicate in-pharmacy drug utilization review messages with online claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of preadjudication drug utilization review messages (i.e., drug utilization review communication between the prescriber and claims processor) to the pharmacist.

8. APhA supports efforts to:

- (a) improve online drug utilization review messages by the establishment of evidence-based criteria to prevent drug-related conflicts that have the potential for causing serious harm, and
- (b) eliminate drug utilization review messages that have questionable or inconsequential impact on patient outcomes.

[JAPhA. NS4(5);(suppl 1):57; September/October 2001] (Reviewed 2003) (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2001**

### **Automation and Technical Assistance**

APhA supports the use of automation for prescription preparation and supports technical and personnel assistance for performing administrative duties and facilitating pharmacists' provision of pharmaceutical care.

[JAPhA. NS4(5);(suppl 1):58; September/October 2001] (Reviewed 2004) (Reviewed 2007) (Reviewed 2008) (Reviewed 2013) (Reviewed 2015)

**2001**

### **Medication Error Reporting**

1. APhA strongly encourages participation in error reporting at the organizational (pharmacy/institution) level and in other established state and national reporting programs.
2. APhA encourages direct error reporting by the individual(s) involved in the incident to ensure that the most relevant and detailed information is available for evaluation of the incident and for systems improvement.
3. Error reporting programs should regularly analyze and report information about the leading types and causes of errors reported to their system so that practitioners can utilize this information for systems enhancements and quality improvement.
4. APhA encourages state boards of pharmacy and other responsible entities to consider pharmacists participation in reporting of errors as a mitigating factor in determining any legal or disciplinary action related to the incident.

[JAPhA. NS4(5);(suppl 1):S8; September/October 2001] (Reviewed 2007) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2001**

### **Pharmacist Counseling on Administration Devices**

APhA encourages patient and caregiver education by a pharmacist on the appropriate use of drug administration devices.

[JAPhA. NS4(5);(suppl 1):S9; September/October 2001] (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

**2001, 1990**

### **Regulatory Infringements on Professional Practice**

1. APhA, in cooperation with other national pharmacy organizations, shall take a leadership role in the establishment and maintenance of standards of practice for existing and emerging areas in the profession of pharmacy.
2. APhA encourages a cooperative process in the development, enforcement, and review of rules and regulations by agencies that affect any aspect of pharmacy practice, and this process must utilize the expertise of affected pharmacist specialists and their organizations.
3. APhA supports the right of pharmacists to exercise professional judgment in the implementation of standards of practice in their practice settings.

[Am Pharm. NS30(6):45; June 1990] [JAPhA. NS4(5)(suppl 1):S7; September/October, 2001] (Reviewed 2007) (Reviewed 2012) (Reviewed 2017) (Reviewed 2020)

**2000**

### **Use of the Phrase "Community Pharmacy"**

APhA supports use of the phrase "community pharmacy" rather than "retail pharmacy."

[JAPhA. NS40(5);(suppl 1):S8; September/October 2000] (Reviewed 2002) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

**1996**

### **Quality Assurance and Improvement in Pharmacy Practice**

1. APhA recommends that all pharmacists incorporate principles and tools available to continually improve the quality of patient care and management activities in their practices.
2. APhA recommends that content on principles and tools available to continually improve the quality of patient care and management practices be incorporated into pharmacy school curricula and into postgraduate education for pharmacists.
3. APhA supports appropriate evaluation and recognition of providers of pharmaceutical care.

[JAPhA. NS36(6):395; June 1996] (Reviewed 2004) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016)

1993

### **Patient Counseling Environment**

APhA encourages the development and use of responsible and effective design of pharmacy facilities to allow for convenient, comfortable, and private pharmacist-patient communications.

[Am Pharm. NS33(7):56; July 1993] [Reviewed 2002] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017] [Reviewed 2019]

1991

### **Emerging Technologies**

1. APhA supports programs to monitor the development of emerging technologies and their impact on the delivery of pharmaceutical care.
2. APhA supports education of pharmacists regarding emerging technology including their development and impact on the delivery of pharmaceutical care.
3. APhA supports the inclusion of pharmacists in the development and application of the emerging technologies in the delivery of pharmaceutical care.

[Am Pharm. NS31(6):28; June 1991] [Reviewed 2004] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

1991

### **Mission of Pharmacy**

APhA affirms that the mission of pharmacy is to serve society as the profession responsible for the appropriate use of medications, devices, and services to achieve optimal therapeutic outcomes.

[Am Pharm. NS31(6):29; June 1991] [Reviewed 2004] [Reviewed 2010] [Reviewed 2015] [Reviewed 2018]

1991

### **Pharmaceutical Care and the Provision of Cognitive Services with Technologies**

1. APhA supports the utilization of technologies to enhance the pharmacist's ability to provide pharmaceutical care.
2. APhA believes that the use of technologies should not replace the pharmacist/patient relationship.
3. APhA emphasizes that maximizing patient benefit from technologies depends on the pharmacist/patient relationship.
4. APhA affirms that the utilization of technologies by pharmacists shall not compromise the patient's right to confidentiality.

[Am Pharm. NS32(6):515; June 1991] [Reviewed 2001] [Reviewed 2007] [Reviewed 2009] [Reviewed 2013] [Reviewed 2014] [Reviewed 2019]

1988

### **Drug Usage Evaluation (DUE)**

1. APhA supports drug usage evaluation (DUE) as one element of a quality assurance program for medication use.
2. APhA advocates that DUE must address enhancement of the quality of care as well as the control of costs.
3. APhA advocates pharmacists' participation along with other health care providers and consumers in the development, implementation, and administration of DUE programs.
4. APhA encourages further development of data collection systems to improve the extent and accuracy of DUE programs.
5. APhA maintains that the primary emphasis of DUE intervention should be educational with the goal of positive behavior modification.

[Am Pharm. NS28(6):394; June 1988] [Reviewed 2004] [Reviewed 2010] [Reviewed 2015]

1983

### **Stocking a Complete Inventory of Pharmaceutical Product**

APhA supports the rights and responsibilities of individual pharmacists to determine their inventory and dispensing practices based on patient need, practice economics, practice security, and professional judgment.

[Am Pharm. NS23(6):52; June 1983] [Reviewed 2004] [Reviewed 2010] [Reviewed 2015]

## *Facility Design and Face-to-Face Communication*

2012, 1992

### **Patient Care and Medication Distribution Systems**

APhA encourages those responsible for practice environments without direct patient/pharmacist contact to use methods to enhance communication, face-to-face interaction, and patient care.

[Am Pharm. NS32(6):515; June 1992] [Reviewed 2001] [Reviewed 2007] [JAPhA. NS52(4) 459; July/August 2012] [Reviewed 2017]

1993

### **Patient Counseling Environment**

APhA encourages the development and use of responsible and effective design of pharmacy facilities to allow for convenient, comfortable, and private pharmacist-patient communications.

[Am Pharm. NS33(7):56; July 1993] [Reviewed 2002] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017] [Reviewed 2019]

## **PHARMACY TECHNICIANS**

2020

### **Pharmacy Technician Role in Immunization Administration**

1. APhA supports the development of standardized training in immunization administration and continuing education opportunities for immunizing pharmacy technicians.
2. APhA supports immunizing pharmacist's individual discretion in delegating immunization administration to pharmacy technicians with the requisite education, training, and experience.
3. APhA supports voluntary participation by pharmacy technicians in the training and provision of immunization administration.
4. APhA supports the role of immunizing pharmacists as the health care professional providing clinical patient assessment, decision making, and patient counseling when delegating immunization administration to a pharmacy technician.

[JAPhA. 2020;60(5):e10]

2019

### **Creating Safe Work and Learning Environments for Student Pharmacists, Pharmacists, and Pharmacy Technicians**

1. APhA strongly believes that all pharmacists, student pharmacists, and pharmacy technicians should be safe in their work and learning environments and be free from firearm-related violence.
2. APhA strongly recommends that technician training programs, schools and colleges of pharmacy, postgraduate training programs, and employers should develop programs to increase readiness in the event of an active shooter.
3. APhA strongly believes pharmacists, student pharmacists, and pharmacy technicians should be trained to recognize and refer patients at high risk of violence to themselves or others.
4. APhA encourages pharmacists, student pharmacists, and pharmacy technicians who are victims of firearm-related violence to seek the help of counselors and other trained mental health professionals.

[JAPhA. 59(4):e17; July/August 2019]

2019

### **Expanding Technician Roles**

1. APhA encourages state boards of pharmacy to develop regulations allowing expanded pharmacy technician roles that allow both technicians and pharmacists to practice at the top of their training and license or certification.
2. APhA supports state board of pharmacy regulations that standardize and set minimum didactic and experiential standards for technicians to allow for functioning in expanded roles.

[JAPhA. 59(4):e17; July/August 2019]

2017

### **Pharmacy Technician Education, Training, and Development**

1. APhA supports the following minimum requirements for all new pharmacy technicians:
  - (a) Successful completion of an accredited or state-approved education and training program.
  - (b) Certification by the Pharmacy Technician Certification Board (PTCB).
2. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, certification, and recertification. APhA encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians. APhA also encourages boards of pharmacy to delineate between pharmacy technicians and student pharmacists for the purposes of education, training, certification, and recertification.
3. APhA recognizes the important contribution and role of pharmacy technicians in assisting pharmacists and student pharmacists with the delivery of patient care.
4. APhA supports the development of resources and programs that promote the recruitment and retention of qualified pharmacy technicians.

5. APhA supports the development of continuing pharmacy education programs that enhance and support the continued professional development of pharmacy technicians.
6. APhA encourages the development of compensation models for pharmacy technicians that promote sustainable career opportunities.

[JAPhA. 57(4):442; July/August 2017]

**2014**

### **Audits of Health Care Practices**

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

[JAPhA. 54(4)357; July/August 2014] (Reviewed 2019)

**2007**

### **Privacy of Pharmacists' Personal Information**

1. APhA supports protecting pharmacist, student pharmacist, and pharmacy technician personal information (e.g., home address, telephone, and personal email address).
2. APhA opposes legislative or regulatory requirements that mandate the publication of pharmacist, student pharmacist and pharmacy technician personal information (e.g., home address, telephone, and personal email address).
3. APhA encourages state boards of pharmacy to remove from their websites personal addresses, phone numbers, email, and other nonbusiness contact information of pharmacists, student pharmacists, and pharmacy technicians.

[JAPhA. NS45(5):580; September–October 2007] (Reviewed 2012) (Reviewed 2017)

**2004, 1996**

### **Technician Licensure and Registration**

APhA recognizes the following definitions with regards to technician licensure and registration:

- (a) Licensure: The process by which an agency of government grants permission an individual to engage in a given occupation upon finding that the applicant has attained the minimal degree of competency necessary to ensure that the public health, safety, and welfare will be reasonably well protected. Within pharmacy, a pharmacist is licensed by a State Board of Pharmacy.
- (b) Registration: The process of making a list or being enrolled in an existing list.

[JAPhA. NS36(6):396; June 1996] (Reviewed 2001) [JAPhA. NS44(5):551; September/October 2004] (Reviewed 2008) (Reviewed 2010) (Reviewed 2015) (Reviewed 2018)

**2001**

### **Automation and Technical Assistance**

APhA supports the use of automation for prescription preparation and supports technical and personnel assistance for performing administrative duties and facilitating pharmacists' provision of pharmaceutical care.

[JAPhA. NS41(5);[suppl 1]:58; September/October 2001] (Reviewed 2004) (Reviewed 2007) (Reviewed 2008) (Reviewed 2013) (Reviewed 2015)

# POISON PREVENTION

2004, 1967

## Poison Control, Information, and Treatment: Pharmacists' Responsibilities

APhA recommends that pharmacists take a more active role in poison prevention and establishing poison information, poison treatment, and poison control centers where none exists.

[JAPhA. NS7:323; June 1967] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

2004, 1968

## Poison Control, Information, and Treatment: Pharmacists' Responsibility

1. APhA encourages pharmacists to familiarize themselves with the available resources on poisons and toxicology.
2. APhA encourages pharmacists to become familiar with the poison control, information, and treatment center in their localities.

[JAPhA. NS8:383; July 1968] [JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

# POSTMARKETING SURVEILLANCE

2010

## Pharmacogenomics/Personalized Medicine

1. APhA supports evidence-based personalized medicine, defined as the use of a person's clinical, genetic, genomic, and environmental information to select a medication or its dose, to choose a therapy, or to recommend preventive measures, as a means to improve patient safety and optimize health outcomes.
2. APhA promotes pharmacists as health care providers in the collection, use, interpretation, and application of pharmacogenomic data to optimize health outcomes.
3. APhA supports the development and implementation of programs, tools, and clinical guidelines that facilitate the translation and application of pharmacogenomic data into clinical practice.
4. APhA supports the inclusion of pharmacogenomic analysis in the drug development/approval and postmarketing surveillance processes.

[JAPhA. NS50(4):471; July/August 2010] [Reviewed 2015] [Reviewed 2019]

2009

## Pharmacist's Role in Patient Safety

1. It is APhA's position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and post-marketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized, and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, nonpunitive, easily accessible, and user friendly for all providers within the health care system.
6. APhA supports the elimination of handwritten prescriptions or medication orders.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2010] [Reviewed 2015] [Reviewed 2019]

1988

## **Postmarketing Surveillance**

1. APhA supports and encourages the active participation of pharmacists in initiating, organizing, and maintaining postmarketing surveillance programs including, but not limited to, adverse drug reaction reporting and drug product problem reporting for drugs and other health care products.
2. APhA recognizes postmarketing surveillance as a process that systematically and comprehensively monitors the patterns of use and the harmful or beneficial effects (whether expected or unexpected) of prescription and nonprescription drugs and other health care products as they are used in the general population. The ultimate purpose of postmarketing surveillance is to develop and systematically disseminate information that can be used to provide safe and cost-effective drug therapy.
3. APhA supports the development of educational programs to foster the active involvement of pharmacy practitioners and students in postmarketing surveillance programs.
4. APhA encourages public and private collaboration in the funding and development of postmarketing surveillance methodologies and programs.
5. APhA encourages FDA and the pharmaceutical industry to actively involve pharmacists in spontaneous adverse reaction reporting systems and to provide appropriate and timely feedback on collected data.

[Am Pharm. NS28(6):396; June 1988] [Reviewed 2004] [Reviewed 2009] [Reviewed 2010] [Reviewed 2015]

# **PRESCRIBING AUTHORITY**

2020

## **Accountability of Pharmacists**

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role Within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

[JAPhA. 2020;60(5):e9]

2017, 2012

## **Contemporary Pharmacy Practice**

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2016] [JAPhA. 57(4):441; July/August 2017] [Reviewed 2019]

2017

### **Patient Access to Pharmacist-Prescribed Medications**

1. APhA asserts that pharmacists' patient care services and related prescribing by pharmacists help improve patient access to care, patient outcomes, and community health, and they align with coordinated, team-based care.
2. APhA supports increased patient access to care through pharmacist prescriptive authority models.
3. APhA opposes requirements and restrictions that impede patient access to pharmacist-prescribed medications and related services.
4. APhA urges prescribing pharmacists to coordinate care with patients' other health care providers through appropriate documentation, communication, and referral.
5. APhA advocates that medications and services associated with prescribing by pharmacists must be covered and compensated in the same manner as for other prescribers.
6. APhA supports the right of patients to receive pharmacist-prescribed medications at the pharmacy of their choice.

[JAPhA. 57(4):441; July/August 2017] (Reviewed 2019) (Reviewed 2020)

2013, 2009

### **Independent Practice of Pharmacists**

1. APhA recommends that health plans and payers contract with and appropriately compensate individual pharmacist providers for the level of care rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to the independent practice of pharmacists when those laws and rules are consistent with APhA policy.
3. APhA, recognizing the positive impact that pharmacists can have in meeting unmet needs and managing medical conditions, supports the adoption of laws and regulations and the creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services, including prescribing, as part of the health care team.

[JAPhA. NS49(4):492; July/August 2009] (Reviewed 2012) [JAPhA. 53(4):366; July/August 2013] (Reviewed 2018)

2013, 1980

### **Medication Selection by Pharmacists**

APhA supports the concept of a team approach to health care in which health care professionals perform those functions for which they are educated. APhA recognizes that the pharmacist is the expert on drugs and drug therapy on the health care team and supports a medication selection role for the pharmacist, based on the specific diagnosis of a qualified health care practitioner.

[Am Pharm. NS20(7):62; July 1980] (Reviewed 2003) (Reviewed 2007) (Reviewed 2008) (Reviewed 2009) (Reviewed 2011) (Reviewed 2012) [JAPhA. 53(4):366; July/August 2013] (Reviewed 2018)

2003, 2000

### **Emergency Contraception**

APhA supports the voluntary involvement of pharmacists, in collaboration with other health care providers, in emergency contraceptive programs that include patient evaluation, patient education, and direct provision of emergency contraceptive medications.

[JAPhA. NS40(5)(suppl 1):S8; September/October 2000] [JAPhA. NS43(5):(suppl 1):S58; September/October 2003] (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2018)

2003, 1992

### **The Pharmacist's Role in Therapeutic Outcomes**

1. APhA affirms that achieving optimal therapeutic outcomes for each patient is a shared responsibility of the health care team.
2. APhA recognizes that a primary responsibility of the pharmacist in achieving optimal therapeutic outcomes is to take an active role in the development and implementation of a therapeutic plan and in the appropriate monitoring of each patient.

[Am Pharm. NS32(6):515; June 1992] [JAPhA. NS43(5):(suppl 1):S57; September/October 2003] (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016) (Reviewed 2016)

# PRESCRIPTIONS AND PRESCRIPTION ORDERS

2020

## **Increasing Access to and Advocacy for Medications for Opioid Use Disorder (MOUD)**

1. APhA supports the use of evidence-based medicine as first-line treatment for opioid use disorder for patients, including health care professionals in and out of the workplace, for as long as needed to treat their disease.
2. APhA encourages pharmacies to maintain an inventory of medications used in treatment of opioid use disorder to ensure access for patients.
3. APhA encourages pharmacists and payers to ensure patients have equitable access to, and coverage for, at least one medication from each class of medications used in the treatment of opioid use disorder.

[JAPhA. 2020;60(5):e11]

2020, 2015

## **Integrated Nationwide Prescription Drug Monitoring Program**

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, system response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for
  - (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud;
  - (b) providing focused provider education and patient referral to treatment programs; and
  - (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

[JAPhA. N55(4):364; July/August 2015] [JAPhA. 2020;60(5):e10]

2020

## **Transfer of Schedule III–V Prescriptions for Purposes of Initial Fill as Well as Refill**

APhA supports regulations that would allow pharmacies to transfer prescriptions for controlled substances for the purposes of an initial fill.

[JAPhA. 2020;60(5):e10]

2017

## **Indication on Prescription Labels and Medication Safety**

APhA supports pharmacists' authority to include a medication's purpose on prescription labels, on the basis of professional knowledge, judgment, and patient preference, using vocabulary that is appropriate for their unique practice sites and that addresses the needs of their specific patient populations.

[JAPhA. 57(4):442; July/August 2017]

2011, 1995

### **Adequacy of Directions for Use on Prescriptions and Prescription Orders**

1. APhA recommends that all professions with prescriptive authority address the issue of prescribers' responsibility for specific instructions to the pharmacist and the patient in all prescription orders.
2. APhA affirms the pharmacist's responsibility, as the patient's advocate, to obtain and communicate adequate directions for use of medications.

[Am Pharm. NS35(6):37; June 1995] (Reviewed 2006) [JAPhA. NS51(4):484 July/August 2011] (Reviewed 2016) (Reviewed 2017)

2009

### **Pharmacist's Role in Patient Safety**

1. It is APhA's position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and postmarketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized, and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, nonpunitive, easily accessible, and user friendly for all providers within the health care system.
6. APhA supports the elimination of handwritten prescriptions or medication orders.

[JAPhA. NS49(4):492; July/August 2009] (Reviewed 2010) (Reviewed 2015) (Reviewed 2019)

2001

### **Prescription Order Requirements**

1. APhA supports the use of technology to facilitate the transmission of prescription order information from the prescriber to the pharmacist of the patient's choice at no additional cost to the pharmacy.
2. APhA supports the use of technology where appropriate standards for patient confidentiality and prescriber and pharmacist verification are established.
3. APhA supports the transmission of complete prescriber information on or with the prescription order that enables the pharmacist to readily identify and facilitate communication with the prescriber.
4. APhA supports the use of specific instructions with prescription orders. Use of potentially confusing terminology (e.g., "as directed," unclear use of Latin phrases, confusing abbreviations) should be avoided.
5. APhA supports the inclusion of the diagnosis or indication for use for which the medication is ordered on or with the transmission of the prescription order by use of standard diagnosis codes or within the directions for use. APhA further supports the inclusion of patient-specific information on or with the prescription order where appropriate.
6. APhA supports public education about the benefits and risks of technological advances in pharmacy practice.

[JAPhA. NS41(5)[suppl 1]:S8; September/October 2001] (Reviewed 2007) (Reviewed 2009) (Reviewed 2010) (Reviewed 2012) (Reviewed 2017) (Reviewed 2018)

1989

### **Multiple-Copy Prescription Order Programs**

1. APhA opposes federally mandated, multiple copy prescription order programs.
2. APhA supports the right of individual states to develop programs to prevent drug abuse and drug diversion.

