

# HOUSE OF DELEGATES

## Policy and Procedure Manual



1963–2018

# APhA POLICY MANUAL

## 1963-2018

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# **American Pharmacists Association**

## **House of Delegates**

### **Rules of Procedure**

*Updated 2018*

*The following information reflects the final language adopted by the 2018 APhA House of Delegates.*

#### ***Rule 1 Delegates and Voting***

At the first session of a meeting of the House of Delegates, the Secretary shall report the number of accredited delegates who shall then compose the House of Delegates. Each delegate shall be entitled to one (1) vote. No delegate shall act as proxy of another delegate nor as delegate for more than one (1) association or organization. A member registered as an alternate may, upon proper clearance by the Credentials Committee, be transferred from alternate to delegate at any time during the continuance of business meetings.

#### ***Rule 2 Delegate Identification***

Each delegate is required to wear a delegate ribbon attached to the convention name badge while seated in a session of the House of Delegates.

#### ***Rule 3 Consideration of Committee Reports***

The House shall receive and consider the recommendations of each Association Policy Committee on each whole number section of a Policy Committee report during the first session of the APhA House of Delegates at each Association Annual Meeting. The Committee chair will recommend adoption of policy statements and preside over the debate. Action on the report will be governed by Robert's Rules of Order (current edition).

Debate in the first session of the House will be time limited. If the Speaker, the Committee chair or any delegates feel additional debate on the policy statement is warranted, the item may be carried over to an open hearing at which the Policy Reference Committee will preside. The remaining items requiring action will be brought back to the final session of the House of Delegates for action. The Policy Reference Committee may recommend adoption, referral, rejection or amendments to the original Policy Committee report. Action requires a majority vote.

#### ***Rule 4 New Business***

Items of New Business are due to the Speaker of the House no later than 30 days before the start of the first House of Delegates session.

An urgent item can be considered, without a suspension of the House rules, if presented to the Speaker, with necessary background information, at least 24 hours prior to the beginning of the first session of the House. Urgent items are defined as matters, which due to the nature of their content must be considered by the House outside of the normal policy processes. The House leadership (Speaker, Speaker-elect [when present], and Secretary) will evaluate submitted urgent items based on the timely and impactful nature of the presented item and determine if the urgent item is to be approved as new business. The House shall then be informed during the first House session of any approved urgent items to be considered by the House. Approved urgent items shall be included with other new business items and discussed during the New Business Open Hearing. Appropriate action will then be recommended by the New Business Review Committee in the same manner as other new business items and acted upon during the second House session. Urgent items denied consideration by House Officers may still be addressed by the House with a suspension of House rules at the House Session where New Business will be acted upon.

Delegates wishing to amend existing APhA policy on topics not covered within the Policy Committee or Policy Review Committee agenda may submit proposed policy statements through the New Business Review Process. Re-statements of existing policy are discouraged.

The New Business Review Committee's report to the House of Delegates shall include one of the following

recommended actions for each New Business Item considered:

- (a) Adoption of the New Business Item
- (b) Rejection of the New Business Item
- (c) Referral of the New Business Item
- (d) Adoption of the New Business Item as amended by the committee
- (e) No action

The New Business Review Committee's recommendations will be addressed by the House of Delegates in the following order:

1. New Items submitted by the Policy Review Committee
2. General New Business Items
3. Urgent New Business Items

If the New Business Review Committee recommends no action on a New Business Item, the Speaker of the House shall place the New Business item before the House of Delegates for consideration and action. Each whole-numbered statement within the New Business Item shall be considered separately. Consideration of the New Business Item in its entirety requires suspension of House rules.

#### ***Rule 5 Privilege of the Floor***

Only delegates may introduce business on the floor of the House of Delegates. Any individual that is duly recognized by the Speaker and/or the House may have the privilege of the floor in order to address the delegates during a session of the House of Delegates. Any individual may present testimony during an open hearing.

#### ***Rule 6 Nomination and Election of Speaker-elect***

The House of Delegates Committee on Nominations shall consist of five delegates including the Chairman and shall be appointed by the Immediate Past (non-incumbent) Speaker of the House of Delegates, and that Committee shall meet preceding the first session of the House of Delegates at the Association Annual Meeting to select candidates for the office of Speaker-elect of the House of Delegates.

Elections for Speaker-elect will occur every even-numbered year. Only two candidates for the office of Speaker-elect of the House of Delegates shall be nominated by the Committee on Nominations, and this report shall be presented at the first session of the House of Delegates. No member of the Committee on Nominations shall be nominated by that Committee. All candidates examined by the Committee shall be notified of the results as soon as possible after the nominees have been selected by the Committee on Nominations.

Nominations may then be made from the floor at the first session of the House of Delegates by any delegate immediately following the presentation of the Report of the Committee on Nominations. Candidates nominated from the floor must submit biographical data to the Secretary of the House not less than 24 hours prior to the start of the final session of the House of Delegates in order to qualify as a candidate.