[Am Pharm. NS29(7):464; July 1989] (Reviewed 2001) (Reviewed 2006) (Reviewed 2011) (Reviewed 2015)

# PUBLIC HEALTH

2020

## Pharmacy Technician's Role in Immunization Administration

1. APhA supports the development of standardized training in immunization administration and continuing education opportunities for immunizing pharmacy technicians.
2. APhA supports immunizing pharmacist's individual discretion in delegating immunization administration to pharmacy technicians with the requisite education, training, and experience.
3. APhA supports voluntary participation by pharmacy technicians in the training and provision of immunization administration.
4. APhA supports the role of immunizing pharmacists as the health care professional providing clinical patient assessment, decision making, and patient counseling when delegating immunization administration to a pharmacy technician.

[JAPhA. 2020;60(5):e10]

2020

## Providing Affordable and Comprehensive Pharmacy Services to the Underserved

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower health care costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable law.

[JAPhA. 2020;60(5):e11]

2019, 2016

## Substance Use Disorder

1. APhA supports legislative, regulatory, and private sector efforts that include pharmacists' input and that will balance patient/consumers' need for access to medications for legitimate medical purposes with the need to prevent the diversion, misuse, and abuse of medications.
2. APhA supports consumer sales limits of nonprescription drug products, such as methamphetamine precursors, that may be illegally converted into drugs for illicit use.
3. APhA encourages education of all personnel involved in the distribution chain of nonprescription products so they understand the potential for certain products, such as methamphetamine precursors, to be illegally converted into drugs for illicit use. APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.
4. APhA supports public and private initiatives to fund treatment and prevention of substance use disorders.
5. APhA supports stringent enforcement of criminal laws against individuals who engage in drug trafficking.

[JAPhA. 56(4):369; July/August 2016] [JAPhA. 59(4):e28; July/August 2019]

## *Alcohol and Tobacco*

2016, 2006

## Tobacco and Nicotine Use Data Entry Field in Pharmacy Patient Records

APhA supports standardizing patient records and clinical decision support tools (including pharmacy dispensing systems) to collect, document, and utilize information regarding the patient's tobacco and nicotine use.

[JAPhA. NS46(5):561; September/October 2006] [Reviewed 2011] [JAPhA. 56(4):380; July/August 2016]

2014

## The Use and Sale of Electronic Cigarettes (e-cigarettes)

1. APhA opposes the sale of e-cigarettes and other vaporized nicotine products in pharmacies until such time that scientific data support the health and environmental safety of these products.
2. APhA opposes the use of e-cigarettes and other vaporized nicotine products in areas subject to current clean air regulations for combustible tobacco products until such time that scientific data support the health and environmental safety of these products.
3. APhA urges pharmacists to become more knowledgeable about e-cigarettes and other vaporized nicotine products.

[JAPhA. 54(4):358; July/August 2014] [Reviewed 2019]

2010

### **Discontinuation of the Sale of Tobacco Products in Pharmacies and Facilities That Include Pharmacies**

1. APhA urges pharmacies and facilities that include pharmacies to discontinue the sale of tobacco products.
2. APhA urges the federal government and state governments to limit participation in government-funded prescription programs to pharmacies that do not sell tobacco products.
3. APhA urges state boards of pharmacy to discontinue issuing and renewing licenses to pharmacies that sell tobacco products and to pharmacies that are in facilities that sell tobacco products.
4. APhA urges colleges of pharmacy to only use pharmacies that do not sell tobacco products as experience sites for their students.
5. APhA urges the Accreditation Council for Pharmacy Education (ACPE) to adopt the position that college-administered pharmacy experience programs should only use pharmacies that do not sell tobacco products.
6. APhA urges pharmacists and student pharmacists who are seeking employment opportunities to first consider positions in pharmacies that do not sell tobacco products.

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2015)

2005, 1971

### **Cigarette Sales in Pharmacies**

1. APhA recommends that tobacco products not be sold in pharmacies.
2. APhA recommends that state and local pharmacist associations develop similar policy statements for their membership and increase their involvement in public educational programs regarding the health hazards of smoking.
3. APhA recommends that individual pharmacists give particular attention to educating young people on the health hazards of smoking.
4. APhA recommends that APhA-ASP develop projects aimed at educating young people on the health hazards of smoking, such as visiting schools and conducting health education programs.

[JAPhA. NS11:270; May 1971] [JAPhA. NS45(5):555; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2018)

1996

### **Exclusion of Alcohol and Tobacco Sales in Pharmacy Practice Settings**

APhA opposes the sale of tobacco products and nonmedicinal alcoholic beverages in pharmacies.

[JAPhA. NS36(6):396; June 1996] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

## *Community Awareness and Education*

2014

### **Use of Social Media**

1. APhA encourages the use of social media in ways that advance patient care and uphold pharmacists as trusted and accessible health care providers.
2. APhA supports the use of social media as a mechanism for the delivery of patient-specific care in a platform that allows for appropriate patient and provider protections and access to necessary health care information.
3. APhA supports the inclusion of social media education, including but not limited to appropriate use and professionalism, as a component of pharmacy education and continuing professional development.
4. APhA affirms that the patient's right to privacy and confidentiality shall not be compromised through the use of social media.
5. APhA urges pharmacists and student pharmacists to self-monitor their social media presence for professionalism and that posted clinical information is accurate and appropriate.
6. APhA advocates for continued development and utilization of social media by pharmacists and other health care professionals during public health emergencies.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2012, 2005, 1992

### **The Role of Pharmacists in Public Health Awareness**

1. APhA recognizes the unique role and accessibility of pharmacist in public health.
2. APhA encourages pharmacists to provide services, education, and information on public health issues.
3. APhA encourages the development of public health programs for use by pharmacists and student pharmacists.

4. APhA should provide necessary information and materials for student pharmacists and pharmacists to carry out their role in disseminating public health information.
5. APhA encourages organizations to include pharmacists and student pharmacists in the development of public health programs.

[Am Pharm. NS32(6):515; June 1992] [JAPhA. 45(5):556; September/October 2005] [Reviewed 2009] [Reviewed 2010] [JAPhA. NS52(4):460; July/August 2012] [Reviewed 2017] [Reviewed 2020]

**2000**

### **Medication Use in Schools**

APhA recognizes the role of pharmacists in improving the use of medications in schools and supports pharmacist activities to work with teachers, school nurses, parents, school administrators and other personnel to improve medication use in this environment. APhA recommends that pharmacists be involved in the development of guidelines for medication use in schools.

[JAPhA. NS1(9):40; September/October 2000] [Reviewed 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

## *HIV/AIDS*

**2020, 1996**

### **Human Immunodeficiency Virus (HIV) Testing in Women**

APhA encourages pharmacists to provide pharmaceutical care for women, including education about the availability and benefits of opt-out human immunodeficiency virus (HIV) testing in prenatal and perinatal care, to decrease the risk of HIV transmission to unborn children and between partners. APhA encourages pharmacists to provide education about the availability and benefits of opt-out HIV testing in prenatal and perinatal care, including offering and/or performing testing to the patients and their partners.

[Am Pharm. NS36(6):395; June 1996] [Reviewed 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019] [JAPhA. 2020;60(5):e9]

**2005, 1993**

### **Human Immunodeficiency Virus (HIV) Testing**

1. APhA opposes mandatory human immunodeficiency virus (HIV) testing of pharmacists, student pharmacists, and pharmacy personnel.
2. APhA supports voluntary and confidential human immunodeficiency virus (HIV) testing of pharmacists, student pharmacists, and pharmacy personnel, to facilitate early detection and disease intervention.
3. APhA supports training designed to foster compliance with infection control procedures outlined in current Centers for Disease Control and Prevention (CDC) guidelines for universal precautions and OSHA standards for blood-borne pathogens.
4. APhA encourages the development of support networks to assist human immunodeficiency virus (HIV) positive health care professionals and students.

[Am Pharm. NS33(7):54; July 1993] [JAPhA. NS45(5):556; September/October 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019] [Reviewed 2020]

**1999**

### **Sale of Sterile Syringes**

APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to permit the unrestricted sale or distribution of sterile syringes and needles by or with the knowledge of a pharmacist in an effort to decrease the transmission of blood-borne diseases.

[JAPhA. 39(4):447; July/August 1999] [Reviewed 2003] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019] [Reviewed 2020]

## *Immunizations*

**2018**

### **Proactive Immunization Assessment and Immunization Information Systems**

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.

3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

[JAPhA. 58(4):355; July/August 2018]

**2011**

### **Requiring Influenza Vaccination for All Pharmacy Personnel**

APhA supports an annual influenza vaccination as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination).

[JAPhA. NS51(4):482 July/August 2011] [Reviewed 2012] [Reviewed 2017]

**2007**

### **Pharmacy Personnel Immunization Rates**

1. APhA supports efforts to increase immunization rates of health care professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for health care workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (e.g., physicians, nurses, police) and prioritize pharmacists to receive medications and immunizations.

[JAPhA. NS45(5):580; September/October 2007] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

**2005, 2003, 1996**

### **Pharmacist's Role in Immunizations**

1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through
  - (a) advocacy,
  - (b) contracting with other health care professionals, or
  - (c) administering vaccines to vulnerable patients.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

[JAPhA. NS36(6):395; June 1996] [JAPhA. NS43(5)[suppl 1]:S57 ; September/October 2003] [JAPhA. NS45(5):556; September/October 2005] [Reviewed 2007] [Reviewed 2009] [Reviewed 2012] [Reviewed 2014] [Reviewed 2019] [Reviewed 2020]

## *Other Public Health Issues*

**2020**

### **Pharmaceutical Safety and Access During Emergencies**

1. APhA urges government authorities to hold pharmaceutical manufacturers, wholesalers, pharmacies, and other pharmaceutical supply distributors and providers accountable to state and federal price gouging laws in selling those items to patients, pharmacies, hospitals, and other health care providers during times of local, state, or national emergency.
2. APhA urges government authorities to aggressively enforce laws and regulations against adulterated products and false and misleading claims by entities offering to sell pharmaceutical and medical products to health care providers and consumers.

[JAPhA. 2020;60(5):e11]

2020

### **Protecting Pharmacy Personnel During Public Health Crisis**

1. APhA strongly urges all employers of pharmacists and pharmacy personnel, and the settings in which they practice, to implement protection and control measures and procedures, per consensus recommendations when available, and access to protective gear and cleaning supplies that ensure the safety of pharmacy personnel and that of their family members and the public.
2. APhA urges federal and state government officials, manufacturers, distributors, and health system administrators to recognize pharmacists and pharmacy personnel as “frontline providers” who should receive appropriate personal protective equipment and other resources to protect their personal safety and support their ability to continue to provide patient care.

[JAPhA. 2020;60(5):e11]

2018

### **Efforts to Reduce the Stigma Associated with Mental Health Disorders or Diseases**

1. APhA encourages all stakeholders to develop and adopt evidence-based approaches to educate the public and all health care professionals to reduce the stigma associated with mental health diagnoses.
2. APhA supports the increased utilization of pharmacists and student pharmacists with appropriate training to actively participate in the care of patients with mental health diagnoses as members of interprofessional health care teams in all practice settings.
3. APhA supports the expansion of mental health education and training in the curriculum of all schools and colleges of pharmacy, postgraduate training, and within continuing professional development programs.
4. APhA supports the development of education and resources to address health care professional resiliency and burnout.

[JAPhA. 58(4):356; July/August 2018]

2017

### **Drug Disposal Program Involvement**

APhA urges pharmacists to expand patient access to secure, convenient, and ecologically responsible drug disposal options, in accordance with the Secure and Responsible Drug Disposal Act of 2010, by implementing disposal programs they deem appropriate for their individual practice sites, patient care settings, and business models in an effort to reduce the amount of dispensed but unused prescription drug product available for diversion and misuse.

[JAPhA. 57(4):441; July/August 2017]

2017

### **Support for Clinically Validated Blood Pressure Measurement Devices**

1. APhA supports the use of manual and automated blood pressure measurement devices that are clinically validated initially and then undergo routine calibration to ensure accurate results.
2. APhA supports regulations and peer-reviewed clinical validation testing for automated blood pressure measurement devices.
3. APhA promotes public awareness of accuracy of automated blood pressure measurement devices.

[JAPhA. 57(4):442; July/August 2017]

2016

### **Medication-Assisted Treatment**

APhA supports expanding access to medication-assisted treatment (MAT), including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

[JAPhA. 56(4):370; July/August 2016]

2016

### **Point-of-Care Testing**

1. APhA recognizes the value of pharmacist-provided point-of-care testing and related clinical services and promotes the provision of those tests and services in accordance with the Joint Commission of Pharmacy Practitioners Pharmacists’ Patient Care Process.
2. APhA advocates for laws, regulations, and policies that enable pharmacist-provided point-of-care testing and related clinical services that are consistent with the pharmacists’ role in team-based care.
3. APhA opposes laws, regulations, and policies that create barriers to the tests that have been waived by the Clinical Laboratory Improvement Amendments (CLIA) and that are administered and interpreted by pharmacists.
4. APhA encourages use of educational programming and resources to facilitate practice implementation of pharmacist-provided point-of-care testing and related clinical services.

5. APhA supports patients taking active roles in the management of their health, including their ability to request and obtain pharmacist-provided point-of-care tests and related clinical services.
6. APhA advocates for access to, coverage of, and payment for both pharmacist-provided point-of-care tests and any related clinical services.

[JAPhA. 56(4):369; July/August 2016] [Reviewed 2018] [Reviewed 2019] [Reviewed 2020]

**2015**

### **Disaster Preparedness**

APhA encourages pharmacist involvement in surveillance, mitigation, preparedness, planning, response, and recovery related to terrorism and infectious diseases.

[JAPhA. N55(4):365; July/August 2015]

**2015**

### **Prenatal and Perinatal Care and Maternal Health**

APhA supports pharmacists, in collaboration with the health care team, providing adequate and comprehensive prenatal and perinatal care for overall maternal and newborn health and wellness.

[JAPhA. N55(4):365; July/August 2015]

**2015**

### **Role of the Pharmacist in the Care of Patients Using Cannabis**

1. APhA supports regulatory changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in furnishing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to furnish them.
5. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.

[JAPhA. N55(4):365; July/August 2015]

**2013**

### **Medication Take-Back/Disposal Programs**

1. APhA encourages pharmacist involvement in the planning and coordination of medication take-back programs for the purpose of disposal.
2. APhA supports increasing public awareness regarding medication take-back programs for the purpose of disposal.
3. APhA urges public and private stakeholders, including local, state, and federal agencies, to coordinate and create uniform, standardized regulations, including issues related to liability and sustainable funding sources, for the proper and safe disposal of unused medications.
4. APhA recommends ongoing medication take-back and disposal programs.

[JAPhA. 53(4):365; July/August 2013] [Reviewed 2018]

**2013**

### **Pharmacists Providing Primary Care Services**

APhA advocates for the recognition and utilization of pharmacists as providers to address gaps in primary care.

[JAPhA. 53(4):365; July/August 2013] [Reviewed 2018] [Reviewed 2019] [Reviewed 2020]

**2013, 2008**

### **Reuse of Devices Intended for “Single Use”**

APhA opposes the reuse of devices intended for “single use” in the screening and management of patients, consistent with the Centers for Disease Control and Prevention (CDC) and Occupational Safety and Health Administration (OSHA) guidelines.

[JAPhA. NS48(4):471; July/August 2008] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2018]

**2011, 1996**

### **Fluoridation of Water Supplies**

APhA reaffirms its 1954 position in support of appropriate fluoridation of water supplies and encourage pharmacists to assist in implementing such programs in their local communities.

[JAPhA. NS6:293; June 1996] (Reviewed 2005) (Reviewed 2009) [JAPhA. NS51(4):484 July/August 2011] (Reviewed 2016)

**2011**

### **The Role and Contributions of the Pharmacist in Public Health**

In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.

[JAPhA. NS51(4):482 July/August 2011] (Reviewed 2012) (Reviewed 2016) (Reviewed 2020)

**2009**

### **Medication Disposal**

1. APhA encourages appropriate public and private partnerships to accept responsibility for the costs of implementing safe medication disposal programs for consumers. Furthermore, APhA urges DEA to permit the safe disposal of controlled substances by consumers or on their behalf.
2. APhA encourages provision of patient-appropriate quantities of medication supplies to minimize unused medications and unnecessary medication disposal.

[JAPhA. NS49(4):493; July/August 2009] (Reviewed 2012) (Reviewed 2013) [2018]

**2007**

### **Redistribution of Previously Dispensed Medications**

1. As a matter of patient safety, APhA opposes the redispensing of a previously dispensed medication once it has been out of the control of a health care professional.
2. APhA supports a public awareness program to explain why the redispensing of a previously dispensed medication once it is out of the control of the health care professional is a public health safety concern.

[JAPhA. NS45(5):580; September/October 2007] (Reviewed 2012) (Reviewed 2017)

**2007**

### **WHO Policy on Infectious Diseases**

1. APhA supports the World Health Organization's (WHO) requirements for accurate and expeditious reporting of infectious diseases from all countries, including unrestricted sharing of infectious substance samples with WHO.
2. APhA supports access to affordable vaccines in all countries.

[JAPhA. NS45(5):580; September/October 2007] (Reviewed 2012) (Reviewed 2017)

**2005, 1997**

### **Complementary/Alternative Medications and Integrative Health**

1. APhA supports pharmacists using professional judgment to make informed decisions regarding the appropriateness of use or the sale of complementary and alternative medicines.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety, and possible interactions.

[JAPhA. NS37(4); July/August 1997] (Reviewed 2002) [JAPhA. NS45(5):556-557; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2005, 2002**

### **Health Literacy**

1. APhA encourages pharmacists and student pharmacists to increase their awareness of health literacy. Health literacy is the degree to which people can obtain, process, and understand basic health information and services they need to make appropriate health decisions.
2. APhA encourages pharmacists and student pharmacists to assess patients' health literacy and then implement appropriate communications and education.
3. APhA encourages the review of all patient information for health literacy appropriateness.

[JAPhA. NS42(5)(suppl 1):S60; September/October 2002] [JAPhA. NS45(5):556; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005, 1972

## **Prevention and Control of Sexually Transmitted Infections**

1. APhA calls upon all producers of prophylactic devices to include in or on their packaging adequate instructions for use so as to better ensure the effectiveness of the devices in the prevention of sexually transmitted infections.
2. APhA urges pharmacists to make more readily available to the public educational materials, prophylactic devices, and adequate instructions for use in combating sexually transmitted infections.

[JAPhA. NS12:304; June 1972] [JAPhA. NS45(5):557; September/October 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019] [Reviewed 2020]

2002

## **Homeopathy**

1. APhA supports the demonstration of safety and efficacy of homeopathic products from adequate, well-designed scientific studies before pharmacists advocate or sell homeopathic products.
2. APhA recognizes patient autonomy regarding the use of homeopathic products. Pharmacists should educate patients who choose to use homeopathic products.
3. APhA supports the modification of the Food, Drug and Cosmetic Act to require that homeopathic manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.

[JAPhA. NS42(5)[suppl 1]:S60; September/October 2002] [Reviewed 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

2000

## **Regulation of Dietary Supplements**

1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other legislation to require that dietary supplement manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.
2. APhA supports the establishment and implementation of clear and effective enforcement policies to remove promptly unsafe or ineffective dietary supplement products from the marketplace.
3. APhA shall work with the FDA to improve dietary supplement product labeling to ensure full disclosure of all product components and their source with associated strengths and recommendations for use in specific patient populations.
4. APhA supports the development and enforcement of dietary supplement good manufacturing practices (GMPs) and compliance with USP/NF standards to ensure quality, safe, contaminant-free products.
5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.

[JAPhA. NS1(9):40; September/October 2000] [Reviewed 2005] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

1986

## **Reye Syndrome**

APhA supports all initiatives that enhance public education about the potential relationship between Reye Syndrome and oral and rectal salicylate-containing products, including settings where pharmacists are not available for consultation.

[Am Pharm. NS26(6):419; June 1986] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

# **PUBLIC RELATIONS**

2012, 2002, 1964

## **Health Education: Selection of Pharmacist**

APhA supports education of consumers about the importance of selecting their personal pharmacist to assist them in the proper use of all medications and medical devices.

[JAPhA. NS4:429; August 1964] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] [Reviewed 2007] [JAPhA. NS52(4):459; July/August 2012] [Reviewed 2017] [Reviewed 2018]

2002, 1971

## **Promotion of Pharmacists' Value**

APhA encourages a coordinated effort by state and national associations, individual pharmacists, pharmacy employers and stakeholders to promote public understanding about the nature, value, and necessity of pharmacists' services.

[JAPhA. NS11:264; May 1971] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

1999

### **Promotion of Pharmaceutical Care**

1. APhA should continue to promote to the public the concepts and benefits of pharmaceutical care, differentiating pharmaceutical care practice from other pharmacy services.
2. APhA opposes the use of the term “pharmaceutical care” by any individual or entity unless the pharmaceutical care service provided by the individual or entity incorporates the concepts specified in the APhA Principles of Practice for Pharmaceutical Care.

[JAPhA. NS39(4):447-48; July/August 1999] [Reviewed 2002] [Reviewed 2008] [Reviewed 2013] [Reviewed 2018]

1986

### **Use of the Title “Pharmacist”**

APhA encourages the use of the title “pharmacist” in communications and all public media.