All candidates must be an APhA Member as defined in Article III, Section 2, of the APhA Bylaws, and a seated delegate in the House of Delegates. Candidates will be introduced at the first session of the House of Delegates and permitted to speak to the House for no more than two (2) minutes. Candidates will then be permitted to address the House for a maximum of three (3) minutes at the second session prior to voting on the candidates by the House. Candidates shall be listed in alphabetical order on the ballot regardless of whether they were slated by the Committee on Nominations or nominated from the floor of the House. A majority vote of delegates present and voting is required for election. If no majority is obtained on the first ballot, a second ballot shall be cast for the two candidates who received the largest vote on the first ballot. If electronic voting mechanisms are available, then the election shall be conducted utilizing the technology, with the results not publicly displayed.

If a vacancy occurs in the office of Speaker, the vacancy process detailed in Article VI, Section 5, of the

APhA Bylaws shall be followed.

***Rule 7 Amendments to Resolutions***

All amendments to Policy Committee recommendations or New Business Resolutions shall be submitted in writing to the Secretary on a form provided to Delegates. There are no secondary amendments or “friendly” amendments. The Speaker will rule any Delegates out of order who express a desire to make a secondary amendment or “friendly” amendment.

***Rule 8 Amendments to House of Delegates Rules***

Every proposed amendment of these rules shall be submitted in writing and will require a two-third vote for passage. A motion to suspend the rules shall require an affirmative vote of two-thirds of the total number of delegates present and voting.

***Rule 9 Rules of Order***

The procedures of the House of Delegates shall be governed by the latest edition of Robert's Rules of Order provided they are consistent with the APhA Bylaws and the House of Delegates Rules of Procedure.

***Rule 10 Policy Review Committee***

The House shall receive and consider the recommendations of the House Policy Review Committee to archive, rescind, retain, or amend existing policy at each Annual Meeting of the Association. A singular motion to archive, rescind, retain, or amend, all such existing policy, with limited debate, shall be in order. Items identified by the Policy Review Committee as needing amendment shall be reviewed by the Committee and Speaker of the House to determine that the amendment does not change the intent of the original policy and included in a separate section of the Policy Review Committee report provided to Delegates at the Annual Meeting. Any substantive amendments or those that change the intent of the original policy should be submitted by the Policy Review Committee to the New Business Review Committee for consideration. The Policy Review Committee shall meet annually and review any policy that has not been reviewed or revised in the past 4 years and policy related to statements adopted in the previous House session.

The Speaker may engage the Policy Review Committee to review contemporary issues, where appropriate.

***Rule 11 Grammar/Punctuation Corrections***

The House shall allow the APhA Speaker and staff to the APhA House make to grammar and punctuation corrections to adopted House policy immediately after the conclusion of the House session. To ensure that these corrections do not inadvertently change the meaning of the adopted policy statement, the current sitting APhA House Rules Review Committee will review and approve the corrected statements.

***Rule 12 Policy Reference Committee***

The House of Delegates Policy Reference Committee shall consist of the chair of the Policy Committee, two members of the Policy Committee, and three or four new members appointed by the Speaker of the House of Delegates. The Policy Reference Committee will hear comments during the First Session of the House of Delegates and the Open Hearing of the Policy Committee at the APhA Annual Meeting and issue the Final Report of the House of Delegates.



*The following recommendations were submitted by the APhA House Rules Review Committee and adopted by the 1995 APhA House of Delegates.*

## **Administrative Recommendations for Improvements in House Operations**

In 1995, the Rules Review Committee made the following recommendations for managing administrative aspects of the House of Delegates operations. The status of each recommendation is noted after the item:

- A. *Create a single governance document for adoption by the House of Delegates named "House of Delegates Rules" incorporating the actions of the House in 1994 and 1995; this will amend the current House of Delegates Rules and Bylaws.*  
**Status: Single House of Delegates Rules were adopted by delegates at the conclusion on 1995 House of Delegates.**
  
- B. *Policy Committees should consist of 11 - 13 members each in order to reflect the diversity of membership (e.g., practice site, geography, gender) and provide expertise relevant to the assigned topic.*  
**Status: This recommendation guides staff and Trustees in developing budget and the Speaker in selecting committee participants.**
  
- C. *The Policy Committee reports shall be printed in the Pharmacy Today rather than the Journal to permit their timely distribution.*  
**Status: All proposed policy recommendations (including those of STATs) will be published in a timely manner. Reports are posted on the APhA website.**
  
- D. *The title of the summary information supporting the policy statements in the final report should be entitled "Summary of the Committee Discussions" rather than "Background".*  
**Status: Accomplished.**
  
- E. *Recommendations on the floor of the House to change the title of a Policy Committee report or the Summary of Discussion will be ruled out of order by the Speaker as these are not retained as part of the official policy.*  
**Status: This has been incorporated into House operations.**
  