[Am Pharm. NS26(6):421; June 1986] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

## **QUALITY ASSURANCE**

2019

### **Consolidation Within Health Care**

1. APhA advocates that health care mergers and acquisitions must preserve the pharmacist–patient relationship.
2. APhA supports optimizing the role of pharmacists in the provision of team-based care following health care mergers and acquisitions in order to:
  - Enhance patient experience and safety,
  - Improve population health,
  - Reduce health care costs, and
  - Improve the work life of health care providers.
3. APhA asserts that the scope of review by federal agencies must have a focus on the impact of health care mergers and acquisitions on patient access and the provision of care to ensure optimal patient outcomes. Therefore, APhA calls for
  - Reform of the pre–health care mergers and acquisitions process,
  - Implementation of an ongoing post–health care mergers and acquisitions evaluation process to preserve patient choice and access to established patient–pharmacist relationships, and
  - Continuous transparent dialogue among stakeholders throughout the process.
4. APhA calls for the Federal Trade Commission (FTC) to develop a task force to monitor health care mergers and acquisitions activity.

[JAPhA. 59(4):e16; July/August 2019]

2018

### **Pharmacist Workplace Environment and Patient Safety**

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy practice employers to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may negatively impact patient safety.
6. APhA opposes retaliation against pharmacy staff for reporting workplace issues that may negatively impact patient safety.

[JAPhA. 58(4):355; July/August 2018] [Reviewed 2020]

## Audits of Health Care Practices

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

[JAPhA. 54(4):357; July/August 2014] (Reviewed 2019)

2013, 2001, 1994

## Pharmacist–Patient–Prescriber–Payer Responsibilities in Appropriate Drug Use

1. APhA advocates the following guidelines for pharmacist–patient–prescriber–payer responsibilities in appropriate drug use:
  - (a) Pharmacists' responsibilities
    - Serve as a drug information resource.
    - Provide primary care.
    - Collaborate with the prescriber and patient in the design of cost-effective treatment regimens that produce beneficial outcomes.
    - Identify formulary or generic products as a means to reduce costs.
    - Intervene on behalf of the patient to identify alternate therapies.
    - Educate the patient about the treatment regimen and expectations, and verify the patient's understanding.
    - Identify, prevent, resolve, and report drug-related problems.
    - Document and communicate pharmaceutical care activities.
    - Monitor drug therapy in collaboration with the patient and prescriber to ensure compliance and assess therapeutic outcomes.
    - Maintain an accurate and efficient drug distribution system.
    - Maintain proficiency through continuing education.
  - (b) Patients' responsibilities
    - Assume a responsibility for wellness,
    - Understand the coverage policies of their benefit plan.
    - Share complete information with providers, including demographics and payment mechanism(s).
    - Share complete information regarding medical history, lifestyle, diet, use of prescription and OTC medications and other substances.
    - Participate in the design of the treatment regimen.
    - Understand the treatment regimen and expected outcomes.
    - Adhere to the treatment regimen.
    - Alert prescribers and pharmacists to possible drug-related problems or changes in health status.
  - (c) Prescribers' responsibilities
    - Assess and diagnose the patient.
    - Share pertinent information in collaboration with the pharmacist and patient in the design of cost-effective treatment regimens that produce beneficial outcomes.
    - Clearly communicate the treatment plan and its intended outcomes to the patient directly or in collaboration with the pharmacist.
    - Remain alert to the possible occurrence of drug-related problems and initiate needed changes in therapy.
    - Collaborate with the patient and the pharmacist in drug therapy monitoring.
    - Maintain proficiency through continuing medical education.

(d) Payers' responsibilities

- Determine the objectives and desired benefits of pharmacy service.
- Design the coverage with patient and provider input using products and services to produce beneficial outcomes.
- Contract with providers on the basis of outcomes and efficient use of resources.
- Adopt efficient, clear, and uniform administrative processes.
- Communicate requirements of compensation for levels of care.
- Educate patients and providers about current eligibility and benefit information.
- Expeditiously process payments.
- Be responsive to advances in contemporary practice.

[Am Pharm. NS34(6):57; June 1994] [JAPhA. NS41(5)(suppl 1):S9; September/October 2001] [Reviewed 2008] [Reviewed 2010] [Reviewed 2011] [Reviewed 2012] [JAPhA. 53(4):367; July/August 2013] [Reviewed 2018]

**2011, 1995**

### **Measuring the Quality of Patient Care**

1. APhA believes that quality assessment measures must evaluate the accessibility, acceptability, and technical quality of pharmacy services, as well as the patient-centered and economic outcomes of patient care. These measures must consider the perspectives of patients, pharmacists, and other health care providers.
2. APhA believes quality assessment measures of patient care should be tested for validity and reliability in various pharmacy practice settings prior to widespread application.
3. APhA should develop tools and/or programs that enable pharmacists to apply quality assessment measures to their delivery of patient care.
4. APhA should promote efforts to educate patients, pharmacists, other health care providers, payers, policy makers, and other interested parties on the appropriate use of quality assessment measures to evaluate and improve the delivery of patient care.

[Am Pharm. NS35(6):37; June 1995] [Reviewed 2006 – Statement 1 archived in 2006] [(JAPhA. NS51(4)484 July/August 2011) [Reviewed 2016]

**2011**

### **Pharmacy Practice Accreditation**

1. APhA should lead the creation of consensus-based, pharmacy profession–developed accreditation standards and methods of evaluation to optimize the quality and safety of patient care and promote best practices.
2. APhA urges that accrediting bodies use profession-developed standards for pharmacy.
3. APhA supports only those pharmacy accreditation processes that are voluntary, transparent, consensus-based, reasonably executable, and affordable, while avoiding duplication and barriers to patient care.
4. APhA opposes mandatory pharmacy accreditation.
5. APhA shall assume the leadership role among stakeholders on the design and implementation of an appropriate process for any new pharmacy accrediting program.
6. APhA supports the appropriate use of data gathered from pharmacy practice monitoring processes to facilitate the advancement of pharmacy practice and quality of patient care.

[JAPhA. NS51(4)482 July/August 2011] [Reviewed 2016]

**2009**

### **Pharmacist's Role in Patient Safety**

1. It is APhA's position that patient safety initiatives must include pharmacists in leadership roles.
2. APhA encourages dissemination of best practices derived from nationally aggregated reporting data systems to pharmacists for the purpose of improving the medication use process and making informed decisions that directly impact patient safety and quality.
3. APhA encourages the profession of pharmacy to continually review and evaluate ways to enhance training, curricula, continuing education and accountability of pharmacists to improve patient safety.
4. APhA encourages risk management and postmarketing surveillance programs to be standardized and include infrastructures and compensation necessary to allow pharmacists to support these patient safety programs.
5. APhA supports the creation of voluntary, standardized, and interoperable reporting systems for patient safety events to minimize barriers to pharmacist participation and to enable aggregation of data and improve quality of medication use systems. The system should be free, voluntary, nonpunitive, easily accessible, and user friendly for all providers within the health care system.
6. APhA supports the elimination of handwritten prescriptions or medication orders.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2010] [Reviewed 2015] [Reviewed 2019]

2005

### **Continuing Professional Development**

1. APhA supports continuing professional development, a self-directed, individualized, systematic approach to lifelong learning, to support pharmacist's efforts to maintain professional competence in their practice.
2. APhA should work with appropriate organizations to provide self-assessment and plan development tools. APhA shall help identify and facilitate access to quality educational programs.
3. Employers should foster and support pharmacist participation in continuing professional development.
4. Continuing professional development is a learning process that requires full participation to achieve desired individual outcomes. To facilitate that participation, each pharmacist controls disclosure of their individual assessments and outcomes.

[JAPhA. NS45(5):554; September/October 2005] (Reviewed 2006) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2001

### **Credentialing and Pharmaceutical Care**

1. APhA should continue to assist in the unification of the profession and the development of a national strategy by its continued support of the Council on Credentialing in Pharmacy as the body responsible for the leadership, standards, public information, and coordination of the profession's voluntary credentialing programs.
2. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should provide competence-based material and testing via technology, such as the APhA website and state association websites, to further the profession's self-assessment.
3. APhA, in conjunction and cooperation with the Council on Credentialing and other national associations, should develop the necessary products and programs to educate the public, insurers, and health professionals on credentialing and make them available to state associations at cost.
4. APhA supports the development, on a continuing basis, of programs such as Project ImPACT, that provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.

[JAPhA. NS41(5)[suppl 1]:S8; September/October 2001] (Reviewed 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1996

### **Quality Assurance and Improvement in Pharmacy Practice**

1. APhA recommends that all pharmacists incorporate principles and tools available to continually improve the quality of patient care and management activities in their practices.
2. APhA recommends that content on principles and tools available to continually improve the quality of patient care and management practices be incorporated into pharmacy school curricula and into postgraduate education for pharmacists.
3. APhA supports appropriate evaluation and recognition of providers of pharmaceutical care.

[JAPhA. NS36(6):395; June 1996] (Reviewed 2004) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016)

## *Drug Product*

2020

### **Protecting Pharmaceuticals as a Strategic Asset**

1. APhA asserts that the quality and safety of pharmaceutical and other medical products and the global pharmaceutical and medical product supply chain are essential to the United States national security and public health.
2. APhA advocates for pharmacist engagement in the development and implementation of national and global strategies to ensure the availability, quality, and safety of pharmaceutical and other medical products.
3. APhA calls for the development, implementation, and oversight of enhanced and transparent processes, standards, and information that ensure quality and safety of all pharmaceutical ingredients and manufacturing processes.
4. APhA calls on the federal government to penalize entities who create barriers that threaten the availability, quality, and safety of United States pharmaceutical and other medical product supplies.
5. APhA calls for the development of redundancy and risk mitigation strategies in the manufacturing process to ensure reliable and consistent availability of safe and high-quality pharmaceutical and other medical products.
6. APhA advocates for regulatory and market incentives that bolster the availability, quality, and safety of pharmaceutical and other medical products.
7. APhA calls for greater transparency, accuracy, and timeliness of information and notification to health care professionals regarding drug shortages, product quality and manufacturing issues, supply disruption, and recalls.

8. APhA encourages pharmacy providers, health systems, and payers to develop coordinated response plans, including the use of therapeutic alternatives, to mitigate the impact of drug shortages and supply disruptions.
9. APhA supports federal legislation that engages pharmacists, other health professionals, and manufacturers in developing a United States-specific essential medicines list and provides funding mechanisms to ensure consistent availability of these products.
10. APhA recommends the use of pharmacists in the delivery of public messages, through media and other communication channels, regarding pharmaceutical supply and quality issues.

[JAPhA. 2020;60(5):e9]

## **RECORD SYSTEMS**

**2020, 2010**

### **E-prescribing Standardization**

1. APhA supports the standardization of user interfaces to improve quality and reduce errors unique to e-prescribing.
2. APhA supports reporting mechanisms and research efforts to evaluate the effectiveness, safety, and quality of e-prescribing systems, computerized prescriber order entry (CPOE) systems, and the e-prescriptions that they produce, in order to improve health information technology systems and, ultimately, patient care.
3. APhA supports the development of financial incentives for pharmacists and prescribers to provide high quality e-prescribing activities.
4. APhA supports the inclusion of pharmacists in quality improvement and meaningful use activities related to the use of e-prescribing and other health information technology that would positively impact patient health outcomes.
5. APhA supports laws and regulations that require e-prescribing of controlled substances to reduce fraudulent prescriptions.

[JAPhA. NS40(4):471; July/August 2010] [Reviewed 2012] [Reviewed 2014] [Reviewed 2015] [JAPhA. 2020;60(5):e10]

**2020, 2015**

### **Integrated Nationwide Prescription Drug Monitoring Program**

1. APhA advocates for nationwide integration and uniformity of prescription drug monitoring programs (PDMP) that incorporate federal, state, and territory databases for the purpose of providing health care professionals with accurate and real-time information to assist in clinical decision making when providing patient care services related to controlled substances.
2. APhA supports pharmacist involvement in the development of uniform standards for an integrated nationwide prescription drug monitoring program (PDMP) that includes the definition of authorized registered users, documentation, reporting requirements, Pharmacsystem response time, security of information, minimum reporting data sets, and standard transaction format.
3. APhA supports mandatory prescription drug monitoring program (PDMP) enrollment by all health care providers, mandatory reporting by all those who dispense controlled substances, and appropriate system query by registrants during the patient care process related to controlled substances.
4. APhA advocates for the development of seamless workflow integration systems that would enable consistent use of a nationwide prescription drug monitoring program (PDMP) by registrants to facilitate prospective drug review as part of the patient care process related to controlled substances.
5. APhA advocates for continuous, sustainable federal funding sources for practitioners and system operators to utilize and maintain a standardized integrated and real-time nationwide prescription drug monitoring program (PDMP).
6. APhA supports the use of interprofessional advisory boards, that include pharmacists, to coordinate collaborative efforts for
  - (a) compiling, analyzing, and using prescription drug monitoring program (PDMP) data trends related to controlled substance misuse, abuse, and/or fraud;
  - (b) providing focused provider education and patient referral to treatment programs; and
  - (c) supporting research activities on the impact of PDMPs.
7. APhA supports education and training for registrants about a nationwide prescription drug monitoring program (PDMP) to ensure proper data integrity, use, and confidentiality.

[JAPhA. N55(4):364; July/August 2015] [JAPhA. 2020;60(5):e10]

2018

### **Pharmacists Electronic Referral Tracking**

1. APhA supports the development of electronic systems that enhance and simplify the ability of pharmacists in all practice settings to receive, send, and track referrals among all members of the health care team, including other pharmacists, irrespective of the health care system, model, or network in which the patient participates.
2. APhA supports the interoperability and integration of referral tracking systems with electronic health records so patients can receive the benefit of optimally coordinated care from all members of the health care team.

[JAPhA. 58(4):356; July/August 2018] [Reviewed 2020]

2018

### **Proactive Immunization Assessment and Immunization Information Systems**

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

[JAPhA. 58(4):355; July/August 2018]

2015, 1994

### **Confidentiality of Computer-Generated Patient Records**

APhA, in cooperation with the National Council of Prescription Drug Programs, Inc. (NCPDP) and similar groups, shall encourage the development and implementation of uniform, prescription, computer software standards to prevent unauthorized access to confidential patient records.

[Am Pharm. NS34(6):60; June 1994] [Reviewed 2005], [Reviewed 2009] [Reviewed 2010] [JAPhA. 55(4):375; July/August 2015]

2015

### **Interoperability of Communications Among Health Care Providers to Improve Quality of Patient Care**

1. APhA supports the establishment of secure, portable, and interoperable electronic patient health care records.
2. APhA supports the engagement of pharmacists with other stakeholders in the development and implementation of multidirectional electronic communication systems to improve patient safety, enhance quality care, facilitate care transitions, increase efficiency, and reduce waste.
3. APhA advocates for the inclusion of pharmacists in the establishment and enhancement of electronic health care information technologies and systems that must be interoperable, HIPAA compliant, integrated with claims processing, updated in a timely fashion, allow for data analysis, and do not place disproportionate financial burden on any one health care provider or stakeholder.
4. APhA advocates for pharmacists and other health care providers to have access to view, download and transmit electronic health records. Information shared among providers using a health information exchange should utilize a standardized secure interface based on recognized international health record standards for the transmission of health information.
5. APhA supports the integration of federal, state, and territory health information exchanges into an accessible, standardized, nationwide system.
6. APhA opposes business practices and policies that obstruct the electronic access and exchange of patient health information because these practices compromise patient safety and the provision of optimal patient care.
7. APhA advocates for the development of systems that facilitate and support electronic communication between pharmacists and prescribers concerning patient adherence, medication discontinuation, and other clinical factors that support quality care transitions.

8. APhA supports the development of education and training programs for pharmacists, student pharmacists, and other health care professionals on the appropriate use of electronic health records to reduce errors and improve the quality and safety of patient care.
9. APhA supports the creation and nonpunitive application of a standardized, interoperable system for voluntary reporting of errors associated with the use of electronic health care information technologies and systems to enable aggregation of protected data and develop recommendations for improved quality.

[JAPhA. N55(4):364; July/August 2015] (Reviewed 2019)

**2015, 1993**

### **Patient Information**

1. APhA shall facilitate the development, dissemination, and use of an information system that documents the components of comprehensive medication management services.
2. APhA encourages development of quality assurance standards that guarantee the integrity and accuracy of information included in proprietary and nonproprietary information systems.

[Am Pharm. NS33(7):53; July 1993] (Reviewed 2005) (Reviewed 2009) (Reviewed 2010) [JAPhA. 55(4):375; July/August] (Reviewed 2019)

**2013**

### **Ensuring Access to Pharmacists' Services**

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.
4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.

[JAPhA. 53(4):365; July/August 2013] (Reviewed 2018) (Reviewed 2019)

**2010**

### **Personal Health Records**

1. APhA supports patient utilization of personal health records, defined as records of health-related information managed, shared, and controlled by the individual, to facilitate self-management and communication across the continuum of care.
2. APhA urges both public and private entities to identify and include pharmacists and other stakeholders in the development of personal health record systems and the adoption of standards, including but not limited to terminology, security, documentation, and coding of data contained within personal health records.
3. APhA supports the development, implementation, and maintenance of personal health record systems that are accessible and searchable by pharmacists and other health care providers, interoperable and portable across health information systems, customizable to the needs of the patient, and able to differentiate information provided by a health care provider and the patient.
4. APhA supports pharmacists taking the leadership role in educating the public about the importance of maintaining current and accurate medication-related information within personal health records.

[JAPhA. NS40(4):471; July/August 2010] (Reviewed 2013) (Reviewed 2014) (Reviewed 2015) (reviewed 2019)

**2009**

### **Health Information Technology**

1. APhA supports the delivery of informatics education within pharmacy schools and continuing education programs to improve patient care, understand interoperability among systems, understand where to find information, increase productivity, and improve the ability to measure and report the value of pharmacists in the health care system.
2. APhA urges that pharmacists have read/write access to electronic health record data for the purposes of improving patient care and medication use outcomes.

3. APhA encourages inclusion of pharmacists in the definition, development, and implementation of health information technologies for the purpose of improving the quality of patient-centric health care.
4. APhA urges public and private entities to include pharmacist representatives in the creation of standards, the certification of systems, and the integration of medication use systems with health information technology.

[JAPhA. NS49(4):492; July/August 2009] [Reviewed 2010] [Reviewed 2013] [Reviewed 2014] [Reviewed 2015] [Reviewed 2019]

**2008**

### **Billing and Documentation of Medication Therapy Management (MTM) Services**

1. APhA encourages the development and use of a system for billing of MTM services that
  - (a) includes a standardized data set for transmission of billing claims,
  - (b) utilizes a standardized process that is consistent with claim billing by other health care providers, and
  - (c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC).

[JAPhA. NS48(4):471; July/August 2008] [Reviewed 2010] [Reviewed 2015] [Reviewed 2016]

**2005, 1993**

### **Documentation**

1. APhA encourages development of systems that document review of patient therapy, the type and intensity of services provided, and the result or outcome of the services.
2. APhA believes that systems of payment and documentation must be compatible with contemporary computer systems used by providers and payers and should emphasize administrative efficiency.

[Am Pharm. NS33(7):54; July 1993] [JAPhA. NS45(5):560; September/October 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

**1998**

### **Access and Contribution to Health Records**

1. APhA urges the integration of pharmacy-based patient data into patient health records to facilitate the delivery of integrated care.
2. APhA recognizes pharmacists' need for patient health care data and information and supports their access and contribution to patient health records.
3. APhA supports public policies that protect the patient's privacy yet preserve access to personal health data for research when the patient has consented to such research or when the patient's identity is protected.
4. APhA encourages interdisciplinary discussion regarding accountability and oversight for appropriate use of health information.

[JAPhA. 38(4):417; July/August 1998] [Reviewed 2005] [Reviewed 2009] [Reviewed 2010] [Reviewed 2013] [Reviewed 2014] [Reviewed 2015]

### **1994 Implications of Online Prospective DUR on the Application of Pharmacists' Scientific and Clinical Judgments**

1. APhA recognizes that effective drug utilization review (prospective, concurrent, retrospective), as a component of pharmaceutical care, depends upon complete and accurate patient information.
2. APhA advocates eliminating the economic and operational obstacles pharmacists encounter when conducting drug utilization review for optimal patient care.
3. APhA supports utilization of universal and comprehensive standards for online real-time drug utilization review (ORDUR).
4. APhA encourages the development of a standardized method of electronic transfer of patient medical data among all health professionals involved in the care of a patient.

[Am Pharm. NS34(6):58; June 1994] [Reviewed 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

1983

### **Patient Counseling and Information Program**

1. APhA shall strongly and actively encourage pharmacists to be available for and provide patient consultation, including written drug information, when requested or professionally appropriate.
2. APhA supports patient information programs that include reference to seeking medication information from pharmacists and does not endorse programs which, by ignoring the professional capabilities of pharmacists, may limit the patient's ability to receive needed drug information and consultation.

[Am Pharm. NS23(6):53; June 1983] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

## **REIMBURSEMENT AND COMPENSATION**

2020

### **Accountability of Pharmacists**

1. APhA affirms pharmacists' professional accountability within their role in all practice settings.
2. APhA advocates that pharmacists be granted and accept authority, autonomy, and accountability for patient-centric actions to improve health and medication outcomes, in coordination with other health professionals, as appropriate.
3. APhA reaffirms 2017 Pharmacists' Role within Value-based Payment Models and supports continued expansion of interprofessional patient care models that leverage pharmacists as accountable members of the health care team.
4. APhA advocates for sustainable payment and attribution models to support pharmacists as accountable patient care providers.
5. APhA supports continued expansion of resources and health information infrastructures that empower pharmacists as accountable health care providers.
6. APhA supports the enhancement of comprehensive and affordable professional liability insurance coverage that aligns with evolving pharmacist accountability and responsibility.

[JAPhA. 2020;60(5):e9]

2020

### **Community-Based Pharmacists as Providers of Care**

1. APhA advocates for the identification of medical conditions that may be safely and effectively treated by community-based pharmacists.
2. APhA encourages the training and education of pharmacists and student pharmacists regarding identification, treatment, monitoring, documentation, follow-up, and referral for medical conditions treated by community-based pharmacists.
3. APhA advocates for laws and regulations that allow pharmacists to identify and manage medical conditions treated by community-based pharmacists.
4. APhA advocates for appropriate remuneration for the assessment and treatment of medical conditions treated by community-based pharmacists from government and private payers to ensure sustainability and access for patients.
5. APhA supports research to examine the outcomes of services that focus on medical conditions treated by community-based pharmacists.

[JAPhA. 2020;60(5):e10]

2020

### **Coordination of the Pharmacy and Medical Benefit**

APhA supports coordination of patients' comprehensive pharmacy and medical benefits that allows for provision of and compensation for pharmacists' patient care services; aligns incentives to optimize patient outcomes; streamlines administrative processes; reduces overall health care costs; and preserves patients' right to choose providers under their pharmacy and medical benefits.

[JAPhA. 2020;60(5):e10]

2020

### **Providing Affordable and Comprehensive Pharmacy Services to the Underserved**

1. APhA supports the expansion and increased sources of funding for pharmacies and pharmacist-provided care services that serve the needs of underserved populations to provide better health outcomes and lower health care costs.
2. APhA supports charitable pharmacies and pharmacy services that ensure the quality, safety, drug storage, and integrity of the drug product and supply chain, in accordance with applicable law.

[JAPhA. 2020;60(5):e11]

2019

### **Referral System for the Pharmacy Profession**

1. APhA supports referrals of patients to pharmacists, among pharmacists, or between pharmacists and other health care providers to promote optimal patient outcomes.
2. APhA supports referrals to and by pharmacists that ensure timely patient access to quality services and promote patient freedom of choice.
3. APhA advocates for pharmacists' engagement in referral systems that are aligned with those of other health care providers and facilitate collaboration and information sharing to ensure continuity of care.
4. APhA supports attribution and equitable payment to pharmacists providing patient care services as a result of a referral.
5. APhA promotes the pharmacist's professional responsibility to uphold ethical and legal standards of care in referral practices.
6. APhA reaffirms its support of development, adoption, and use of policies and procedures by pharmacists to manage potential conflicts of interest in practice, including in referral systems.

[JAPhA. 59(4):e16; July/August 2019]

2018

### **Direct and Indirect Remuneration Fees**

APhA opposes retroactive direct and indirect remuneration (DIR) fees and supports initiatives to prohibit such fees on pharmacies.

[JAPhA. 58(4):356; July/August 2018]

2018

### **Pharmacist Workplace Environment and Patient Safety**

1. APhA supports staffing models that promote safe provision of patient care services and access to medications.
2. APhA encourages the adoption of patient centered quality and performance measures that align with safe delivery of patient care services and opposes the setting and use of operational quotas or time-oriented metrics that negatively impact patient care and safety.
3. APhA denounces any policies or practices of third-party administrators, processors, and payers that contribute to a workplace environment that negatively impacts patient safety. APhA calls upon public and private policy makers to establish provider payment policies that support the safe provision of medications and delivery of effective patient care.
4. APhA urges pharmacy practice employers to establish collaborative mechanisms that engage the pharmacist in charge of each practice, pharmacists, pharmacy technicians, and pharmacy staff in addressing workplace issues that may have an impact on patient safety.
5. APhA urges employers to collaborate with the pharmacy staff to regularly and systematically examine and resolve workplace issues that may negatively impact patient safety.
6. APhA opposes retaliation against pharmacy staff for reporting workplace issues that may negatively impact patient safety.

[JAPhA. 58(4):355; July/August 2018] [Reviewed 2020]

2018, 2013

### **Revisions to the Medication Classification System**

1. APhA supports the Food and Drug Administration's (FDA) efforts to revise the drug and medical device classification paradigms for prescription and nonprescription medications and medical devices to allow greater access to certain medications and medical devices under conditions of safe use while maintaining patients' relationships with their pharmacists and other health care providers.
2. APhA supports the implementation or modification of state laws and regulations to facilitate pharmacists' implementation and provision of services related to a revised drug and medical device classification system.
3. APhA supports a patient care delivery model built on coordination and communication between pharmacists and other health care team members in the evaluation and management of care delivery.
4. APhA affirms that pharmacists are qualified to provide clinical interventions on medications and medical devices under FDA's approved conditions of safe use.
5. APhA urges manufacturers, FDA, and other stakeholders to include pharmacists' input in the development and adoption of technology and standardized processes for services related to medications and medical devices under FDA's defined conditions of safe use.
6. APhA supports the utilization of best practices, treatment algorithms, and clinical judgment of pharmacists and other health care providers to guide the evaluation and management of care delivery related to medications and medical devices under FDA's approved conditions of safe use.

7. APhA encourages the inclusion of medications, medical devices, and their associated services provided under FDA's defined conditions of safe use within health benefit coverage.
8. APhA supports compensation of pharmacists and other health care professionals for the provision of services related to FDA's defined conditions of safe use programs.

[JAPhA. 53(4):365; July/August 2013] [JAPhA. 58(4):356; July/August 2018]

**2018**

### **Use of Genomic Data within Pharmacy Practice**

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct to consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

**2017, 2012**

### **Contemporary Pharmacy Practice**

1. APhA asserts that pharmacists should have the authority and support to practice to the full extent of their education, training, and experience in delivering patient care in all practice settings and activities.
2. APhA supports continuing efforts toward establishing a consistent and accurate perception of the contemporary role and practice of pharmacists by the general public, patients, and all persons and institutions engaged in health care policy, administration, payment, and delivery.
3. APhA supports continued collaboration with stakeholders to facilitate adoption of standardized practice acts, appropriate related laws, and regulations that reflect contemporary pharmacy practice.
4. APhA supports the establishment of multistate pharmacist licensure agreements to address the evolving needs of the pharmacy profession and pharmacist-provided patient care.
5. APhA urges the continued development of consensus documents, in collaboration with medical associations and other stakeholders, that recognize and support pharmacists' roles in patient care as health care providers.
6. APhA urges universal recognition of pharmacists as health care providers and compensation based on the level of patient care provided using standardized and future health care payment models.

[JAPhA. NS52(4):457; July/August 2012] [Reviewed 2016] [JAPhA. 57(4):441; July/August 2017] [Reviewed 2019]

2017

### **Pharmacists' Role Within Value-Based Payment Models**

1. APhA supports value-based payment models that include pharmacists as essential health care team members and that promote coordinated care, improved health outcomes, and lower total costs of health care.
2. APhA encourages the development and implementation of meaningful, consistent process-based and outcomes-based quality measures that allow attribution of pharmacist impact within value-based payment models.
3. APhA advocates for mechanisms that recognize and compensate pharmacists for their contributions toward meeting goals of quality and total costs of care in value-based payment models, separate and distinct from the full product and dispensing cost reimbursement.
4. APhA advocates that pharmacists must have real-time access to and exchange of electronic health record data within value-based payment models in order to achieve optimal health and medication-related outcomes.
5. APhA supports education, training, and resources that help pharmacists transform and integrate their practices with value-based payment models and programs.

[JAPhA. 57(4):441; July/August 2017]

2017

### **Pharmacy Performance Networks**

1. APhA supports performance networks that improve patient care and health outcomes, reduce costs, use pharmacists as an integral part of the health care team, and include evidence-based quality measures.
2. APhA urges collaboration between pharmacists and payers to develop distinct, transparent, fair, and equitable payment strategies for achieving performance measures associated with providing pharmacists' patient care services that are separate from the reimbursement methods used for product fulfillment.
3. APhA advocates for prospective notification of evidence-based quality measures that will be used by a performance network to assess provider and practice performance. Furthermore, updates on provider and practice performance against these measures should be provided in a timely and regular manner.
4. APhA supports pharmacists' professional autonomy to determine processes that improve performance on evidence-based quality measures.

[JAPhA. 57(4):441; July/August 2017] [Reviewed 2019]

2014

### **Audits of Health Care Practices**

1. APhA recognizes that audits of health care practices, when used appropriately, may improve patient care and deter fraud, waste, and abuse.
2. APhA advocates for the use of standardized and efficient audit procedures with transparent criteria clearly communicated by the payor and readily accessible to providers in advance.
3. APhA advocates that audit processes should result in minimal disruption to practice workflow, minimal financial burden, and no impact on patient care.
4. APhA urges timely notification and scheduling of claims audits to minimize disruption of patient care delivery.
5. APhA supports the inclusion of education as a component of the audit process to improve documentation of services, meet payor requirements, and enhance the quality-of-care delivery.
6. APhA opposes incentive-based auditor compensation and the use of statistical methodologies, such as sample extrapolation, for determining the recoupment of funds from health care providers or health care organizations.
7. APhA advocates that audit reports include complete information listing audit discrepancies and appropriate guidelines for documenting and appealing these findings.
8. APhA advocates that pharmacy audits be performed in a professional manner by a pharmacist or certified pharmacy technician.

[JAPhA. 54(4):357; July/August 2014] [Reviewed 2019]

2013

### **Ensuring Access to Pharmacists' Services**

1. Pharmacists are health care providers who must be recognized and compensated by payers for their professional services.
2. APhA actively supports the adoption of standardized processes for the provision, documentation, and claims submission of pharmacists' services.
3. APhA supports pharmacists' ability to bill payers and be compensated for their services consistent with the processes of other health care providers.

4. APhA supports recognition by payers that compensable pharmacist services range from generalized to focused activities intended to improve health outcomes based on individual patient needs.
5. APhA advocates for the development and implementation of a standardized process for verification of pharmacists' credentials as a means to foster compensation for pharmacist services and reduce administrative redundancy.
6. APhA advocates for pharmacists' access and contribution to clinical and claims data to support treatment, payment, and health care operations.
7. APhA actively supports the integration of pharmacists' service level and outcome data with other health care provider and claims data.

[JAPhA. 53(4):365; July/August 2013] (Reviewed 2018) (Reviewed 2019)

**2013, 2009**

### **Independent Practice of Pharmacists**

1. APhA recommends that health plans and payers contract with and appropriately compensate individual pharmacist providers for the level of care rendered without requiring the pharmacist to be associated with a pharmacy.
2. APhA supports adoption of state laws and rules pertaining to the independent practice of pharmacists when those laws and rules are consistent with APhA policy.
3. APhA, recognizing the positive impact that pharmacists can have in meeting unmet needs and managing medical conditions, supports the adoption of laws and regulations and the creation of payment mechanisms for appropriately trained pharmacists to autonomously provide patient care services, including prescribing, as part of the health care team.

[JAPhA. NS 49(4):492; July/August 2009] (Reviewed 2012) [JAPhA. 53(4):366; July/August 2013] (Reviewed 2018)

**2005, 1987**

### **Catastrophic Illness: Coverage for Pharmacist Services Included**

1. APhA supports comprehensive, catastrophic illness insurance coverage that recognizes the essential need for pharmaceutical products and pharmacist services in all patient care environments, including the home.
2. APhA encourages inclusion of pharmacist services and the most efficient and readily accessible system of drug delivery in any insurance coverage for catastrophic illness that may be enacted.

[Am Pharm. NS27(6):422; June 1987] [JAPhA. NS45(5):557; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2005, 2003, 1996**

### **Pharmacist's Role in Immunizations**

1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through
  - (a) advocacy,
  - (b) contracting with other health care professionals, or
  - (c) pharmacists administering vaccines to vulnerable patients.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

[JAPhA. NS36(6):395; June 1996] [JAPhA. NS43(5)[suppl 1]:S57; September/October 2003] [JAPhA. NS45(5):556; September/October 2005] (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

**2005, 1985**

### **Pharmacists and Home Health Care**

1. APhA supports establishment of pharmacist consulting services for home care.
2. Medicaid and other third-party programs should recognize the consulting role of the pharmacist in reducing the misuse of drugs and maximizing their therapeutic effectiveness through fair and equitable reimbursement for consulting functions that is not tied to the provision of medications.
3. Medicaid and other third-party programs also should reimburse pharmacists for innovative packaging and services that will maximize adherence, increase the opportunity for drug utilization review, and better meet the informational needs of the patient and the care giver.

[Am Pharm. NS25(5):51; May 1985] [JAPhA. NS45(5):557; September/October 2005] (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

2005, 1990

### **Reimbursement for Unapproved (Off-Label) Uses of FDA-Approved Drug Products**

APhA supports coverage of FDA-approved drugs and pharmacist services connected with the delivery of such drugs by government and other third-party payers when used rationally for indications other than those specified in the product labeling. [Am Pharm. NS30(6):45; June 1990] [JAPhA. NS45(5):557; September/October 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

1993

### **Pharmacists' Services**

1. APhA supports development of pharmacy payment systems that include reimbursement of the cost of any medication or device provided; the cost of preparing the medication or device; the costs of administrative services; return on capital investment; and payment for both dispensing-related and nondispensing-related pharmacy services.
2. APhA believes that appropriate incentives for the pharmacist providing care should be part of any payment system. [Am Pharm. NS33(7):53; July 1993] [Reviewed 2005] [Reviewed 2007] [Reviewed 2009] [Reviewed 2010] [Reviewed 2011] [Reviewed 2012] [Reviewed 2017]

## *Federal Programs*

2016, 2011

### **Pharmacists as Providers Under the Social Security Act**

APhA supports changes to the Social Security Act to allow pharmacists to be recognized and paid as providers of patient care services.

[JAPhA. NS51(4):482 July/August 2011] [JAPhA. 56(4):379; July/August 2016]

2012, 2005, 1969

### **Medicare and Patient Care Service**

1. APhA believes that health care, including the essential component of patient care services, should be made available to as many people as possible in our society through the most economical system compatible with an acceptable standard of quality.
2. APhA should support the Part B mechanism, which is the voluntary supplementary medical insurance program financed equally by beneficiaries and the government.
3. APhA should oppose legislation that would restrict the Medicare drug benefit to specific, chronic diseases.
4. APhA should support the inclusion of patient care services under Medicare or any other federal financing mechanism, providing the program is designed to help persons who need it most and is administratively efficient and economical. [JAPhA. NS9:363; July 1969] [JAPhA. NS45(5):558; September/October 2005] [Reviewed 2009] [JAPhA. NS52(4):460; July/August 2012] [Reviewed 2017] [Reviewed 2018]

2011

### **Pharmacist's Role in Health Care Reform**

1. APhA affirms that pharmacists are the medication experts whose accessibility uniquely positions them to increase access to and improve quality of health care while decreasing overall costs.
2. APhA asserts that pharmacists must be recognized as the essential and accountable patient care provider on the health care team responsible for optimizing outcomes through medication therapy management (MTM).
3. APhA asserts the following:
  - (a) Medication Therapy Management Services: Definition and Program Criteria is the standard definition of MTM that must be recognized by all stakeholders.
  - (b) Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, as adopted by the profession of pharmacy, shall serve as the foundational MTM service model.
4. APhA asserts that pharmacists must be included as essential patient care provider and compensated as such in every health care model, including but not limited to, the medical home and accountable care organizations.
5. APhA actively promotes the outcomes-based studies, pilot programs, demonstration projects, and other activities that document and reconfirm pharmacists' impact on patient health and well-being, process of care delivery, and overall health care costs.

[JAPhA. NS51(4):482 July/August 2011] [Reviewed 2016]

**2005, 1977**

### **Government-Financed Reimbursement**

1. APhA supports only those government-operated or -financed third-party prescription programs that ensure participating pharmacists receive individualized, equitable compensation for professional services and reimbursement for products provided under the program.
2. APhA regards equitable compensation under any government-operated or -financed third-party prescription programs as requiring payments equivalent to a participating pharmacist's prevailing charges to the self-paying public for comparable services and products, plus additional documented direct and indirect costs that are generated by participation in the program.
3. APhA supports those government-operated or -financed third-party prescription programs that base compensation for professional services on professional fees and reimbursement for products provided on actual cost, with the provision of a specific exception to this policy in those instances when equity in professional compensation cannot otherwise be attained.

[JAPhA. NS17:452; July 1977] [JAPhA. NS45(5):558; September/October 2005] [Reviewed 2009] [Reviewed 2011] [Reviewed 2012] [Reviewed 2017]

**2005, 1980**

### **Inclusion of Pharmacist-Provided Patient Care Services in Health Programs**

APhA supports the inclusion of pharmacist-provided patient care services in health care programs that are developed and/or funded by governments and private agencies and organizations.

[Am Pharm. NS20(7):69; July 1980] [JAPhA. NS45(5):558; September/October 2005] [Reviewed 2009] [Reviewed 2010] [Reviewed 2011] [Reviewed 2012] [Reviewed 2017]

**2005, 1970**

### **Medicare, Medicaid, and Other Third-Party Payment Programs**

1. APhA advocates a professional fee system of reimbursement in Medicare and Medicaid and other third-party payment programs that would recognize variations in services provided and costs incurred by individual pharmacies.
2. APhA supports maintaining close liaison with proponents of national health insurance programs to ensure that pharmacy will have an opportunity to make its views known in the development of such proposals.

[JAPhA. NS10:346; June 1970] [JAPhA. NS45(5):558; September/October 2005] [Reviewed 2009] [Reviewed 2010] [Reviewed 2012] [Reviewed 2014] [Reviewed 2019]

**2005, 1968**

### **Medicare: Reimbursement Procedures**

APhA should educate pharmacists on aspects of reimbursement procedures and concepts associated with Medicare.

[JAPhA. NS8:368; July 1968] [JAPhA. NS45(5):558; September/October 2005] [Reviewed 2009] [Reviewed 2012] [Reviewed 2014] [Reviewed 2019]

**2004**

### **Tablet Splitting**

APhA opposes mandatory tablet splitting.

[JAPhA. NS44(5):551; September/October 2004] [Reviewed 2010] [Reviewed 2015]

**1969**

### **Medicare Task Force: Policy Guidelines**

1. The following guidelines supplement those adopted by APhA in 1967:
  - (a) Provide for beneficiary contribution toward program financing.
  - (b) Provide for government reimbursement of claims directly to the pharmacist.
  - (c) Compensate pharmacists by means of a professional fee commensurate with the level of professional service performed in addition to making reimbursement for the cost of the drugs.
  - (d) Establish a per-prescription, fixed amount (copayment) that must be paid by the beneficiary when obtaining drugs.
  - (e) To ensure patients receive safe and effective drugs, establish a list of reimbursable amounts for each drug based on a nationally available product of acceptable quality and cost.
  - (f) Include all drugs having therapeutic use, whether for chronic or acute conditions.
  - (g) Include all persons eligible for Part B Medicare coverage.

[JAPhA. NS9:343; July 1969] [Reviewed 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

1967

### **Drugs Provided Under Social Security Act: Guidelines for Pharmaceutical Service**

1. Since it is probable or likely that APhA may have to consider and act upon some proposals in the area of drug costs before the next annual meeting, we recommend that APhA Board of Trustees be guided by whether the proposals
  - (a) Permit pharmacists to select and dispense a quality drug product,
  - (b) Establish some mechanism to assist pharmacists in selecting quality drug products under the cost and other criteria established.
  - (c) Permit the use of any available drug product when unique medical circumstances so require,
  - (d) Establish a reasonable remuneration base for pharmacists rendering services under the program,
  - (e) Guarantee recipients free choice of pharmacy, and
  - (f) Limit the reimbursement for pharmacists' services to those provided by duly licensed pharmacists.

[JAPhA. NS7:315; June 1967] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

### *National Health Insurance*

2005, 1971

### **National Health Insurance (NHI)**

1. APhA endorses the concept of national health insurance as one means by which the costs of health care may be controlled and rational order brought to the health care system:
  - (a) A national health insurance plan must recognize that high quality health care is a right of every citizen regardless of his economic or social status.
  - (b) A national health insurance plan must, as a point of departure, provide a health care delivery system that will correct the inadequacies in the delivery of health care.
  - (c) A national health insurance plan must allow for maximum utilization of pharmacists in health care roles.
  - (d) Group practices established under national health insurance must permit pharmacists participation on an equitable basis and not merely as employees of physician-controlled groups.
  - (e) A national health insurance plan should, to the extent feasible, utilize existing community pharmacies as health care facilities.

[JAPhA. NS11:265 May 1971] [JAPhA. NS45(5):558; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1977

### **National Health Insurance (NHI): Pharmaceutical Service Benefit**

1. A National Health Insurance (NHI) pharmaceutical service benefit must include acceptable methods for ensuring equitable reimbursement to pharmacists for products and services that are to be provided under the program.
2. Reimbursement to pharmacists for dispensed medication and devices under an NHI plan should be based on professional fees for professional services, plus reimbursement for the actual cost of any drug product or device provided.
3. An NHI pharmaceutical service benefit must optimize administrative efficiency and minimize administrative costs.

[JAPhA. NS17:451; July 1977] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

### *New Payment Systems*

2011, 1994

### **APhA's Role in the Development and Support of New Payment Systems**

1. APhA should continue its work with pharmacy benefit managers and other private and public payers to develop innovative pharmacy benefit designs and compensation strategies for pharmacists' services.
2. APhA will endorse benefit design concepts that recognize and compensate pharmacists for their cognitive services to maximize therapeutic outcomes.

[Am Pharm. NS34(6):58; June 1994] (Reviewed 2005) (Reviewed 2009) (Reviewed 2010)[JAPhA. NS51(4):484 July/August 2011] (Reviewed 2016)

2005, 1993

### **Payment System Reform**

1. APhA must advocate reform of pharmacy payment systems to enhance the delivery of comprehensive medication-use management services.
2. APhA must assume a leadership role, in cooperation with other pharmacy organizations, patients, other providers of health services, and third-party payers, in developing a payment system reform plan.
3. APhA should encourage universal acceptance of all components of pharmaceutical care and their integration into pharmacy practice to support payment for services.