- F. *If a Policy Committee is assigned a topic but determines that no policy recommendations are needed, the topic will appear in an "information only" section of the Policy Committee report. The Speaker will rule any discussion on the topic out of order.*  
**Status: This has been incorporated into House operations.**
  
- G. *Any amendments offered during all House sessions shall be presented in writing on a standard form available to all delegates.*  
**Status: House Rule #7.**

- H. *Association leadership reports should be scheduled during a general session, not a session of the House of Delegates.*  
**Status:** These oral reports were deleted from House of Delegates sessions beginning in 1996. Delegates received a written report and are encouraged to ask officers questions.
- I. *The Rules Review Committee affirms that the New Business Review Committee should continue to hold an open hearing on all new business items that will be open to any person. The Committee shall then meet in Executive Session to discuss the testimony and formulate the Committee's recommendations, if any, to the House of Delegates.*  
**Status:** Standard procedure since 1993.
- J. *The rule which specifies that only delegates may introduce business on the floor of the House of Delegates shall be retained.*  
**Status:** House Rule #5.
- K. *Any individual that is duly recognized by the Speaker and/or House may have the privilege of the floor in order to address the delegates.*  
**Status:** House Rule #5.

# Parliamentary Procedures At A Glance

<i>To Do This:</i>	<i>You Say This:</i>	<i>Must you interrupt speaker?</i>	<i>Must you be seconded?</i>	<i>Debatable?</i>	<i>Amendable?</i>	<i>Vote Required</i>
Introduce business (primary motion)	“I move that...”	No	Yes	Yes	Yes	Majority
Amend a motion	“I move that this motion be amended by...”	No	Yes	Yes	Yes	Majority
End debate	“I move the previous question.”	No	Yes	No	No	Two-thirds
Request information	“Point of information.”	Yes	No (urgent)	No	No	No vote
Verify a voice vote	“I call for division of the House.”	No	No	No	No	No vote
Complain about noise, room	“Question of privilege.” temperature, smoking	Yes	No	No	No	Chair decides
≡ Object to procedure or to a personal affront	“Point of order.”	Yes	No	No	No	Chair decides
Lay aside an issue temporarily	“I move to lay on the table ...” because of emergency	No	Yes	No	No	Majority
Take up a matter previously tabled	“I move to take from the table...”	No	Yes	No	No	Majority
Consider something out of scheduled order	“I move to suspend the rules to consider...”	No	Yes	No	No	Two-thirds
Vote on a ruling by the Chair	“I appeal the decision.”	Yes	Yes	Yes	No	Majority
Postpone consideration of something	“I move we postpone this matter until...”	No	Yes	Yes	Yes	Majority
Reconsider something already disposed of	“I move to reconsider the vote on issue X...”	Yes	Yes	Yes	No	Majority
Have something studied further	“I move to refer this to...”	No	Yes	Yes	Yes	Majority



# APhA Committee Handbook

## I. APhA Policy Committees and Strategic & Tactical Analysis Teams

### *Importance of Committees in Developing APhA Policy*

APhA's Policy Committees play a key role in the development of Association policy. Its recommendations are considered at open hearings held at the APhA Annual Meeting & Exposition and by the APhA House of Delegates. APhA's Strategic & Tactical Analysis Teams focus more time and resources on implementing APhA policy and less time on establishing policy positions. STATs will focus their energy on implementation of programs, legislation and regulations, but may also propose policy when existing policy statements fail to address key issues.

### *A. Appointment*

APhA Policy Committee members are appointed by the Speaker of the APhA House. Members of the STATs are jointly appointed by the APhA President and Speaker of the APhA House. Nominations for APhA Policy & STAT members are solicited from the membership and organizations represented in the APhA House of Delegates.

### *B. Terms*

APhA Policy Committee appointments are for a one year term, terminating at the Annual Meeting. A STAT, unlike a Policy Committee, may remain active for a longer period of time, depending on its topic.

### *C. Topics and Issues for Consideration*

#### *1. Official Policy*

Topics on which the APhA Policy Committee may recommend that the APhA House of Delegates adopt official policy. Such recommendations to the House of Delegates deal only with initiating new policy or changing existing policy. STATs may also propose policy when there is no existing policy for their implementation recommendations.

#### *2. General Guidance*

Topics on which the APhA Board of Trustees seeks the general thinking and opinion of the committees. The APhA Policy Committee and STATs are not expected to develop a specific policy recommendation on these topics; rather they are asked to initiate preliminary consideration of a major issue. It is anticipated that, as a result of such preliminary discussion, the Board of Trustees can determine what action to take on the topic.

### *D. Duties*

Each APhA Policy Committee and STAT with an assigned agenda meets at least once annually prior to the next Annual meeting and submits a written report of its recommendations to the members of the House of Delegates prior to the next Annual meeting.