[Am Pharm. NS33(7):53; July 1993] [Reviewed 2005] [Reviewed 2009] [Reviewed 2011] [Reviewed 2016] [Reviewed 2018]

1995

### **Integrated Risk/Capitation Payment Systems**

1. APhA should provide pharmacists with tools to evaluate compensation for their pharmaceutical care services through mechanisms based on concepts other than fee-for-service.
2. APhA must facilitate both economic and clinical research on cost-to-outcomes benefits of pharmaceutical care services under integrated risk/capitated health care systems.
3. APhA affirms the principle that any pharmacist or pharmacy that adheres to a program's quality standards and agrees to accept its compensation plan shall be able to participate in an integrated risk/capitated system or network.

[Am Pharm. NS35(6):37; June 1995] [Reviewed 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

1994

### **Product and Payment Systems**

1. APhA shall work with public and private sectors in developing timely educational processes that assist pharmacists to implement patient care, understand new payment systems, and apply emerging therapeutic advances to achieve desired patient outcomes.
2. APhA supports payment systems that distinguish between compensation for the provision of pharmaceutical care and reimbursement for product distribution.
3. APhA shall participate in the identification, development, and implementation of models for procurement and handling of therapeutic and diagnostic pharmaceutical products and devices that ensure the continuous provision of pharmaceutical care by pharmacists.

[Am Pharm. NS34(6):56; June 1994] [Reviewed 2005] [Reviewed 2009] [Reviewed 2010] [Reviewed 2018]

## *Professional Fees*

2008

### **Billing and Documentation of Medication Therapy Management (MTM) Services**

1. APhA encourages the development and use of a system for billing of MTM services that
  - (a) includes a standardized data set for transmission of billing claims,
  - (b) utilizes a standardized process that is consistent with claim billing by other health care providers, and
  - (c) utilizes a billing platform that is accepted by the Centers for Medicare and Medicaid Services (CMS) and is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
2. APhA supports the pharmacist's or pharmacy's choice of a documentation system that allows for transmission of any MTM billing claim and interfaces with the billing platform used by the insurer or payer.
3. APhA encourages pharmacists to use the American Medical Association (AMA) Current Procedural Terminology (CPT) codes for billing of MTM services.
4. APhA supports efforts to further develop CPT codes for billing of pharmacists' services, through the work of the Pharmacist Services Technical Advisory Coalition (PSTAC).

[JAPhA. NS48(4):471; July/August 2008] [Reviewed 2010] [Reviewed 2015] [Reviewed 2016]

2005, 1975

### **Periodic Adjustments of Professional Fees in Federal Programs**

It is essential that federal regulations governing pharmacist professional fees in federally supported health care programs require review and equitable adjustments on a regularized, periodic basis.

[JAPhA. NS15:330; June 1975] [Reviewed 2005] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

1987

### **Compensation for Cognitive Services**

1. APhA recognizes that pharmacists provide cognitive services (i.e., services requiring professional judgment) to patients ( that may or may not be related to the dispensing or sale of a product.
2. APhA supports compensation of pharmacists for providing cognitive services (i.e., services requiring professional judgment) that may or may not be related to the dispensing or sale of a product.

[Am Pharm. NS27(6):422; June 1987] (Reviewed 2005) (Reviewed 2009) (Reviewed 2011) (Reviewed 2013) (Reviewed 2018)

### *Third-Party and Prepaid Programs*

2005, 1984

### **Exemption from the Employee Retirement Income Security Act (ERISA)**

APhA seeks introduction of legislation exempting state, third-party, and prescription program legislation from preemption by ERISA.

[Am Pharm. NS24(7):61; July 1984] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2005, 1981

### **Third-Party Reimbursement Legislation**

APhA supports enactment of legislation requiring that third-party program reimbursement to pharmacists be at least equal to the pharmacists' prevailing charges to the self-paying public for comparable services and products, plus additional documented direct and indirect costs that are generated by participating in the program.

[Am Pharm. NS21(5):40 May 1981] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1994

### **The Scientific Implications of Health Care Reform**

1. APhA advocates that the public and private sectors maintain or increase their level of commitment to ensure adequate resources for both basic and applied research within a reformed health care system.
2. APhA encourages the public and private research communities to preferentially expend resources for the discovery and development of new drugs and technologies that provide substantive, innovative therapeutic advances.
3. APhA advocates an increased emphasis on outcomes research in all areas of health services, including drug and disease-specific research encompassing clinical, economic, and humanistic dimensions (e.g., quality of life, patient satisfaction, ethics) and advocates for action related to conclusions for such research.
4. APhA encourages interdisciplinary collaboration in research efforts within and between the public and private research communities.

[Am Pharm. NS34(6):55; June 1994] (Reviewed 2004) (Reviewed 2005) (Reviewed 2010) (Reviewed 2011) (Reviewed 2016)

## **RESEARCH**

### *Investigational New Drugs*

2019, 1990

### **Federal Funding to Evaluate the Impact of Health Care Policies**

1. APhA supports the study of economic, scientific, and social issues related to health care, particularly pharmaceutical services.
2. APhA urges the federal government to establish funding mechanisms for objective research to assess the impact of public policy on the health care system, particularly pharmaceutical services.
3. APhA urges that all federally funded research addressing public policy pertaining to pharmaceutical services incorporate input from the pharmacy profession.

[Am Pharm. NS30(6):46; June 1990] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) [JAPhA. 59(4) e28; July/August 2019]

2019, 2018

### **Gluten Content and Labeling in Medications**

1. APhA supports labeling of all prescription and nonprescription products, as well as dietary supplement products, to indicate the presence of gluten.
2. APhA encourages manufacturers to formulate drug products without use of wheat, barley, rye, or their derivatives whenever possible.

3. APhA supports additional research on the effects of gluten intolerance and celiac malabsorption, particularly as it relates to medication absorption.
4. APhA supports pharmacist education regarding celiac disease and nonceliac gluten sensitivity.
5. APhA encourages the development of analytical methods that can accurately detect lower levels of gluten than the current standard (20 ppm) and for the establishment of evidence-based gluten-free standards for the labeling of foods, excipients, dietary supplements, and prescription and nonprescription products.

[JAPhA. 58(4):356; July/August 2018] [JAPhA. 59(4):e16; July/August 2019] [Reviewed 2020]

**2019, 2005, 1990**

### **Use of Representative Populations in Clinical Studies**

1. APhA supports the use of representative populations in clinical studies, including, but not limited to protected populations such as women, minorities, the elderly, transgender individuals, and children when appropriate.
2. APhA encourages the development of research techniques that would identify possible problems not readily detected in adult clinical investigations to aid in the safe and effective evaluation of drugs in children.

[Am Pharm. NS30(6):46; June 1990] [JAPhA. NS45(5):559; September/October 2005] [Reviewed 2009(Reviewed 2014)] [JAPhA. 59(4):e28; July/August 2019]

**2018**

### **Use of Genomic Data within Pharmacy Practice**

1. APhA emphasizes genomics as an essential aspect of pharmacy practice.
2. APhA recognizes pharmacists as the health care professional best suited to provide medication-related consults and services based on a patient's genomic information. All pharmacists involved in the care of the patient should have access to relevant genomic information.
3. APhA supports processes to protect patient data confidentiality and opposes unethical utilization of genomic data.
4. APhA demands payers include pharmacists as eligible providers for covered genomic interpretation and related services to support sustainable models that optimize patient care and outcomes.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the exchange, storage, utilization, and documentation of clinically actionable genetic variations and actions taken by the pharmacist in the provision of patient care.
6. APhA recommends pharmacists and pharmaceutical scientists lead the collaborative development of evidence-based practice guidelines for pharmacogenomics and related services.
7. APhA recommends the inclusion of pharmacists and pharmaceutical scientists in the collaborative development of pharmacogenomics clinical support tools and resources.
8. APhA encourages pharmacists to use their professional judgment and published guidelines and resources when providing access to testing or utilizing direct to consumer genomic test results in their patient care services.
9. APhA urges schools and colleges of pharmacy to include clinical application of genomics as a required element of the Doctor of Pharmacy curriculum.
10. APhA encourages the creation of continuing professional development and postgraduate education and training programs for pharmacists in genomics and its clinical application to meet varying practice needs.
11. APhA encourages the funding of pharmacist-led research examining the cost-effectiveness of care models that utilize pharmacists providing genomic services.

[JAPhA. 58(4):355; July/August 2018]

**2016**

### **Biologic, Biosimilar, and Interchangeable Biologic Drug Products**

1. APhA urges the development of programs and policies that facilitate patient access to and affordability of biologic products.
2. APhA urges the Food and Drug Administration (FDA) to expedite the development of standards and pathways that will evaluate the interchangeability of biologic products.
3. APhA recognizes the Food and Drug Administration's (FDA) Purple Book as an authoritative reference about biologic product interchangeability within the United States.
4. APhA opposes interchangeable biologic product substitution processes that require authorization, recordkeeping, or reporting beyond generic product substitution processes.
5. APhA encourages scientific justification for extrapolation of indications for biologic products to ensure patient safety and optimal therapeutic outcomes.

[JAPhA. 56(4):369; July/August 2016]

2015

### **Role of the Pharmacist in the Care of Patients Using Cannabis**

1. APhA supports regulatory changes to further facilitate clinical research related to the clinical efficacy and safety associated with the use of cannabis and its various components.
2. APhA encourages health care provider education related to the clinical efficacy, safety, and management of patients using cannabis and its various components.
3. APhA advocates that the pharmacist collect and document information in the pharmacy patient profile about patient use of cannabis and its various components and provide appropriate patient counseling.
4. APhA supports pharmacist participation in furnishing cannabis and its various components when scientific data support the legitimate medical use of the products and delivery mechanisms, and federal, state, or territory laws or regulations permit pharmacists to furnish them.
5. APhA opposes pharmacist involvement in furnishing cannabis and its various components for recreational use.

[JAPhA. N55(4):365; July/August 2015]

2013, 2008

### **Pharmacy Practice–Based Research Networks**

1. APhA supports establishment of pharmacy practice–based research networks (PBRNs) to strengthen the evidence base in support of pharmacists' patient care services.
2. APhA encourages collaborations among stakeholders to determine the minimal infrastructure and resources needed to develop and implement local, regional, and nationwide networks for performing pharmacy practice–based research.
3. APhA encourages pharmacy residency programs to actively participate in pharmacy practice-based research networks (PBRNs).

[JAPhA. NS48(4):471; July/August 2008] [JAPhA. 53(4):366; July/August 2013] [Reviewed 2018]

2011

### **Pharmacist's Role in Health Care Reform**

1. APhA affirms that pharmacists are the medication experts whose accessibility uniquely positions them to increase access to and improve quality of health care while decreasing overall costs.
2. APhA asserts that pharmacists must be recognized as the essential and accountable patient care provider on the health care team responsible for optimizing outcomes through medication therapy Management (MTM).
3. APhA asserts the following:
  - (a) Medication Therapy Management Services: Definition and Program Criteria is the standard definition of MTM that must be recognized by all stakeholders.
  - (b) Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, as adopted by the profession of pharmacy, shall serve as the foundational MTM service model.
4. APhA asserts that pharmacists must be included as essential patient care provider and compensated as such in every health care model, including but not limited to, the medical home and accountable care organizations.
5. APhA actively promotes the outcomes-based studies, pilot programs, demonstration projects, and other activities that document and reconfirm pharmacists' impact on patient health and well-being, process of care delivery, and overall health care costs.

[JAPhA. NS51(4):482 July/August 2011] [Reviewed 2016]

2005

### **Public Access to Clinical Trials Data**

APhA supports access by health care professionals and the public to all clinical trial data derived from scientifically valid studies.

APhA supports the establishment of a single, independent, publicly accessible clinical trials database that includes but is not limited to the following components:

- (a) All studies, pre- and post- drug approval, throughout the research period (whether completed, in-progress or discontinued).
- (b) Clear statements of the size, demographics, limitations, and citations, if published, of each study listed.
- (c) An interpretative statement by an independent review body regarding the purpose of the study, methodology, and outcomes to assist the public in understanding the posted information in a timely manner.
- (d) Warnings to the public regarding inappropriate or incomplete use of the data in making clinical decisions in absence of an interpretive statement.

- (e) Clear identification of the sponsor and any supporting company, organization, or partnered institution of each clinical trial listed (this includes clinical research Organizations, academic research organizations, site management organizations, or any other group that is responsible other than the investigator's research site).

[JAPhA. NS45(5):554–555; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2005, 1986, 1981**

### **Use of Animals in Drug Research**

1. APhA recognizes that animal experiments continue to be an essential, and indeed irreplaceable, component of biomedical research and testing.
2. When animals must be used for biomedical research and testing, APhA strongly supports humane treatment and adequate regulation, controls, and enforcement of appropriate measures relating to animal procurement, transportation, housing, care, and treatment.
3. APhA encourages the further development of methods of biomedical research and testing that do not require the use of animals.
4. APhA opposes legislative provisions that would penalize the properly controlled and conducted use of animals for biomedical research and testing.

[Am Pharm. NS21(5):41; May 1981] [Am Pharm. NS26(6):420; June 1986] [JAPhA. NS45(5):559; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**1989**

### **Pharmacists as Principal Investigators in Clinical Drug Research**

1. APhA urges the sponsors of drug research to permit pharmacists to serve as principal investigators.
2. APhA encourages state and federal agencies to eliminate regulatory and policy obstacles that prohibit pharmacists from being investigators, including principal investigators, in drug research or sponsors of Investigational New Drug Applications, Investigational Device Evaluations, and Animal Investigational New Drug Applications.

[Am Pharm. NS29(7):465; July 1989] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**1989**

### **Scientist Manpower**

1. APhA supports efforts to increase the number of pharmacists pursuing graduate education and research in the pharmaceutical sciences, including, but not limited to
  - (a) dissemination of information to create awareness about graduate programs and career opportunities;
  - (b) pursuit of increased government, industry, and foundation funding; and
  - (c) encouragement of innovative recruitment programs and curricula to facilitate career development.

[Am Pharm. NS29(7):463; July 1989] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**1987**

### **Impact of National Institutes of Health (NIH) Budget on Future Research**

APhA recognizes the fundamental role of biomedical research in the profession of pharmacy and actively supports continued and predictable funding of NIH research.

[Am Pharm. NS27(6):424; June 1987] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**1986**

### **Positive Controls Versus Placebo Controls in Testing New Drugs**

APhA recognizes the importance of and the need for placebo-controlled trials in testing new drugs. In addition, APhA supports the use of alternative study designs (such as positive controls), as well as innovative methodologies where they appear to be appropriate and useful.

[Am Pharm. NS26(6):420; June 1986] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**1984**

### **Freedom of Scientific Information**

1. APhA supports the principle of the free dissemination and exchange of scientific information with only the following exceptions:
  - (a) prior mutual confidentiality agreement between sponsor and researcher,
  - (b) material that is essential to national security, and
  - (c) legitimate trade secrets and/or proprietary information.

[Am Pharm. NS24(7):61; July 1984] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1981

### **Investigational New Drug (IND) Studies**

APhA encourages investigators and sponsors who are conducting IND studies to utilize the professional services of pharmacists in carrying out such studies.

[Am Pharm. NS2(5):40; July 1981] (Reviewed 2004) (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

1981

### **Modification of Patent Periods**

APhA supports modifications of patent periods for prescription drugs and drug products that would create reasonable incentives for needed research on new drugs and drug products.

[Am Pharm. NS21(5):41; May 1981] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

## **SAMPLING**

2002, 1993

### **Traditional Sampling and Pharmacy-Based Starter Dose Programs**

1. APhA encourages the use of pharmacy-based starter dose programs.
2. APhA recommends that pharmacy-based starter dose programs should promote patient access, be cost-effective, ensure product integrity, maximize patient outcomes, and provide appropriate compensation to the pharmacist.
3. APhA recommends that patients and prescribers communicate with pharmacists regarding the use of traditional drug samples to promote safe and effective medication use.
4. APhA encourages that sampling and starter dose programs limit the quantity of medications involved to amounts sufficient for beginning doses only.

[Am Pharm. NS33(7):55; July 1993] [JAPhA. NS42(5)(suppl 1):S60; September/October 2002] (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

## **SPECIALTIES IN PHARMACY**

2020

### **Specialty Pharmacy and Specialized Pharmacy Services**

1. APhA recognizes that certain complex medications require more specialized care and resources. Further, APhA asserts that delineation of medications as specialty versus nonspecialty, and associated payer and manufacturer practices, may introduce continuity of care disruption, patient access issues, and financial inequities.
2. APhA supports pharmacists and pharmacies choosing to specialize or incorporate specialty pharmacy services into their practice to optimize patient outcomes.
3. APhA opposes payer policies and practices that limit patient choice of pharmacy providers, disrupt continuity of care, or compromise patient safety through the creation of specialty drug lists, and restrictive specialty pharmacy networks.
4. APhA opposes manufacturer distribution and related business practices that restrict patient or pharmacy access to medications, medical products, and patient care services.
5. APhA advocates for the adoption of pharmacy profession-developed, harmonized practice standards for specialized pharmacy practices, and specialty pharmacy services and products.
6. APhA encourages increased availability and use of data integration, patient financial assistance, and other resources to inform clinical practice and support the provision of specialized pharmacy practices and specialty pharmacy services.
7. APhA supports the availability of education and training for pharmacists and student pharmacists related to specialized pharmacy practices and specialty pharmacy services.

[JAPhA. 2020;60(5):e10]

2012, 1989

### **Recognition of Pharmacy Practice Specialties**

1. APhA endorses the Board of Pharmacy Specialties' process for recognizing specialties and certifying pharmacists in pharmacy practice specialties.
2. APhA believes that because of the existence of the Board of Pharmacy Specialties' process, separate governmental recognition of pharmacy specialties and pharmacists in pharmacy practice specialties is not necessary.

[Am Pharm. NS29(7):464; July 1989] (Reviewed 2001) (Reviewed 2007) [JAPhA. NS52(4):460; July/August 2012] (Reviewed 2017)

1980

## **Nuclear Pharmacy Regulations**

1. APhA supports the concept of state boards of pharmacy retaining their authority to regulate all aspects of professional pharmacy practice including nuclear pharmacy practice.
2. APhA urges state boards of pharmacy to promptly adopt appropriate rules and regulations for the practice of nuclear pharmacy, using the NABP Model Regulations for the Licensure of Nuclear Pharmacies as a model.

[Am Pharm. NS20:69; July 1980] [Reviewed 2006] [Reviewed 2011] [Reviewed 2016]

## **TITLES/DESIGNATIONS**

### *Community Pharmacy*

2000

## **Use of the Phrase “Community Pharmacy”**

APhA supports use of the phrase “community pharmacy” rather than “retail pharmacy.”

[JAPhA. NS40(5)[suppl 1]:S8; September/October 2000] [Reviewed 2002] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

### *Nonpharmacists*

1999

## **Use of Titles**

APhA opposes the use of titles such as “pharmaceutical specialist” and “pharmaceutical consultant” by sales representatives of pharmaceutical manufacturers.

[JAPhA. 39(4):447; July/August 1999] [Reviewed 2006] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

### *Pharmacist*

1981

## **“P.D.” (Pharmacy Doctor) Designation for Pharmacists**

APhA opposes the term “P.D.” (Pharmacy Doctor) as the uniform designation for pharmacists.

[Am Pharm. NS21(5):40; May 1981] [Reviewed 2002] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

1977

## **Uniform Designation for Pharmacists**

1. The profession of pharmacy should establish and use a uniform designation to identify an individual as a pharmacist.
2. The profession should adopt and use the designation “pharmacist” following an individual’s name as the uniform designation identifying that individual as a pharmacist.
3. At the discretion of individual pharmacists, earned academic degrees or state licensure designation may be indicated following the uniform designation.

[JAPhA. NS17:454; July 1977] [Reviewed 2002] [Reviewed 2007] [Reviewed 2012] [Reviewed 2017]

### *Student Pharmacist*

2005

## **Regulation of Student Pharmacists’ Practice Experience**

1. APhA encourages state boards of pharmacy to use the title “student pharmacist” to identify all students enrolled in their professional years of pharmacy education in an Accreditation Council for Pharmacy Education (ACPE) accredited program.
2. APhA encourages state boards of pharmacy to permit a student pharmacist to perform the duties of a pharmacist within the applicable state’s scope of practice under a pharmacist’s supervision. Preceptors shall consider the experience and education of student pharmacists when providing pharmacy practice opportunities.

[JAPhA. NS45(5):554; September/October 2005] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009] [Reviewed 2013] [Reviewed 2018]

# VACCINES

2020

## Pharmacy Technician Role in Immunization Administration

1. APhA supports the development of standardized training in immunization administration and continuing education opportunities for immunizing pharmacy technicians.
2. APhA supports immunizing pharmacist's individual discretion in delegating immunization administration to pharmacy technicians with the requisite education, training, and experience.
3. APhA supports voluntary participation by pharmacy technicians in the training and provision of immunization administration.
4. APhA supports the role of immunizing pharmacists as the health care professional providing clinical patient assessment, decision making, and patient counseling when delegating immunization administration to a pharmacy technician.

[JAPhA. 2020;60(5):e10]

2018

## Proactive Immunization Assessment and Immunization Information Systems

1. APhA supports mandatory requirements for ALL immunization providers to report pertinent immunization data into Immunization Information Systems (IIS).
2. APhA calls for government entities to fund enrollment and engagement of all immunization providers in Immunization Information Systems (IIS). This engagement should support lifetime tracking of immunizations for patients.
3. APhA supports nationwide integration of Immunization Information Systems (IIS) that incorporate federal, state, and local databases for the purpose of providing health care professionals with accurate and timely information to assist in clinical decision making related to immunization services.
4. APhA advocates that all appropriate health care personnel involved in the patient care process have timely access to Immunization Information Systems (IIS) and other pertinent data sources to support proactive patient assessment and delivery of immunization services while maintaining confidentiality.
5. APhA urges pharmacy management system vendors to include functionality that uses established and adopted electronic health record standards for the bidirectional exchange of data with Immunization Information Systems (IIS).

[JAPhA. 58(4):355; July/August 2018]

2011

## Requiring Influenza Vaccination for All Pharmacy Personnel

APhA supports an annual influenza vaccination as a condition of employment, training, or volunteering within an organization that provides pharmacy services or operates a pharmacy or pharmacy department (unless a valid medical or religious reason precludes vaccination).

[JAPhA. NS51(4):482;; July/August 2011] [Reviewed 2012] [Reviewed 2017]

2007

## Pharmacy Personnel Immunization Rates

1. APhA supports efforts to increase immunization rates of health care professionals, for the purposes of protecting patients, and urges all pharmacy personnel to receive all immunizations recommended by the Centers for Disease Control (CDC) for health care workers.
2. APhA encourages employers to provide necessary immunizations to all pharmacy personnel.
3. APhA encourages federal, state, and local public health officials to recognize pharmacists as first responders (e.g., physicians, nurses, police) and prioritize pharmacists to receive medications and immunizations.

[JAPhA. NS45(5):580; September/October 2007] [Reviewed 2009] [Reviewed 2014] [Reviewed 2019]

**2005, 2003, 1996**

### **Pharmacist's Role in Immunizations**

1. APhA encourages pharmacists to take an active role in achieving the goals of the Healthy People program regarding immunizations through
  - (a) advocacy,
  - (b) contracting with other health care professionals, or
  - (c) administering vaccines to vulnerable patients.
2. APhA encourages the availability of all vaccines to all pharmacies in order to meet public health needs.
3. APhA supports the compensation of pharmacists for the administration of immunizations and the reimbursement for vaccine distribution.
4. APhA should facilitate the development of programs that educate pharmacists about their role in immunizations in public health.

[JAPhA. NS36(6):395; June 1996] [JAPhA. NS43(5)[suppl 1]:S57; September/October 2003] [JAPhA. NS45(5):556; September/October 2005] (Reviewed 2007) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

**1997**

### **Standards for Pharmacy-Based Immunization Advocacy**

(Note: Guidelines approved by the APhA Board of Trustees in May 1997; noted in Appendix.)

APhA should adopt and disseminate standards for immunization advocacy and delivery by pharmacists.

[JAPhA. NS37(4):460; July/August 1997] (Reviewed 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019)

**1987**

### **Encouraging Availability and Use of Vaccines**

1. APhA encourages the continued availability of vaccines to meet public health needs.
2. APhA supports the development of programs that educate the public about the role of immunizations in public health.
3. APhA supports the reimbursement by public and private third-party payers for immunizations.

[Am Pharm. NS27(6):424; June 1987] (Reviewed 2005) (Reviewed 2009) (Reviewed 2012) (Reviewed 2014) (Reviewed 2019) (Reviewed 2020)

## **VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS, AND FOOD**

**2005, 1997**

### **Complementary/Alternative Medications and Integrative Health**

1. APhA supports pharmacists using professional judgment to make informed decisions regarding the appropriateness of use or the sale of complementary and alternative medicines.
2. APhA shall assist pharmacists and student pharmacists in becoming knowledgeable about complementary and alternative medications to facilitate the counseling of patients regarding effectiveness, proper use, indications, safety and possible interactions.

[JAPhA. NS37(4): July/August 1997] (Reviewed 2002) [JAPhA. NS45(5):556–557; September/October 2005] (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2002**

### **Homeopathy**

1. APhA supports the demonstration of safety and efficacy of homeopathic products from adequate, well-designed scientific studies before pharmacists advocate or sell homeopathic products.
2. APhA recognizes patient autonomy regarding the use of homeopathic products. Pharmacists should educate patients who choose to use homeopathic products.
3. APhA supports the modification of the Food, Drug, and Cosmetic Act to require that homeopathic manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.

[JAPhA. NS42(5)[suppl 1]:S60; September/October 2002] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

**2002, 1986**

### **Medication Claims Associated with Foods**

APhA encourages efforts that would require the listing of all active ingredients of a food promoted as a drug or drug product in written promotional and advertising material.

[Am Pharm. NS26(6):420; June 1986] [JAPhA. NS42(5)[suppl 1]:S62; September/October 2002] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

2000

### **Regulation of Dietary Supplements**

1. APhA shall work with Congress to modify the Dietary Supplement Health and Education Act or enact other legislation to require that dietary supplement manufacturers provide evidence of efficacy and safety for all products, including products currently in the marketplace.
2. APhA supports the establishment and implementation of clear and effective enforcement policies to remove promptly unsafe or ineffective dietary supplement products from the marketplace.
3. APhA shall work with the FDA to improve dietary supplement product labeling to ensure full disclosure of all product components and their source with associated strengths and recommendations for use in specific patient populations.
4. APhA supports the development and enforcement of dietary supplement good manufacturing practices (GMPs) and compliance with USP/NF standards to ensure quality, safe, contaminant-free products.
5. APhA encourages health care professionals, manufacturers, and consumers to report adverse health events associated with dietary supplements. APhA encourages the FDA to create a database with this information and make it available to all interested parties.

[JAPhA. NS1(9):40; September/October 2000] (Reviewed 2005) (Reviewed 2007) (Reviewed 2012) (Reviewed 2017)

1988

### **Vitamins, Minerals, and Other Nutritional Supplement Usage**

1. APhA advocates programs that address the public health implications of the misuse and/or abuse of vitamins, minerals, and other nutritional supplements.
2. APhA encourages pharmacists to provide health education regarding unsubstantiated and/or misleading health claims as they apply to vitamins, minerals, and other nutritional supplements.

[Am Pharm. NS28(6):395; June 1988] (Reviewed 2002) (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1981

### **Restriction of Salt Content in Processed Foods**

APhA encourages manufacturers of processed foods to voluntarily reduce the salt (sodium chloride) added to their products and to use the minimum amount of salt necessary in the manufacturing process.

[Am Pharm. NS21(5):41; May 1981] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

1980

### **Food Labeling**

APhA supports requirements for disclosure in the labeling of processed food and the identity and, whenever appropriate, the quantity of ingredients, such as those preservatives, artificial colors and flavors, salts, sugars, and other substances that represent a potential risk to the health or therapy of a portion of the general population.

[Am Pharm. NS20(7):73; July 1980] (Reviewed 2005) (Reviewed 2009) (Reviewed 2014) (Reviewed 2019)

## **WOMEN IN PHARMACY**

1979

### **Consideration of the Equal Rights Amendment**

APhA supports efforts to ensure equal rights of all persons.

[Am Pharm. NS19(7):60; June 1979] (Reviewed 2009) (Reviewed 2014) (Reviewed 2018)



# APPENDICES

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# American Pharmacists Association Bylaws as amended through May 13, 2019.

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## ARTICLE I. NAME AND SEAL

- 1 **Section 1. Name.** This ASSOCIATION shall be called the  
2 "AMERICAN PHARMACISTS ASSOCIATION."  
3 **Section 2. Seal.** This ASSOCIATION shall have an official seal.

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## ARTICLE II. PURPOSE

- 4 **Section 1. Purpose.** This ASSOCIATION provides information,  
5 education, and advocacy to help all pharmacists improve  
6 medication use and advance patient care.  
7 **Section 2. Membership Benefits and Services.** In furtherance of  
8 its lawful purposes and within its corporate powers, this  
9 ASSOCIATION shall conduct such programs and activities and  
10 shall provide such other membership benefits and services as  
11 may be established from time to time by its members or Board  
12 of Trustees.  
13 **Section 3. Code of Ethics.** This ASSOCIATION shall provide and  
14 maintain a Code of Ethics for pharmacists.

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## ARTICLE III. MEMBERSHIP

- 15 **Section 1. Classes of Membership.** This ASSOCIATION shall have  
16 Member, Student Pharmacist Member, Pharmacy Technician  
17 Member, and Honorary Member classes of membership and  
18 such other classes of membership as may be established from  
19 time to time by the Board of Trustees.  
20 **Section 2. Member.** Any pharmacist who is licensed in the  
21 United States or a graduate of an Accreditation Council for  
22 Pharmacy Education (ACPE) accredited school/college of  
23 pharmacy, any member of a pharmacy faculty, or any other  
24 individual who shares the ASSOCIATION's mission and vision.  
25 Members of the former Life membership class shall be Members  
26 without payment of dues. A Member shall have full voting rights  
27 and may hold office in this ASSOCIATION as allowed by the  
28 individual office and in any of its membership organization  
29 groups in which membership is held as allowed by the individual  
30 office.  
31 **Section 3. Student Pharmacist Member.** Any student enrolled in  
32 a school or college of pharmacy holding membership in the  
33 American Association of Colleges of Pharmacy or accredited by  
34 ACPE, or a student enrolled in a pre-pharmacy program, shall be  
35 eligible for membership as a Student Pharmacist Member. A  
36 Student Pharmacist Member shall also be a member of the  
37 ASSOCIATION's student pharmacist membership organization  
38 group. A Student Pharmacist Member shall have full voting rights  
39 in the student pharmacist membership organization group and  
40 may hold office only in the ASSOCIATION's student pharmacist  
41 membership organization group, provided, however, that a  
42 Student Pharmacist Member shall have full voting rights as a  
43 member of an ASSOCIATION committee or as a delegate in the  
44 ASSOCIATION House of Delegates. Student Pharmacist Members  
45 representing the student pharmacist membership organization

46 group in the APhA House of Delegates shall have the right to vote  
47 in that year's annual election for at-large APhA Board of Trustees  
48 members and APhA President-Elect, as well as any additional  
49 issues that may be placed on the ballot from time to time.

50 **Section 4. Pharmacy Technician Member.** Any individual who is  
51 a pharmacy technician shall be eligible for membership as a  
52 Pharmacy Technician Member. A Pharmacy Technician Member  
53 shall have full voting rights in a selected Association membership  
54 organization group and may hold office only in that selected  
55 membership organization group, provided, however, that a  
56 Pharmacy Technician Member shall have full voting rights as a  
57 member of an ASSOCIATION committee or as a delegate in the  
58 ASSOCIATION House of Delegates.

59 **Section 5. Honorary Membership.** Any individual may be granted  
60 Honorary membership by the Board of Trustees. An Honorary  
61 Member shall have no voting rights and may not hold office in  
62 this ASSOCIATION or any of its membership organization groups  
63 unless entitled to do so under another class of membership.

64 **Section 6. Admission to Membership.** Any individual shall be  
65 admitted to membership in the appropriate class of membership  
66 upon completion of administrative processing of any required  
67 application accompanied by required dues, provided, however,  
68 that the Board of Trustees may deny any individual membership  
69 for cause, meaning conduct tending to damage the public  
70 reputation of this ASSOCIATION.

71 **Section 7. Membership Benefits and Services.** Membership  
72 benefits and services for each class of membership shall be those  
73 established from time to time by the Board of Trustees. The  
74 Board of Trustees may add, delete, or adjust membership  
75 benefits and services as it deems necessary or desirable in  
76 furtherance of ASSOCIATION purposes. No addition, deletion, or  
77 adjustment of membership benefits or services shall require any  
78 adjustment of dues for the membership period during which the  
79 addition, deletion, or adjustment of membership benefits or  
80 services occurs.

81 **Section 8. Termination of Membership.** Any member may  
82 voluntarily terminate membership by notice to this  
83 ASSOCIATION. Termination of membership shall be effective  
84 upon completion of administrative processing of such notice. No  
85 such voluntary termination of membership shall be effective to  
86 avoid any debt to this ASSOCIATION. This ASSOCIATION may  
87 terminate the membership of any member for failure to pay  
88 required dues. Such termination of membership shall be  
89 effective at the convenience of this ASSOCIATION. Termination  
90 of membership shall terminate the right of any member to all  
91 membership benefits and services.

92 **Section 9. Dues.** Each member shall pay such dues as may be  
93 required from time to time by the Board of Trustees for each class  
94 of membership. The Board of Trustees may establish from time  
95 to time such administrative policies and procedures as it deems  
96 necessary or desirable to facilitate the payment and receipt of  
97 required dues. The Board of Trustees may also establish from  
98 time to time special dues within established classes of  
99 membership.

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## ARTICLE IV. OFFICERS

100 **Section 1. Officers.** The officers of the ASSOCIATION shall be the  
101 President, the President-elect, the Immediate Past President, the  
102 Treasurer, and the Executive Vice President.

103 **Section 2. President, President-elect and Immediate Past**  
104 **President.** The President shall be a pharmacist from the  
105 ASSOCIATION's Member category and the principal elected  
106 officer of the ASSOCIATION and shall serve as a Trustee of this  
107 ASSOCIATION.

108 The President shall first be elected as President-elect, and the  
109 year thereafter shall serve as President with the third year of  
110 service as Immediate Past President. The President shall preside  
111 at meetings of this ASSOCIATION and shall appoint, with the  
112 approval of the Board of Trustees, all ASSOCIATION committees  
113 other than the ASSOCIATION House of Delegates Committees.

114 The President shall perform such other duties as may be  
115 assigned from time to time by the Board of Trustees, but shall  
116 have no individual duties or responsibility for administrative  
117 decisions or actions with regard to the continuing management  
118 of ASSOCIATION affairs.

119 No individual shall serve as President-elect immediately  
120 following a term as President or Immediate Past President. A  
121 vacancy in the office of President shall be filled by the President-  
122 elect. A vacancy in the office of President-elect or Immediate Past  
123 President may be filled by a pharmacist from the ASSOCIATION's  
124 Member category appointed by the Board of Trustees, except  
125 that any appointment of a President-elect will be effective only  
126 until the next regular election at which time the membership  
127 shall elect both a President-elect and a President.

128 **Section 3. Executive Vice President.** The Executive Vice President  
129 shall be a pharmacist from the ASSOCIATION's Member category  
130 appointed by the Board of Trustees and employed by the  
131 ASSOCIATION as chief executive officer on such terms and  
132 conditions as are approved by the Board of Trustees. The  
133 Executive Vice President shall be responsible to the Board of  
134 Trustees in the exercise of assigned duties and authorities for  
135 executive and administrative decisions or actions with regard to  
136 the continuing management of the ASSOCIATION's affairs. The  
137 Executive Vice President shall serve as Secretary of the  
138 ASSOCIATION and as Secretary of the House of Delegates. A  
139 vacancy in the office of Executive Vice President shall be filled  
140 by a pharmacist from the ASSOCIATION's Member category  
141 appointed by the Board of Trustees.

142 **Section 4. Treasurer.** The Treasurer shall be a Member appointed  
143 by the Board of Trustees and shall serve for a term of three (3)  
144 years from the effective date of the appointment. No individual  
145 shall serve more than two (2) consecutive full three-year terms  
146 as Treasurer. A vacancy in the office of Treasurer shall be filled  
147 for the unexpired term by a Member appointed by the Board of  
148 Trustees.

149 **Section 5. Removal.** An Officer of the ASSOCIATION (except for  
150 the Executive Vice President) may be removed from office for  
151 any reason by a two-thirds (2/3) vote in favor of removal by the  
152 whole Board of Trustees, excluding the vote of the affected  
153 Officer. Trustees may only vote in person at an assembled  
154 meeting, face-to-face. No proxies, mail, telephone or other  
155 indirect means of voting shall be permitted. The vote shall be  
156 taken by secret written ballot. Counsel to the ASSOCIATION shall  
157 tally the ballots and shall announce only the result.

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## ARTICLE V. BOARD OF TRUSTEES

158 **Section 1. Composition.** Six (6) Elected Trustees, the Officers, the  
159 Speaker of the House of Delegates, and the Presidents of the  
160 membership organization groups of this ASSOCIATION shall  
161 constitute the Board of Trustees.

162 **Section 2. Duties and Authority.** The Board of Trustees shall be  
163 responsible for the general supervision and management of  
164 ASSOCIATION affairs, including, but not limited to, the specific  
165 duties and authority stated in these Bylaws. It shall have, in  
166 addition to the specific duties and authority stated in these  
167 Bylaws, such duties and authority which from time to time are  
168 imposed on or recognized by law as being applicable to nonprofit  
169 corporations. It shall adopt Bylaws and rules or procedures for  
170 the conduct of its business.

171 It shall act with regard to matters of ASSOCIATION policy for the  
172 House of Delegates in the interim between House of Delegates  
173 meetings and shall make an annual report to the membership  
174 regarding the programs and activities of this ASSOCIATION.

175 **Section 3. Election of Trustees.** Elected Trustees shall be elected  
176 as provided for in the Article on elections in these Bylaws.

177 **Section 4. Term of Office.** Elected Trustees shall be elected for a  
178 term of three (3) years and shall serve until their successors have  
179 been duly elected and installed. No individual shall serve more  
180 than two (2) successive full terms as an Elected Trustee.  
181 However, nothing in this Article shall prevent a Trustee who has  
182 served two full successive terms from being elected as President-  
183 elect or President.

184 **Section 5. Vacancies.** A vacancy among Elected Trustees shall be  
185 filled by a pharmacist from the ASSOCIATION's Member category  
186 selected by the Board of Trustees to serve the remainder of the  
187 unexpired term. A vacancy among Officer Trustees shall be filled  
188 as provided for in the Article on Officers in these Bylaws. A  
189 vacancy in the Office of Speaker or the Office of Speaker-elect of  
190 the House of Delegates shall be filled as provided for in the Article  
191 on the House of Delegates in these Bylaws.

192 **Section 6. Meetings.** The Board of Trustees shall meet at the call  
193 of the President or on the call of a quorum of the Board of  
194 Trustees. The time and place of Board of Trustees meetings shall  
195 be established by the President.

196 **Section 7. Quorum.** A majority of Trustees plus one shall  
197 constitute a quorum for the transaction of business.

198 **Section 8. Removal.** A Trustee of the ASSOCIATION may be  
199 removed from office for any reason by a two-thirds (2/3) vote in  
200 favor of removal by the whole Board of Trustees, excluding the  
201 vote of the affected Trustee. Trustees may only vote in person at  
202 an assembled meeting, face-to-face. No proxies, mail, telephone  
203 or other indirect means of voting shall be permitted. The vote  
204 shall be taken by secret written ballot. Counsel to the  
205 ASSOCIATION shall tally the ballots and shall announce only the  
206 result.

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## ARTICLE VI. HOUSE OF DELEGATES

207 **Section 1. Composition.** The House of Delegates shall consist of  
208 delegates from Affiliated State Organizations (See Article VII),  
209 ASSOCIATION membership organization groups, Recognized  
210 National Organizations (See Article VII), Delegates Ex Officio, and  
211 Speaker-appointed delegates. Each delegate and Delegate Ex  
212 Officio must be a member of this ASSOCIATION.