### *E. Quorum*

A majority of the members of the APhA Policy Committee or STAT constitutes a quorum for the transaction of business.

### *F. Basic Responsibilities of APhA Policy Committee or STAT Members*

- 1. Acknowledge immediately all communications requiring a response.*
- 2. Review thoroughly the agenda and pertinent background information before meeting.*
- 3. Do related research, if necessary.*
- 4. Approach all policy issues objectively.*
- 5. Participate actively in discussion of policy issues related to the subject under discussion.*
- 6. Prepare to advocate policy recommendations at Annual Meeting.*
- 7. Work with the Chair to speak on behalf of recommendations at the Annual Meeting.*

### ***G. Functions of the Chair***

The key to a successful APhA Policy Committee or STAT – even with able members and solid objectives – is the Chair. The smooth management and creative achievements of an APhA Policy Committee or STAT are largely dependent on the Chair's ability to lead and direct the group's activities.

#### ***1. Basic Functions***

The basic function of the Chair is to preside and to assure that the Policy Committee or STAT completes its business.

#### ***2. General Responsibilities and Duties***

The Policy Committee Chair is responsible to the Speaker of the House of Delegates. The STAT Chair is responsible to the Speaker of the House of Delegates and the President of the Association. His or her primary duties are:

##### ***a. Planning***

The Chairman consults with the staff in preparing for the meeting of the committee.

##### ***b. Conducting Meetings***

The Chair directs the Policy Committee or STAT in reviewing and achieving its objectives. The Chair should stimulate group thinking, encourage and channel discussion, weigh the value of expressed ideas and suggestions, summarize constructive suggestions, and seek out decisions.

### ***H. Voting***

APhA Policy Committee or STAT meetings are conducted in an informal manner according to the directions of the Chair. Votes are taken to determine a position regarding final recommendation. A majority of the votes cast by a quorum is sufficient to decide a question. The yeas, nays and abstentions of such votes are recorded. In the event that a vote is not unanimous, any member wishing to do so may submit written "minority views" explaining his or her disagreement with the Policy Committee or STAT action.

In all questions arising between meetings which can be settled by vote, the Chair may order the vote to be taken by mail, fax, email, or telephone ballot. This vote has the same force and effect as if the members had been personally present.

### ***I. Association Staff Services***

APhA staff resources are available to all Policy Committee and STAT Members. Staff assists in developing a final report, which includes the groups' recommendations for that specific policy topic.

Progress reports from each STAT group will be presented during the Association's Annual Meeting.

### ***J. Consideration of STAT Reports***

The APhA Policy Committee and STAT reports, which are mailed to delegates in the House of Delegates, are considered at open hearings conducted during the Annual Meeting.

Action is taken on policy recommendations at both the first and second sessions of the APhA House of Delegates.

## **II. APhA New Business Review Committee**

The APhA House of Delegates has a New Business Review Committee.

### ***A. Appointment***

The Speaker of the APhA House of Delegates appoints a chairman and four other members to the APhA New Business Review Committee from among the delegates attending the Annual Meeting.

### ***B. Term***

The APhA New Business Review Committee members serve until the end of the Annual Meeting of their appointment.

### *C. Duties*

The APhA New Business Review Committee receives testimony at an open hearing during the Annual Meeting on items of new business submitted by the delegates. The hearing of the APhA New Business Review Committee is open to any person.

### *D. Quorum*

A majority of the members of the APhA New Business Review Committee constitutes a quorum of that Committee for the transaction of business.

### *E. New Business Review Committee Executive Session*

Following the open hearing, the Committee shall meet in Executive Session to discuss the testimony and formulate the Committee's recommendations, if any, to the House of Delegates.

### *F. APhA Staff Services to New Business Review Committee*

APhA staff is available for consultation throughout the open hearing and Executive Session of the New Business Review Committee. Staff will also assist the Committee in preparing its report and will arrange for its reproduction and distribution to delegates.

### *G. Consideration of APhA New Business Review Committee Report by the House of Delegates*

After each motion for a new business item is introduced by the originator to the APhA House of Delegates for action, the chairman of the New Business Review Committee shall be recognized by the Speaker to present the Committee's recommendations, if any, for adoption, referral, amendment, or rejection of the item of new business. The House will vote on the policy resolution if the New Business Review Committee recommends adoption or rejection. If the committee recommends referral or amendment, then the House will vote on the committee recommendation. Originators of New Business items that are referred to the Board or committee for further consideration shall be notified when the item is on the agenda and may attend the meeting at their expense.

## **III. APhA House of Delegates Nominations Committee**

The Committee shall meet preceding the first session of the House of Delegates at Association Annual Meetings held in even-numbered years to select candidates for the office of Speaker-elect of the APhA House of Delegates.

### *A. Appointment*

The APhA House of Delegates Committee on Nominations shall consist of five delegates including the Chairman, and shall be appointed by the Immediate Past (non-incumbent) Speaker of the APhA House of Delegates.