213 **Section 2. Apportionment of Delegates.**  
214 **A.** Affiliated State Organizations: each shall have two (2)  
215 delegates plus one (1) delegate for each two hundred (200)  
216 Members of this ASSOCIATION, or major fraction thereof, who  
217 are members of this ASSOCIATION residing in the state.  
218 Delegates and alternate delegates from each state should reflect  
219 the demographic diversity represented by the ASSOCIATION  
220 membership residing in that state.  
221 i. If either an affiliated state organization delegation has been  
222 inactivated via procedures outlined in Article VII, Section 2.G  
223 of these Bylaws or no delegates have been appointed by the  
224 affiliated state organization by June 1<sup>st</sup>, the Speaker may  
225 appoint one delegate who, at the time of appointment, resides  
226 or is employed in the state or region they are chosen to  
227 represent.  
228 **B.** ASSOCIATION membership organization groups: each shall  
229 have twenty-eight (28) delegates.  
230 **C.** Recognized National Organizations: each shall have two (2)  
231 delegates, delegates who are members of the recognized  
232 organization.  
233 **D.** Delegates Ex Officio: shall be each Trustee, ASSOCIATION  
234 Former Presidents, and Former Speakers of the House of  
235 Delegates.  
236 **E.** The Speaker shall appoint up to 20 delegates from House  
237 committee members not appointed as delegates from other  
238 delegations.  
239 **F.** Each appointing organization shall have the right to appoint  
240 one (1) alternate delegate for up to five (5) delegates that it  
241 appoints, plus one (1) alternate delegate for each additional  
242 five (5) delegates, or major fraction there-of, that it appoints.  
243 **G.** Delegations that have one or more seats unfilled during both  
244 House sessions for 3 consecutive years shall have those seats  
245 inactivated from their delegate allocation. Delegations shall be  
246 notified 60 days prior to the inactivation of delegate seats and  
247 may petition the Secretary of the House for reappointment of  
248 those seats.  
249 **Section 3. Duties and Authority.** The House of Delegates shall  
250 serve as a legislative body in the development of ASSOCIATION  
251 policy. It shall act on such policy recommendations as shall come  
252 before it and shall adopt rules or procedures for the conduct  
253 of its business.  
254 **Section 4. Appointment of Delegates.** Affiliated State  
255 Organizations, Recognized National Organizations, and  
256 ASSOCIATION membership organization groups will appoint the  
257 delegates and alternate delegates to which they are entitled  
258 according to Article VII, Section 2 of these Bylaws and the APhA  
259 House Rules of Procedure. All delegates and alternate delegates  
260 other than Delegates Ex Officio shall serve until May 31<sup>st</sup> of each  
261 year. Delegates Ex Officio shall serve for life or, in the case of  
262 Trustees serving as Delegates Ex Officio, until their successors  
263 have been duly appointed or elected and installed.  
264 **Section 5. Officers.** The Officers of the House of Delegates shall  
265 be a Speaker, a Speaker-elect, and a Secretary. The Speaker shall  
266 appoint delegates and Committees as provided in these Bylaws,  
267 shall preside at meetings of the House of Delegates, and shall be  
268 responsible for a report of the actions of the House of Delegates  
269 to the members of this ASSOCIATION. The Speaker-elect shall  
270 assist the Speaker in the performance of the Speaker's duties  
271 and/or perform such duties as specified by the House of  
272 Delegates. In the event of a vacancy in the Office of Speaker, or  
273 in the event the Speaker is unable to perform the duties of the  
274 office during a meeting of the House of Delegates, the Speaker-

275 elect shall assume the duties of the Speaker. In the event of a  
276 vacancy in both the Office of Speaker and the Office of Speaker-  
277 elect, or in the event both the Speaker and the Speaker-elect are  
278 unable to perform the duties of the offices during a meeting of  
279 the House of Delegates, the House of Delegates shall elect a  
280 Speaker pro tem, at which time a Speaker and a Speaker-elect  
281 shall be elected. The Secretary of the House of Delegates shall be  
282 responsible for the administrative functions of the House of  
283 Delegates.  
284 **Section 6. Elections.** The Speaker-elect shall be elected during  
285 the Annual Meeting of the ASSOCIATION by the House of  
286 Delegates from among a slate of delegates nominated by the  
287 House of Delegates Committee on Nominations and as otherwise  
288 may be provided for in rules or procedures adopted by the House  
289 of Delegates. Speaker-elect elections will be held every other  
290 year. The Speaker-elect shall serve until the end of the next  
291 Annual Meeting of the ASSOCIATION following election at which  
292 time the Speaker-elect shall be installed in the Office of Speaker.  
293 The Speaker shall serve for two years. The Speaker shall serve  
294 until a successor is duly elected and/or installed. The Executive  
295 Vice President of the ASSOCIATION shall serve as Secretary of the  
296 House of Delegates.  
297 **Section 7. Meetings.** The House of Delegates shall hold a regular  
298 meeting during the Annual Meeting of this ASSOCIATION, this  
299 regular meeting to consist of such sessions and to have an order  
300 of business as adopted by the House of Delegates. The House  
301 may, at the discretion of the Speaker, convene using electronic  
302 means prior to the regular meeting outlined herein provided that  
303 the Secretary of the House notifies the delegates at least 30 days  
304 prior to convening such session. All House of Delegates Rules of  
305 Procedure and these Bylaws apply to all House sessions, whether  
306 held electronically or in person. The House of Delegates may  
307 hold special meetings at the call of the Speaker with the approval  
308 of the Board of Trustees, or upon written or electronic petition of  
309 a majority of authorized delegates provided that the Secretary of  
310 the House notifies the delegates at least 10 days prior to  
311 convening such session. Special meetings of the House of  
312 Delegates may occur electronically or be scheduled in person at  
313 a time and location to be established by the Speaker with the  
314 approval of the Board of Trustees.  
315 **Section 8. Quorum.** A majority of the delegates registered at any  
316 regular or special meeting of the House of Delegates shall  
317 constitute a quorum for the transaction of business.  
318 **Section 9. Committees.** The House of Delegates shall have  
319 committees as established by the Speaker and the Board of  
320 Trustees. Such Committees shall be appointed by the Speaker of  
321 the House of Delegates. The House of Delegates shall have the  
322 following standing committees:  
323 **A.** Committee on Nominations  
324 **B.** Canvassers Committee  
325 **C.** Policy Committees.  
326 Committees shall have such number of members as the Board of  
327 Trustees may establish and shall consider subjects only on  
328 agendas approved by the Board of Trustees. The House of  
329 Delegates Committee on Nominations shall nominate candidates  
330 for Speaker of the House of Delegates in accordance with such  
331 Bylaws, rules, or procedures as the House of Delegates deems  
332 necessary or desirable to facilitate its business. The House of  
333 Delegates Canvassers Committee shall certify the results of the  
334 House of Delegates elections.

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## ARTICLE VII. RECOGNIZED AND AFFILIATED ORGANIZATIONS

335 **Section 1. Recognized National Organizations.** Any national  
336 organization representing pharmacy, the purposes of which are  
337 consistent with the purposes of this ASSOCIATION, may be  
338 designated a Recognized National Organization by the Board of  
339 Trustees. The status of such an organization as a Recognized  
340 National Organization may be terminated by the Board of  
341 Trustees.

342 **Section 2. Affiliated State Organizations.** An organization,  
343 representing pharmacy, from a State, Territory, or the District of  
344 Columbia may be designated as an Affiliated State Organization  
345 by the Board of Trustees at its discretion.

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## ARTICLE VIII. ORGANIZATION OF MEMBERS

346 **Section 1. Organization.** The Association shall have a membership  
347 organization group representing at least the following segments  
348 of members: pharmacy practitioners, student pharmacists, and  
349 pharmaceutical scientists. Each group shall have an Executive  
350 Committee consisting of a President, a President-elect, and such  
351 additional members as the Board of Trustees may establish  
352 from time to time. Each Executive Committee shall be elected by  
353 the members of the group pursuant to procedures established by  
354 the Board of Trustees.

355 **Section 2. Additional membership organization groups.** The  
356 Board may, from time to time, establish additional membership  
357 organization groups reflecting the diverse professional needs of  
358 the membership.

359 **Section 3. Programming.** Each membership organization group  
360 shall conduct such programs as may be established from time to  
361 time for the benefit of its members, the profession, or the public.  
362 Programs are subject to the approval of the Board of Trustees.  
363 The student pharmacist organization group may recognize an  
364 affiliated student pharmacist chapter at any ACPE-accredited or  
365 American Association of Colleges of Pharmacy recognized school  
366 or college of pharmacy.

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## ARTICLE IX. MEETINGS

367 **Section 1. Annual Meeting.** This ASSOCIATION shall hold an  
368 Annual Meeting each calendar year at a time and place  
369 established by the Board of Trustees. The Annual Meeting shall  
370 consist of such sessions and shall have an order of business  
371 as specified in the official program for the Annual Meeting.

372 **Section 2. Special Meetings.** The ASSOCIATION may hold special  
373 meetings at the call of the President with the approval of the  
374 Board of Trustees. The time and place of special meetings shall  
375 be established by the President. The order of business for a  
376 special meeting shall be as specified in the call, notice or agenda  
377 of the special meeting.

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## ARTICLE X. ELECTIONS

378 **Section 1. Nominations.** Candidates for election as ASSOCIATION  
379 President-elect and Elected Trustees shall be from among  
380 pharmacists in the Member category. A slate of two (2)

381 candidates shall be nominated for each Elected Trustee slot and  
382 President-Elect.

383 **Section 2. Nominating Committee.** The Committee on  
384 Nominations shall nominate all candidates for President-elect  
385 and Elected Trustees as provided for in this Article. The  
386 Committee on Nominations shall consist of the most recent  
387 nonincumbent Former President, the immediate former Speaker  
388 of the House of Delegates, and three (3) other members  
389 appointed by the President. No individual shall serve on the  
390 Committee on Nominations in more than three (3) consecutive  
391 calendar years.

392 **Section 3. Election Procedure.** Except as may otherwise be  
393 provided in these Bylaws, the names of candidates for election  
394 and a mail ballot shall be provided all members entitled to vote.  
395 Executed ballots must be received by the date published on the  
396 ballot.

397 The Committee of Canvassers shall certify the results of all  
398 ASSOCIATION elections, except for elections in the House of  
399 Delegates. The Committee of Canvassers shall meet following a  
400 tally of timely, valid ballots and shall review the election  
401 procedure for compliance with these Bylaws. It shall certify to the  
402 Board of Trustees the results of the election for each position.  
403 The names of candidates elected shall be made public following  
404 certification of the election by the Committee of Canvassers.  
405 Once certified, the results of any election shall not be subject to  
406 challenge.

407 **Section 4. Time of Election.** Except as may otherwise be provided  
408 in these Bylaws, the ASSOCIATION nomination and election  
409 process shall be conducted pursuant to a schedule established by  
410 the Executive Vice President with the approval of the Board of  
411 Trustees, which will permit candidates elected to assume office  
412 as provided in these Bylaws.

413 **Section 5. Installation.** Except as may otherwise be provided in  
414 these Bylaws, Officers and Elected Trustees of the ASSOCIATION  
415 and the elected officers of the membership organization groups  
416 shall assume office at the conclusion of business on the last day  
417 of the Annual Meeting of the ASSOCIATION following the year in  
418 which they are elected.

419 **Section 6. Honorary President.** When nominated by the Board of  
420 Trustees, an Honorary President of the ASSOCIATION shall be  
421 elected pursuant to the election procedures established in these  
422 Bylaws. The Honorary President shall be a member of the  
423 ASSOCIATION, shall have made significant contributions to the  
424 ASSOCIATION, and shall serve for a one-year term commencing  
425 on the first day of the Annual Meeting following the year in which  
426 elected.

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## ARTICLE XI. FINANCES

427 **Section 1. Financial and Investment Policy.** The financial and  
428 investment policy of this ASSOCIATION shall be as established  
429 from time to time by the Board of Trustees with the advice of the  
430 Treasurer, Executive Vice President, and such other financial  
431 advisors as the Board of Trustees may deem necessary or  
432 desirable. Investments shall not be restricted to those approved  
433 by law by the District of Columbia or any other jurisdiction.

434 **Section 2. Financial Administration.** The Executive Vice  
435 President, with the approval of the Treasurer, shall be  
436 responsible for the continuing management of the financial  
437 affairs of this ASSOCIATION. The Board of Trustees shall approve  
438 any bank intended to serve as a repository of ASSOCIATION

439 assets and a public accounting firm that shall be retained to  
440 conduct an annual audit of ASSOCIATION accounts. All  
441 disbursements of ASSOCIATION funds shall be pursuant to such  
442 policies and procedures as may be established from time to  
443 time by the Board of Trustees and are to be monitored and  
444 reviewed on a regular basis by the Treasurer and the Executive  
445 Vice President or by the Executive Vice President alone.

446 **Section 3. Bonds.** The Treasurer, the Executive Vice President,  
447 and such other members, employees, or agents of this  
448 ASSOCIATION as the Board of Trustees may direct shall be  
449 bonded for proper care and disposition of ASSOCIATION property  
450 in their possession or custody. Such bonds shall be in amounts  
451 and subject to such conditions as the Board of Trustees shall  
452 direct. The expense of such bonds shall be borne by the  
453 ASSOCIATION.

454 **Section 4. Financial Report.** The Treasurer shall make an  
455 annual financial report to the membership that includes an  
456 audited financial statement for the preceding fiscal year.

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## ARTICLE XII. BOARD OF PHARMACY SPECIALTIES

457 **Section 1. Purposes.** The Board of Pharmacy Specialties shall  
458 exist for the following purposes:

459 **A.** To grant recognition of appropriate pharmacy practice  
460 specialties based on criteria established by the Board of  
461 Pharmacy Specialties.

462 **B.** To establish standards for certification and recertification  
463 in recognized pharmacy practice specialties.

464 **C.** To grant qualified pharmacists certification and recertification  
465 in recognized pharmacy practice specialties.

466 **D.** To serve as a coordinating agency and informational  
467 clearinghouse for organizations and pharmacists in recognized  
468 pharmacy practice specialties.

469 **Section 2. Bylaws and Composition.** The Board of Pharmacy  
470 Specialties shall operate under Bylaws (and subsequent  
471 amendments) approved by the ASSOCIATION's Board of  
472 Trustees. The composition of the Board of Pharmacy Specialties  
473 shall be outlined in the approved Bylaws.

474 **Section 3. Finances.** The ASSOCIATION shall act as fiscal agent for  
475 the Board of Pharmacy Specialties in accordance with procedures  
476 established by the ASSOCIATION's Board of Trustees. The  
477 ASSOCIATION shall prepare an annual audited financial report of  
478 Board of Pharmacy Specialties activities.

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## ARTICLE XIII. PARLIAMENTARY AUTHORITY AND PRECEDENCE

479 **Section 1. Parliamentary Authority.** The rules contained in the  
480 current edition of Robert's Rules of Order shall govern this  
481 ASSOCIATION in all cases to which they are applicable. The  
482 Executive Vice President may retain the services of a qualified  
483 parliamentarian for any meeting when such services are deemed  
484 necessary or desirable and shall do so for all deliberative  
485 meetings of the House of Delegates.

486 **Section 2. Precedence.** In any case of conflict between these  
487 Bylaws and any other bylaws, parliamentary authority, or rules or  
488 procedures of any membership organization group, these Bylaws  
489 shall prevail. All such apparent conflicts shall be resolved by the  
490 Board of Trustees whose decision shall be binding on all  
491 interested parties.

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## ARTICLE XIV. AMENDMENTS

492 **Section 1. Bylaws.** Every proposed amendment of these Bylaws,  
493 following the approval of counsel and the Board of Trustees, shall  
494 be submitted with a mail ballot to all members entitled to vote.  
495 Executed ballots must be received by this ASSOCIATION by the  
496 date published on the ballot. A proposed amendment of these  
497 Bylaws shall become effective upon receiving a two-thirds (2/3)  
498 affirmative vote certified by the Committee of Canvassers to the  
499 Board of Trustees. Once certified, the results of any vote on a  
500 proposed Bylaw amendment shall not be subject to challenge.

501 **Section 2. Code of Ethics.** Every proposed amendment of the  
502 Code of Ethics, with the approval of counsel and the Board of  
503 Trustees, shall be submitted with a mail ballot to all members  
504 entitled to vote. Executed ballots must be received by this  
505 ASSOCIATION by the date published on the ballot. A proposed  
506 amendment of the Code of Ethics shall become effective upon  
507 receiving a two-thirds (2/3) affirmative vote certified by the  
508 Committee of Canvassers to the Board of Trustees.

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## ARTICLE XV. NOTICE

509 **Section 1. Previous Notice.** Any previous notice required to be  
510 provided any member of this ASSOCIATION may be given by  
511 printing the notice in a publication regularly provided the  
512 member entitled to notice or by mailing the notice to each  
513 member entitled to notice at the member's mailing address then  
514 indicated in the membership records of this ASSOCIATION.



# American Pharmacists Association

## Seven Principles of Pharmaceutical Care Benefits

**PRINCIPLE I: The Pharmaceutical Care Benefit recognizes the value of the patient-pharmacist relationship.**

- (a) The Pharmaceutical Care Benefit permits any pharmacist willing to meet specified service quality, delivery and financial requirements of a plan to participate in serving patients under that plan.
- (b) Within the limits specified in I(a), the Pharmaceutical Care Benefit (1) ensures that patients have convenient access to prescription drug therapy and professional pharmacy services from the pharmacist of their choice and (2) avoids unreasonable administrative, distribution channel, or financial plan requirements that create unnecessary access barriers.
- (c) The Pharmaceutical Care Benefit encourages the patient's use of the most cost-effective drug therapy and professional pharmacy services through reasonable administrative rules and financial incentives that are equally applied to all participating pharmacists.

**Principle II: The Pharmaceutical Care Benefit supports the provision of pharmaceutical care.**

- (a) The Pharmaceutical Care Benefit uses compensation systems that encourage pharmacists to provide cost-effective professional services and pharmaceutical products.
- (b) The Pharmaceutical Care Benefit facilitates pharmacist-prescriber communication that assists prescribers in selecting optimal cost-effective therapy.
- (c) The Pharmaceutical Care Benefit encourages pharmacist review, continuous oversight, and implementation of supportive care strategies that are based on recognized standards and are aimed at patient adherence to the prescriber's therapy goals.
- (d) The Pharmaceutical Care Benefit encourages patients, prescribers, and pharmacists to openly, actively, and regularly communicate about the anticipated effects, potential side effects, and actual experiences associated with drug use.
- (e) The Pharmaceutical Care Benefit provides financial incentives for performance that promotes interactive pharmacist-patient drug therapy review and counseling that occurs, at a minimum, with the provision of all new medication prescriptions, first refills of new medicines, and at appropriate maintenance medication review periods.

**Principle III: The Pharmaceutical Care Benefit provides support systems and materials to pharmacists and plan beneficiaries that facilitate their roles in achieving optimal therapy outcomes.**

- (a) The Pharmaceutical Care Benefit provides clear, well-articulated materials to pharmacists and plan beneficiaries. These materials include complete and accurate disclosure of plan design, financial incentives, and implementation procedures.
- (b) The Pharmaceutical Care Benefit provides timely notification and educational materials relating to program enhancements to pharmacy providers and plan beneficiaries.
- (c) The Pharmaceutical Care Benefit provides prompt notice of performance incentives to pharmacists, to help them identify appropriate processes and behaviors.

**Principle IV: The Pharmaceutical Care Benefit remuneration to pharmacists should be based on sound, defensible methodology.**

- (a) The Pharmaceutical Care Benefit acknowledges quality, professional service delivery by pharmacists through compensation systems and reporting mechanisms that are identifiably separate and distinct from compensation for the drug product and its distribution.

- (b) The Pharmaceutical Care Benefit provides product and service payment mechanisms to ensure that no provider or group of providers obtains financial arrangements that disadvantage any other provider or group of providers offering similar products and services.

**Principle V: The Pharmaceutical Care Benefit administration uses technology that integrates health information and reflects current national standards.**

- (a) The Pharmaceutical Care Benefit uses an automated point-of-service processing system that complies with national standards.
- (b) Pharmacists should be able to validate the patient's participation in a Pharmaceutical Care Benefit and ensure appropriate coordination of benefits.
- (c) The Pharmaceutical Care Benefit Program's identification cards include all information needed to successfully provide service and adjudicate claims.
- (d) Pharmaceutical Care Benefit Programs ensure prompt payment of claims, as adjudicated.
- (e) The Pharmaceutical Care Benefit Program's charges for participation as a provider, if any, should be fair, reasonable, and clearly disclosed.

**Principle VI: The Pharmaceutical Care Benefit provides for ongoing program evaluation and documentation.**

- (a) The Pharmaceutical Care Benefit uses reporting systems that regularly disseminate relevant information to pharmacists to allow pharmacists to improve their performance and their management of patients. These reports should include drug therapy statistics; therapy guidelines; feedback on behaviors of individual prescribers and dispensing pharmacists with regard to prescribing and patient utilization efficiencies; and relative performance on DUR-related alerts, therapy interventions, and patient outcomes.
- (b) The Pharmaceutical Care Benefit Program uses pharmacist/ practitioner/ patient involvement in program design, operations oversight, and ongoing evaluation.

**Principle VII: The Pharmaceutical Care Benefit facilitates exchange of patient information.**

- (a) The Pharmaceutical Care Benefit Program provides access to patient information that assists pharmacists in providing comprehensive pharmaceutical care services.
- (b) The Pharmaceutical Care Benefit Program uses procedures that ensure the security of patient-specific information and limits its use to health care providers.



## **Guidelines for Pharmacy-based Immunization Advocacy and Administration**

At the 1996 APhA Annual Meeting held in Nashville, Tennessee, the House of Delegates adopted policy encouraging pharmacists to take an active role in increasing the rate of immunizations among vulnerable patient populations. This role could be fulfilled by pharmacists' becoming educators, facilitators, or immunizers of the public.

APhA has invested many resources in the development of education, advocacy, practice support, and scientific programs related to the role of pharmacists in increasing the rate of immunizations. These activities have assisted the profession to develop collaborative relationships with other health professionals and to highlight the pharmacist's position within the health care system.

In response to a call by pharmacists and other entities for assistance in developing these expanded roles, a set of draft guidelines were developed. These proposed guidelines were presented as a New Business Item to the APhA House of Delegates at the 1997 Annual Meeting held in Los Angeles, California. The House referred the guidelines to the Board for the solicitation of further input and the adoption of a set of guidelines that would assist pharmacists in incorporating immunization activities into their practice. After receiving input from pharmacists, and other health care providers and organizations, the APhA Board of Trustees approved the following guidelines. The guidelines are a dynamic document and will be periodically reviewed as the health care arena changes.

The guidelines were reviewed in 2012 and reviewed and revised through the APhA–APPM Immunizing Pharmacists SIG and public comment period in 2018. Final approval of the revised document was made by the APhA Board of Trustees on January 26, 2019.

For additional information, contact Mitchel Rothholz, RPh, MBA, at 202-429-7549 or at [mrothholz@aphanet.org](mailto:mrothholz@aphanet.org).

# Guidelines for Pharmacy-based Immunization Advocacy and Administration

## American Pharmacists Association

**Guideline 1 – Prevention** – Pharmacists should protect their patients’ health by being vaccine advocates.

- (a) Pharmacists should adopt at least one of three levels of involvement in vaccine advocacy:
  - (1) Pharmacist as educator (educate patients, caregivers, and other health care professionals about vaccines, and both serious communicable and preventable diseases; serve as immunization champions);
  - (2) Pharmacist as facilitator (host others who immunize);
  - (3) Pharmacist as immunizer (protect vulnerable patients, consistent with state law).
- (b) Pharmacists should focus their immunization efforts to meet the immunization and disease prevention needs of the patient and protect the public from vaccine-preventable diseases.
- (c) Pharmacists should utilize the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacist’s Patient Care Process, NVAC, and CDC established standards, and available immunization history to routinely determine the immunization status of patients, make appropriate recommendations, administer the indicated immunization or refer patients to an appropriate provider for immunization, and document the vaccination.
- (d) Pharmacists should protect themselves and prevent infection of their patients by being appropriately immunized themselves.

**Guideline 2 – Partnership** – Pharmacists will be a member of the immunization neighborhood by collaborating, coordinating, and communicating with immunization stakeholders to protect the community from vaccine-preventable diseases.

- (a) Pharmacists should support the immunization advocacy goals and other educational programs of health departments in their city, county, and state, in addition to the nation’s vaccine plan.
- (b) Pharmacists should collaborate with prescribers and health departments within their communities.
- (c) Pharmacists should assist their patients in maintaining a medical home, including care such as immunization administration. Pharmacists should identify gaps in immunization history, administer indicated immunizations when appropriate, and communicate vaccinations to identified medical homes.
- (d) Pharmacists should consult with and report immunization delivery, as appropriate, to primary care providers; local, state, and/or multijurisdictional immunization information systems (IIS); and other relevant parties.
- (e) Pharmacists should identify high-risk patients in hospitals and other institutions and ensure that appropriate vaccinations are administered before discharge. If administration is not appropriate before discharge, the pharmacist should develop and implement a plan for vaccination post-discharge.
- (f) Pharmacists should identify high-risk patients in nursing homes and other facilities and ensure that needed vaccinations are administered either upon admission or in drug regimen reviews.
- (g) Pharmacists should collaborate with local health departments, universities, faith-based organizations, and businesses to identify patients traveling to destinations where administration of vaccines are recommended (e.g., yellow fever vaccine) and facilitate the administration of needed vaccines and other services.

**Guideline 3 – Quality** – Pharmacists must achieve and maintain competence to administer immunizations.

- (a) Pharmacists should administer vaccines only after being properly trained and evaluated in disease epidemiology, vaccine characteristics, injection technique, and related topics.
- (b) Pharmacists should administer vaccines only after being properly trained in emergency response to and reporting of adverse events and should provide this service only in settings equipped with epinephrine and related supplies.
- (c) Before immunization, pharmacists should review the vaccine screening questionnaire with patients and/or their families/caregivers about contraindications and inform them about the vaccine, and its risks and benefits.
- (d) Pharmacists should maintain ongoing processes and receive continuing education and training on current immunization recommendations, schedules, and techniques at least annually, and meet all state regulations for licensure.

**Guideline 4 – Documentation** – Pharmacists should document immunizations fully and report clinically significant events appropriately.

- (a) Pharmacists should maintain perpetual immunization records and offer a personal immunization record to each patient and their primary care provider whenever possible.
- (b) Pharmacists should send the immunization record information to the proper immunization information system (IIS) and assess patient’s immunization status from IIS and other appropriate resources.
- (c) Pharmacists should report adverse events following immunization to appropriate primary care providers and to the Vaccine Adverse Event Reporting System (VAERS).
- (d) Pharmacists should report vaccine administration errors using the Institute for Safe Medication Practices (ISMP) National Vaccine Errors Reporting Program (VERP).

**Guideline 5 – Empowerment** – Pharmacists should educate patients about immunizations and respect patients’ rights.

- (a) Pharmacists should advocate for appropriate vaccine use through information campaigns for health care practitioners, employers, and the public about the benefits of immunizations.
- (b) Pharmacists should respect individual patient autonomy and beliefs, as well as educate patients and their caregivers about the benefits of, and risks from, vaccines in language that is culturally sensitive and at an appropriate educational level.
- (c) Pharmacists should act as an immunization resource in an effort to clarify misinformation related to immunizations.
- (d) Before immunizing, pharmacists should document any patient education provided and informed consent obtained, consistent with state law.

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**Originally approved by the APhA Board of Trustees, August 1997. Reviewed, updated and approved by the APhA Board of Trustees in 2012 and on January 26, 2019.**



# APhA MODEL POLICY ON SEXUAL HARASSMENT PREVENTION AND GRIEVANCE PROCEDURES

## INTRODUCTION

The (name of organization or company) is dedicated to providing its employees a work environment free from sexual harassment. Sexual harassment is a form of sexual discrimination as defined by Title VII of the Civil Rights Act of 1964, and therefore is prohibited.

Actions which are consistent with the definition of sexual harassment are in violation of this company's policy. All employees have a responsibility to maintain the work place free of sexual harassment and to report such misconduct when it occurs. Any employee — regardless of position in the organization or gender — found in violation of this policy will be subject to disciplinary action by the organization.

## DEFINITION

Unwelcome behavior or a sexual advance, a request for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
2. Submission to or rejection of such conduct by an individual is used as the basis of employment decisions affecting such individual; and/or
3. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

There are two categories of sexual harassment:

1. *Quid pro quo sexual harassment* occurs when decisions affecting a person's employment are based on whether the person submits to or rejects sexual demands.
2. *Hostile environment sexual harassment* occurs when unwelcome sexual conduct unreasonably interferes with a person's work performance or causes an intimidating, offensive, or hostile work environment even when the victim suffers no tangible or economic job consequences.

Examples of sexual harassment include but are not limited to:

- *Verbal*: sexual innuendo, suggestive comments, insults, threats, jokes about gender-specific traits, or sexual propositions;
- *Nonverbal*: making suggestive or insulting noises, leering, whistling, or making obscene gestures, or displaying pornographic material in the workplace; and
- *Physical*: touching, pinching, brushing the body, coercing sexual intercourse, or assault.

## GRIEVANCE PROCEDURE

Any employee who believes that he or she has been the subject of sexual harassment should report the alleged misconduct immediately to (name(s) of person(s) at organization) in the (name of department).

An investigation of any complaint will be undertaken immediately by (name(s) listed above). The complaint will be held confidential to the extent possible so that a thorough investigation can take place. The employee making the complaint is asked not to talk with other employees about the complaint during the investigation.

The employee making the complaint must document, in writing, the alleged misconduct including the action, time, date, and location. This signed document must give (name(s) of organization) the employee's consent to investigate the incident. This document must be submitted to (name(s) stated above) within (one) week of reporting the incident.

The employee making the complaint is assured that the matter will be investigated and a decision rendered within (30) days of receipt of the complaint.

No retaliation or discrimination against the employee making the complaint will be tolerated regardless of the outcome of the investigation.

#### **INVESTIGATION PROCEDURE and DISCIPLINARY ACTION**

A sexual harassment complaint will be investigated by (name(s) listed above) immediately and a decision rendered within (30) days of the receipt of the written document from the employee making the complaint.

The investigator will:

1. Establish whether the complaint of misconduct is true through interviews with both the complainant and the accused, research for corroborative evidence, and interviews with supervisors and/or colleagues.
2. Determine whether the alleged action constitutes sexual harassment. Is the action prohibited based on the definition of sexual harassment contained in this document? If the action is deemed to be sexual harassment, under which category of sexual harassment does it fall – “quid pro quo” or “hostile environment”?
3. Determine if remedial or more serious action is needed. If the action is deemed to fall under the category of “quid pro quo,” the investigator will recommend that the accused must be terminated. If the action is deemed to fall under the category of “hostile environment,” the investigator will recommend the type of disciplinary action. This action may range from a warning in the employee's file up to termination. The disciplinary action will depend upon the seriousness of the action and/or the accused's previous record. (Whenever possible, the person making the final determination about the type of disciplinary action should not be the investigator).
4. File a full written report to (name of person making final decision on disciplinary action – even if no disciplinary action is recommended) within (20) days of receipt of the original written complaint. After (name in line above) has made a final decision, all parties will be informed in writing within (30) days of the date of original written complaint.
5. Keep on permanent record all materials to the complaint.

The (name of organization) recognizes that the issue of whether sexual harassment has occurred requires a factual determination based on all the evidence received. (Name of organization) also recognizes that false accusations of sexual harassment can have serious effects on innocent men and women.

**This model policy is to be used as a guide only. Individuals and organizations considering adopting this policy should consult with their legal counsel. THERE CAN BE NO ASSURANCE THAT ADOPTION OF THIS POLICY WILL INSURE AGAINST CLAIMS OF SEXUAL HARASSMENT OR THAT THIS POLICY WILL SUCCESSFULLY WITHSTAND JUDICIAL CHALLENGE.**

## Officers of the APhA House of Delegates 1912-2020

Year	Chairman/Speaker	Vice Chairman/Vice Speaker-Elect	Secretary
1912-1913	William C. Anderson	C.M. Snow	C. Roehr
1913-1914	C.M. Snow	W.S. Richardson	R.A. Kuever
1914-1915	W.S. Richardson	C.B. Jordan	J. Weinstein
1915-1916	Henry P. Hynson	F.W. Nitardy	J. Hostmann
1916-1917	James H. Beal	S.C. Henry	J. Hostmann
1917-1918	S.C. Henry	O.F. Claus	J. Hostmann
1918-1919	O.F. Claus	Samuel Hilton	J. Hostmann
1919-1920	Samuel L. Hilton	E.F. Kelly	J. Hostmann
1920-1921	Evander F. Kelly	J.G. Beard	J. Hostmann
1921-1922	Evander F. Kelly	E.L. Newcomb	J. Hostmann
1922-1923	Evander F. Kelly	E.L. Newcomb	William Day
1923-1924	L.L. Walton	W. Bruce Philip	William Day
1924-1925	W. Bruce Philip	W.D. Jones	William Day
1925-1926	W.D. Jones	Jacob Diner	E.F. Kelly
1926-1927	Jacob Diner	L.A. Seltzer	E.F. Kelly
1927-1928	Leonard A. Seltzer	A. Hunsberger	E.F. Kelly
1928-1929	Ambroise Hunsberger	R.L. Swain	E.F. Kelly
1929-1930	Robert L. Swain	C.B. Jordan	E.F. Kelly
1930-1931	C.B. Jordan	Thomas Roach	E.F. Kelly
1931-1932	Thomas Roach	J.W. Slocum	E.F. Kelly
1932-1933	J.W. Slocum	P.H. Costello	E.F. Kelly
1933-1934	Patrick H. Costello	S.A. Williams	E.F. Kelly
1934-1935	Rowland Jones, Jr.	S.A. Williams	E.F. Kelly
1935-1936	Roy Bird Cook	C.T. Gilbert	E.F. Kelly
1936-1937	Robert C. Wilson	A.F. Ludwig	E.F. Kelly
1937-1938	A.L.I. Winne	Ernest Little	E.F. Kelly
1938-1939	C.H. Rogers	R.A. Kuever	E.F. Kelly
1939-1940	M.N. Ford	E.C. Severin	E.F. Kelly
1940-1941	Hugo H. Schaefer	C.L. Guthrie	E.F. Kelly
1941-1942	Henry H. Gregg	C.L. O'Connell	E.F. Kelly
1942-1943	J.K. Atwood	Glenn Jenkins	E.F. Kelly
1943-1944	Glenn L. Jenkins	S.H. Dretzka	E.F. Kelly
1944-1945	Sylvester H. Dretzka	E.L. Hammond	E.F. Kelly
1945-1946	Sylvester H. Dretzka	E.L. Hammond	R.P. Fischelis
1946-1947	Hugh C. Muldoon	E.M. Josey	R.P. Fischelis
1947-1948	Charles H. Evans	Emil C. Horn	R.P. Fischelis
1948-1949	Bert Mull	Louis Fischl	R.P. Fischelis
1949-1950	R.Q. Richards	Newell Stewart	R.P. Fischelis
1950-1951	Newell W. Stewart	Thomas Wyatt	R.P. Fischelis
1951-1952	Louis J. Fischl	Mearl Pritchard	R.P. Fischelis
1952-1953	E.M. Josey	Paul Wilcox	R.P. Fischelis
1953-1954	Leib L. Riggs	Louis Zopf	R.P. Fischelis
1954-1955	Thomas D. Wyatt	James Lynch	R.P. Fischelis
1955-1956	James L. Lynch	W.B. Shangraw	R.P. Fischelis
1956-1957	Troy C. Daniels	John Butts	R.P. Fischelis
1957-1958	Nicholas Gesoalde	E.A. Swinyard	R.P. Fischelis
1958-1959	J. Warren Lansdowne	Calvin Berger	R.P. Fischelis
1959-1960	J. Warren Lansdowne	Wilbur Powers	Wm. S. Apple
1960-1961	Grover C. Bowles	John G. Adams	Wm. S. Apple
1961-1962	Grover C. Bowles	Donald Brodie	Wm. S. Apple

1962-1963	H.C. McAllister	David Stewart	Wm. S. Apple
1963-1964	Calvin Berger	Robert Johnson	Wm. S. Apple
1964-1965	Linwood F. Tice	Robert G. Gibbs	Wm. S. Apple
1965-1966	William R. Whitten	Jack Karlin	Wm. S. Apple
1966-1967	Charles A. Schreiber	W.B. Rumford	Wm. S. Apple
1967-1968	W. Byron Rumford	W.J. Smith	Wm. S. Apple
1968-1969	Mary Louise Andersen	Merritt Skinner	Wm. S. Apple
1969-1970	Mary Louise Andersen	Merritt Skinner	Wm. S. Apple
1970-1971	Clifton J. Latiolais	Philip Sacks	Wm. S. Apple
1971-1972	Philip Sacks	George Inman	Wm. S. Apple
1972-1973	Jacob W. Miller	Joseph McSoley	Wm. S. Apple
1973-1974	Jacob W. Miller	James Wagner	Wm. S. Apple
1974-1975	David J. Krigstein	Louis Jeffrey	Wm. S. Apple
1975-1976	David J. Krigstein	Mark Sullivan	Wm. S. Apple
1976-1977	Merritt L. Skinner	Herbert Carlin	Wm. S. Apple
1977-1978	Mary Munson Runge	Herbert Carlin	Wm. S. Apple
1978-1979	Ralph S. Levi	Earl Giacolini	Wm. S. Apple
1979-1980	William J. Edwards	Earl Giacolini	Wm. S. Apple
1980-1981	William J. Edwards	D.S. Crawford	Wm. S. Apple
1981-1982	D. Stephen Crawford	S. Schondelmeyer	Wm. S. Apple
1982-1983	D. Stephen Crawford	E.M. Valentine	Wm. S. Apple
1983-1984	Lowell J. Anderson	Joseph Fink, III	M.Q. Bectel
1984-1985	Lowell J. Anderson	Shirley McKee	J. Schlegel
1985-1986	Raymond W. Roberts	Lucinda L. Maine	J. Schlegel
1986-1987	Shirley P. McKee	Lucinda L. Maine	J. Schlegel
1987-1988	Shirley P. McKee	-----	J. Schlegel
1988-1989	Lucinda L. Maine	-----	G. Griffenhagen
1989-1990	Lucinda L. Maine	-----	John A. Gans
1990-1991	E. Michelle Valentine	-----	John A. Gans
1991-1992	Hazel M. Pipken	-----	John A. Gans
1992-1993	Hazel M. Pipken	-----	John A. Gans
1993-1994	Leonard "Red" Camp	-----	John A. Gans
1994-1995	Wilma K. Wong	-----	John A. Gans
1995-1996	Wilma K. Wong	-----	John A. Gans
1996-1997	Susan E. Bartlemay	-----	John A. Gans
1997-1998	Timothy L. Tucker	-----	John A. Gans
1998-1999	Betty Jean Harris	-----	John A. Gans
1999-2000	Pamela Tribble	-----	John A. Gans
2000-2001	Bethany Boyd	-----	John A. Gans
2001-2002	Michael A. Moné	-----	John A. Gans
2002-2003	Timothy L. Tucker	-----	John A. Gans
2003-2004	Craig A. Pedersen	-----	John A. Gans
2004-2005	Lawrence "LB" Brown	-----	John A. Gans
2005-2006	Adele Pietrantoni	-----	John A. Gans
2006-2007	Adele Pietrantoni	Michael Ira Smith	John A. Gans
2007-2008	Michael Ira Smith	-----	John A. Gans
2008-2009	Michael Ira Smith	Valerie T. Prince	John A. Gans
2009-2010	Valerie T. Prince	-----	T.E. Menighan
2010-2011	Valerie T. Prince	Bradley P. Tice	T.E. Menighan
2011-2012	Bradley P. Tice	-----	T.E. Menighan
2012-2013	Bradley P. Tice	William H. Riffée	T.E. Menighan
2013-2014	William H. Riffée	-----	T.E. Menighan
2014-2015	William H. Riffée	Theresa Wells-Tolle	T.E. Menighan
2015-2016	Theresa Wells-Tolle	-----	T.E. Menighan
2016-2017	Theresa Wells-Tolle	Michael D. Hogue	T.E. Menighan
2017-2018	Michael D. Hogue	-----	T.E. Menighan
2018-2019	Michael D. Hogue	Joey Mattingly	T.E. Menighan
2019-2020	Joey Mattingly	-----	T. E. Menighan
2020-2021	Joey Mattingly	Melissa Skelton Duke	Scott Knoer

## Glossary of the APhA House of Delegates

<b>AACP:</b>	American Association of Colleges of Pharmacy
<b>AAPS:</b>	American Association of Pharmaceutical Scientists
<b>ACA:</b>	American College of Apothecaries
<b>ACCP:</b>	American College of Clinical Pharmacy
<b>ACPE:</b>	Accreditation Council for Pharmacy Education
<b>AIDS:</b>	Acquired Immunodeficiency Syndrome
<b>AIHP:</b>	American Institute of the History of Pharmacy
<b>AMA:</b>	American Medical Association
<b>AMCP:</b>	Academy of Managed Care Pharmacy
<b>AMVA:</b>	American Medical Veterinary Association
<b>ANDA:</b>	Abbreviated New Drug Approval
<b>APHA:</b>	American Public Health Association
<b>APhA:</b>	American Pharmacists Association
<b>APhA-APPM:</b>	American Pharmacists Association Academy of Pharmacy Practice and Management
<b>APhA-APRS:</b>	American Pharmacists Association Academy of Pharmaceutical Research and Science
<b>APhA-ASP:</b>	American Pharmacists Association Academy of Student Pharmacists
<b>APPE:</b>	Advanced Pharmacy Practice Experiences
<b>ASCP:</b>	American Society of Consultant Pharmacists
<b>ASHP:</b>	American Society of Health Systems Pharmacists
<b>ASPL:</b>	American Society for Pharmacy Law
<b>ASPR:</b>	Office of the Assistant Secretary for Preparedness and Response
<b>BPS:</b>	Board of Pharmacy Specialties
<b>CCP:</b>	Council on Credentialing in Pharmacy
<b>CDC:</b>	Centers for Disease Control and Prevention

<b>CE:</b>	Continuing Education
<b>CMS:</b>	Centers for Medicare and Medicaid Services
<b>CPOE:</b>	Computerized Prescriber Order Entry
<b>CPT:</b>	Current Procedural Terminology
<b>DEA:</b>	Drug Enforcement Agency
<b>DRR:</b>	Drug Regimen Review
<b>DUE:</b>	Drug Use Evaluation
<b>DUR:</b>	Drug Utilization Review
<b>DSHEA:</b>	Dietary Supplement Health and Education Act
<b>EHR:</b>	Electronic Health Record
<b>EPA:</b>	Environmental Protection Agency
<b>ERISA:</b>	Employee Retirement Income Security Act
<b>FDA:</b>	U.S. Food and Drug Administration
<b>FDCA:</b>	Food Drug and Cosmetic Act
<b>FTC:</b>	U.S. Federal Trade Commission
<b>GMP:</b>	Good Manufacturing Practices
<b>HIPAA:</b>	Health Insurance Portability and Accountability Act
<b>HIV:</b>	Human Immunodeficiency Virus
<b>IACP:</b>	International Academy of Compounding Pharmacists
<b>IND:</b>	Investigational New Drug
<b>IPPE:</b>	Introductory Pharmacy Practice Experiences
<b>IRB:</b>	Institutional Review Board
<b>JCPP:</b>	Joint Commission of Pharmacy Practitioners
<b>MAC:</b>	Maximum Allowable Cost
<b>MTM:</b>	Medication Therapy Management
<b>NABP:</b>	National Association of Boards of Pharmacy
<b>NAPLEX:</b>	North American Pharmacist Licensure Examination

<b>NARD:</b>	National Association of Retail Druggists
<b>NCPA:</b>	National Community Pharmacists Association
<b>NCPDP:</b>	National Council of Prescription Drug Programs
<b>NDA:</b>	New Drug Application
<b>NDC:</b>	National Drug Code
<b>NF:</b>	National Formulary
<b>NIH:</b>	National Institutes of Health
<b>NPhA:</b>	National Pharmaceutical Association National Pharmacists Association
<b>OEO:</b>	Office of Economic Opportunity
<b>OPEO:</b>	Office of Preparedness and Emergency Operations
<b>OPM:</b>	U.S. Office of Personnel Management
<b>ORDUR:</b>	On-line Realtime Drug Utilization Review
<b>OSHA:</b>	Occupational Safety and Health Administration
<b>OTC:</b>	Over-the-counter
<b>PBRN:</b>	Practice Based Research Networks
<b>PCAB:</b>	Pharmacy Compounding Accreditation Board
<b>PhRMA:</b>	Pharmaceutical Research and Manufacturers of America
<b>PSRO:</b>	Professional Standards Review Organizations
<b>PSTAC:</b>	Pharmacist Services Technical Advisory Coalition
<b>PTCB:</b>	Pharmacy Technician Certification Board
<b>SBA:</b>	Small Business Administration
<b>USP:</b>	United States Pharmacopeia
<b>USPHS:</b>	U.S. Public Health Services
<b>VA:</b>	Veterans Administration
<b>WHO:</b>	World Health Organization