### *B. Term*

The APhA Nominations Committee members serve until the end of the Annual Meeting of their appointment.

### *C. Duties*

The Committee shall meet preceding the first session of the House of Delegates at Association Annual Meetings held in even-numbered years to select candidates for the office of Speaker-elect of the APhA House of Delegates.

### *D. Quorum*

A majority of the members of the APhA Nominations Committee constitutes a quorum of that Committee for the transaction of business.

### *E. Basic Responsibilities*

The APhA Committee on Nominations selects candidates for the office of Speaker-elect of the APhA House of Delegates. Only two candidates for the office of Speaker-elect of the APhA House of Delegates shall be nominated by the APhA Committee on Nominations, and this report shall be presented at the first session of the House of Delegates. No member of the Committee on Nominations shall be nominated by that Committee. All candidates examined by the Committee shall be notified of the results as soon as possible after the nominees have been selected by the Committee on Nominations.

Nominations may then be made from the floor at the first session of the House of Delegates by any delegate immediately following the presentation of the Report of the APhA Committee on Nominations. Candidates nominated from the floor must submit biographical data to the Secretary of the House not less than 24 hours prior to the start of the final session of the APhA House of Delegates in order to qualify as a candidate.

All candidates must be a Member as defined in Article III, Section 2, of the APhA Bylaws, and a seated delegate in the APhA House of Delegates. Candidates will be introduced at the first session of the APhA House of Delegates. The candidates will be permitted to address the House for a maximum of three minutes at the second session prior to voting on the candidates by the House. Candidates shall be listed in alphabetical order on the ballot regardless of whether they were slated by the APhA Committee on Nominations or nominated from the floor of the House. A majority vote of delegates present and voting is required for election. If no majority is obtained on the first ballot, a second ballot shall be cast for the two candidates who received the largest vote on the first ballot.

If a vacancy occurs in the office of Speaker, the vacancy process detailed in Article VI, Section 5, of the APhA Bylaws shall be followed.





# ***APhA House of Delegates***

## ***Policy Manual***

**1963-2018**



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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 US 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 & Non-Prescription 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**

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 between 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]

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 post graduate 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**

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

1. APhA supports nationwide integration 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]

**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 non-punitive 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]

## 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.

[JAPhA NS40(4):471 July/August 2010][Reviewed 2012][Reviewed 20..14] [Reviewed 2015]

## 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]

## 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]

## 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 post graduate 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 NS40(5):Suppl. 1:58 September/October 2000] [Reviewed 2002] [Reviewed 2007][Reviewed 2012][Reviewed 2016][Reviewed 2017]

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)

**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)

**2005, 2000**

### **Pharmacogenomics**

1. Recognizing the benefits and risks of pharmacogenomics and applications of this technology, APhA supports further research and assessment of the clinical, economic, and humanistic impact of pharmacogenomics on the health care system. This includes collaboration with other health care and consumer organizations for information sharing and development of pharmaceutical care processes involving these therapies. Pharmacogenomics is defined as the application of genomic technology in drug development and therapy.
2. APhA supports ongoing vigilance by all individuals and organizations with access to genetic information to maintain the confidentiality of the information.
3. APhA supports the development of educational materials to train and educate pharmacists, student pharmacists, pharmacy technicians, and consumers regarding pharmacogenomics.

[JAPhA NS40(5):Suppl.1:58 September/October 2000] [JAPhA NS45(5):555 September/October 2005] (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

**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**

**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:

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

1. To cooperate with all responsible agencies and departments of the federal government.
2. To 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. To 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. To 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.

5. To 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]

**2011, 2002, 1996**

### **Health Mobilization**

APhA should continue to:

1. Emphasize its support for programs on disaster preparedness which 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 between 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.
4. Encourage routine inspection of drug stockpiles and disaster kits by state boards of pharmacy.

[JAPhA N]S6:328. June, 1966) [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 healthcare 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 healthcare 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 (like physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.

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

**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]

**2005, 2002**

### **Emergency Preparedness**

APhA supports the continuing efforts of the Joint Commission of Pharmacy Practitioners working group on emergency preparedness and response to network with the Office of Homeland Security and with any other relevant governmental and/or military agency.

[JAPhA NS42(5): Suppl. 1:S61 September/October 2002][JAPhA NS45(5):559 September/October 2005][Reviewed 2006][Reviewed 2009][Reviewed 2014]

## **DISPENSING AUTHORITY**

**2018, 2013**

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

1. APhA supports the Food and Drug Administration's (FDA's) 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]

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 non-prescription 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 non-prescription 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 non-prescription drugs.
3. APhA supports pharmacist compensation for administration of prescription and non-prescription drugs and services related to such administration.
4. APhA urges adoption of state laws and regulations authorizing pharmacist administration of prescription and non-prescription drugs.

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

2004, 1984

### **Issuing of Drugs by Non-pharmacists**

APhA supports issuing drug products to patients by non-pharmacists 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.1:58 September/October 2000] [JAPhA NS43(5):Suppl. 1:558 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, life-saving, 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, 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, which 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, which prohibits 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**

**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 (non-patient recipient) prescriptions for opioid reversal agents that are furnished by pharmacists.
2. APhA affirms that third-party (non-patient recipient) prescriptions should be reimbursed by public and private payers.

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

**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 patient-consumer education of consequences of methamphetamine use, misuse, and abuse.
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]

2016, 2003, 1987

### **Substance Use Disorder Education**

APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.

[Am Pharm. NS27(6):424 June 1987] [JAPhA NS43(5): Suppl. 1:S58 September/October 2003] [Reviewed 2006][Reviewed 2011] [JAPhA 56(4); 369 July/August 2016]

2015

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

1. APhA supports nationwide integration 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]

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**

### **Drug Addiction/Chemical Dependency Education**

APhA urges pharmacists and pharmacy students to become educated in the recognition and treatment of drug addiction and chemical dependency.

[JAPhA NS43(5):Suppl. 1:S57 September/October 2003] [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) control 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]

## *Methadone*

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]

## *State Drug Laws and Legalization Issues*

2016, 1990

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

1. APhA opposes legalization of the possession, sale, distribution, or use of illicit drug substances for non-medical 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]

# DRUG CLASSIFICATION

2018, 2013

## Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA's) 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

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

2016

## Opioid Overdose Prevention

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

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

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 which circumvent the pharmacist and promote the dispensing of prescription, legend drugs by non-pharmacists. 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 which 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 which involves product licensing agreements and/or restricted distribution arrangements which 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 assure 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**

### **Post-Marketing 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

2012

### Counterfeit Medication and Unit-of-Use Packaging

APhA encourages the continued development, distribution, and use of unit-of-use packaging as the industry standard to enhance patient safety, patient adherence, and efficiencies in drug distribution, and to reduce potential for counterfeiting.

[JAPhA NS52(4) 458 July/August 2012][Reviewed 2013][Reviewed 2017]

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]

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]

2006, 2003

### Unit-of-Use Packaging

1. APhA encourages the continued development, distribution, and use of unit-of-use packaging as the industry standard to enhance patient safety, patient compliance, and efficiencies in drug distribution.
2. APhA shall collaborate with the pharmaceutical industry, 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 encourages 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.1:557 September/October 2003] [JAPhA NS46(5):562 September/October 2006] [Reviewed 2007][Reviewed 2012][Reviewed 2013][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's) 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]

**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. 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 repackager 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]

2005, 1997

### **Complementary and Alternative Medications**

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]

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]

## *Anti-Substitution Laws*

2004, 1971

### **Anti-substitution Laws: Pharmacists' Responsibility**

APhA supports state substitution laws which emphasize the 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 NS 44(5):551 September/October 2004] (Reviewed 2006)[Reviewed 2011][Reviewed 2016][Reviewed 2017]

## *Therapeutic Equivalence*

2017, 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 NS40(5):Suppl. 1:58 September/October 2000] (Reviewed 2002) [Reviewed 2007][Reviewed 2012][Reviewed 2016][Reviewed 2017]

2017, 1982

### **Legislative Restrictions on Clinical Judgment**

APhA opposes the enactment of legislation which 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]

1987

### **Therapeutic Equivalence**

1. APhA encourages continuing dialogue with other health care organizations with regard to the role of the pharmacist 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 PHARMACISTS**

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*

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, post-graduate 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**

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

1. APhA supports labeling of all prescription and over the counter medications that indicates 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 non-celiac gluten sensitivity.

[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 post graduate 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]

**2016, 2003, 1987**

### **Substance Use Disorder Education**

APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.

[Am Pharm. NS27(6):424 June 1987] [JAPhA NS43(5): Suppl. 1:558 September/October 2003] [Reviewed 2006][Reviewed 2011] [JAPhA 56(4): 369 July/August 2016]

**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 repackager 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]

**2005, 1997**

### **Complementary and Alternative Medications**

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]

**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]

**2003**

### **Drug Addiction/Chemical Dependency Education**

APhA urges pharmacists and pharmacy students to become educated in the recognition and treatment of drug addiction and chemical dependency.

[JAPhA NS43(5):Suppl. 1:557 September/October 2003] [Reviewed 2006][Reviewed 2011][Reviewed 2016]

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 Web site and state association Web sites, 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, which provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.

[JAPhA NS41(5):Suppl.1:58 Sept/Oct.2001] [Reviewed 2003] [Reviewed 2005] [Reviewed 2006] [Reviewed 2008] [Reviewed 2009][Reviewed 2014]

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]

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*

2015

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

1. APhA supports nationwide integration 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]

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 non-punitive 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]

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.
4. APhA urges the FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

[JAPhA 54(4) 358 July/August 2014]

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]

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, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

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)

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 which 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 which 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 assure 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 on-site 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 Non-traditional Mechanisms**

1. APhA encourages schools and colleges of pharmacy to consider, in their strategic planning process, offering non-traditional, post-baccalaureate, 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 non-traditional, 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]

## *Internships/Externships and Residencies*

**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 the following:
  - (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

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, post-graduate 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

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.

[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 post graduate 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 non-punitive 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]

## 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]

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)

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, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

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 post-graduate 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*

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.

[JAPhANS 49(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 healthcare 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 healthcare 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 (like physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.

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

**2001**

### **Work Schedules**

1. APhA supports a work environment in which innovative work schedules are available to pharmacists and encourages employers to allow meal breaks and rest periods.
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, on-site 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]

**1979**

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

APhA supports efforts to assure equal rights of all persons.

[AmPharm 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, which 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 have an impact on 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]

**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]

**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]

## *Working Conditions*

**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, which 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 have an impact on 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]

**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 which 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 which 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 which may arise.
3. Assisting state pharmacists associations and national specialty associations to use their good offices, whenever invited, to resolve specific issues which may arise.
4. Assisting state pharmacists associations and national specialty associations to develop procedures for mediation or arbitration of disputes which 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]

**2012, 2007, 2001, 1995**

### **Impact of the Pharmacists' Working Conditions on Public Safety**

1. APhA recognizes that the quality of a pharmacist's work-life affects public safety and that a working environment conducive to providing effective patient care is essential.
2. APhA opposes the practice of imposing minimum numbers of prescriptions which pharmacists are to dispense in a given period of time. Further, APhA opposes employment practices that evaluate a pharmacist's performance on the basis of set quotas of work performed.
3. APhA opposes employment practices that limit a pharmacist's ability to provide effective patient care.

[Am Pharm NS35(6):36 June 1995] [JAPhA NS4(5):Suppl. 1:58 September/October 2001] [Reviewed 2001] [JAPhA NS45(5):580 September-October 2007][JAPhA NS52(4) 459 July/August 2012][Reviewed 2017]

**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]

**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".

[AmPharm 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.1:59 September/October, 2001] [Reviewed 2007][Reviewed 2012][Reviewed 2017]

## **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.
4. APhA urges the FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

[JAPhA 54(4) 358 July/August 2014]

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

### **Re-Distribution of Previously Dispensed Medications**

1. As a matter of patient safety, APhA opposes the re-dispensing 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 re-dispensing of a previously dispensed medication once it is out of the control of the healthcare 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 non-hazardous, 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.1:59 September/October 2001][Reviewed 2007][Reviewed 2012][Reviewed 2017]

1990

### **Proper Handling & Disposal of Hazardous Pharmaceuticals & Associated Supplies & 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

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 which 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 which 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) 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**

**2018, 2013**

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

1. APhA supports the Food and Drug Administration's (FDA's) 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]

## 2015

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

1. APhA supports nationwide integration 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]

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]

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]

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 which 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 which 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)**

## 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)

# HEALTHCARE REFORM

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 non-economic 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 assure 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]

# INTERPROFESSIONAL RELATIONS

## *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, post-graduate 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]

2004, 1965

## **Mental Health Programs**

APhA supports pharmacists' participation in the development and implementation of all aspects of mental health programs so that the special needs and problems of the mentally ill can be effectively met.

(JAPhA NS5:274 May 1965) (JAPhA NS44(5):551 September/October 2004)(Reviewed 2010)(Reviewed 2011)

## *Physicians*

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)

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**

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)

2011, 2004, 1963

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

APhA opposes any method which 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]

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 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]

## *Public Health*

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]

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]

## *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 Lables 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.
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]

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 United States 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 non-prescription 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 which 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*

2018

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

1. APhA supports labeling of all prescription and over the counter medications that indicates 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 non-celiac gluten sensitivity.

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

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)

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 assure 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 Web sites personal addresses, phone numbers, email, and other non-business 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*

**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**

1. 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 which 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 non sterile 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, non sterile 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.1:59 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 non-criminal 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 non-criminal 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 which 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]

## *Pharmacy Law and Practice Acts*

**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]

## 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]

## 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]

## 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. 1:560 September/October 2002] [Reviewed 2007] [Reviewed 2008][Reviewed 2011][Reviewed 2016]

## 1991, 2004

### 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]

# 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

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 it 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.

[JPhA 56(4); 369 July/August 2016][Reviewed 2018]

2013, 2008

### Re-use 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 20088] [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.1:59 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.1:59 September/October 2001][Reviewed 2007][Reviewed 2012][Reviewed 2017]

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]

## **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 assure 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.

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

2004, 1980

### Therapeutic Orphans

APhA supports the adoption of policies in the new drug application (NDA) process that, beyond the pre-market, clinical testing, would result in post-marketing, clinical testing of the drug for important new clinical uses or population groups. Post-marketing 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] [JAPhA 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 post graduate 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 it 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.

[JPhA 56(4); 369 July/August 2016](Reviewed 2018)

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]

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]

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 Healthcare**

APhA supports elimination of disparities in health care delivery.

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

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]

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]

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]

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. 1:558 September/October 2003] (Reviewed 2008)(Reviewed 2013)(Reviewed 2015)

**2002, 1991, 1977**

### **Pharmacist/Patient Communication**

1. APhA acknowledges:
  - (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)

**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 on-line claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of pre-adjudication 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 on-line 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)

**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 non-punitive in nature 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)

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;
  - (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)

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 which educate pharmacy's several publics about the cost-effectiveness of drug products and related comprehensive pharmacists 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**

2016

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

1. APhA recognizes the value of pharmacist-provided, point-of-care testing and related clinical services, and it 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.

[JPhA 56(4); 369 July/August 2016](Reviewed 2018)

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]

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]

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. 1:558 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)

**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 healthcare 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. 1:557 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

- 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 Web sites personal addresses, phone numbers, email, and other non-business 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. 1:558 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

- 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, post-graduate 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's) 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 post graduate 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]

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]

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 it 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.

(JPhA 56(4); 369 July/August 2016)(Reviewed 2018)

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

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

1. APhA supports nationwide integration 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]

**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 non-punitive 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]

**2015**

### **Pharmacists 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 non-adherence 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 work flow, 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]

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]

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.
4. APhA urges the FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

(JAPhA 54(4) 358 July/August 2014)

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)

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]

**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.

[JAPhANS 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]

**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 PBRNs (practice-based research networks).

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

2013, 2008

### **Re-use 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.
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)

**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)

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.

(JAPhA NS40(4):471 July/August 2010)(Reviewed 2012)(Reviewed 2014) (Reviewed 2015)

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)

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)

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)

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 repackager 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]

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, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

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 healthcare 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]

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 non sterile 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, non sterile 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.1:59 September/October 2001][JAPhA NS48(4):470 July/August 2008][Reviewed 2013][Reviewed 2018]

**2007**

### **Re-Distribution of Previously Dispensed Medications**

1. As a matter of patient safety, APhA opposes the re-dispensing 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 re-dispensing of a previously dispensed medication once it is out of the control of the healthcare 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]

**2005**

### **Compounding with Multicomponent Vehicles**

1. APhA encourages companies that offer multi-component 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 multi-component vehicles, APhA encourages pharmacists to secure bioavailability data in support of such claims.

[JAPhA NS45(5):555 September/October 2005][Reviewed 2009][Reviewed 2014]

**2005, 2003, 1996**

### **Pharmacists' 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. 1:557 September/October 2003] [JAPhA NS45(5):556 September/October 2005][Reviewed 2007][Reviewed 2009] [Reviewed 2012][Reviewed 2014]

2005, 2000

### **Pharmacogenomics**

1. Recognizing the benefits and risks of pharmacogenomics and applications of this technology, APhA supports further research and assessment of the clinical, economic, and humanistic impact of pharmacogenomics on the health care system. This includes collaboration with other health care and consumer organizations for information sharing and development of pharmaceutical care processes involving these therapies. Pharmacogenomics is defined as the application of genomic technology in drug development and therapy.
2. APhA supports ongoing vigilance by all individuals and organizations with access to genetic information to maintain the confidentiality of the information.
3. APhA supports the development of educational materials to train and educate pharmacists, student pharmacists, pharmacy technicians, and consumers regarding pharmacogenomics.

[JAPhA NS40(5):Suppl.1:58 September/October 2000] [JAPhA NS45(5):555 September/October 2005] (Reviewed 2009) (Reviewed 2010) (Reviewed 2015)

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 patients 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] [APhA 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)

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 on-line claims processing systems to eliminate redundant and/or repetitive messages.
7. APhA encourages the transmission of pre-adjudication 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 on-line 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]

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]

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.1:58 September/October 2001] [Reviewed 2007] [Reviewed 2009][Reviewed 2014]

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.1:59 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.1:57 September/October, 2001][Reviewed 2007][Reviewed 2012][Reviewed 2017]

**2000**

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

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

[JAPhA NS40(5):Suppl. 1:58 September/October 2000] [Reviewed 2002] [Reviewed 2007][Reviewed 2012][Reviewed 2017]

**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 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]

**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 post-graduate 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]

**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]

**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]

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]

## **PHARMACY TECHNICIANS**

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 work flow, 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]

**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 Web sites personal addresses, phone numbers, email, and other non-business 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**

1. 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)

# POST-MARKETING 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)

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, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

1988

## Post-marketing Surveillance

1. APhA supports and encourages the active participation of pharmacists in initiating, organizing, and maintaining post-marketing 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 post-marketing 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 non-prescription drugs and other health care products as they are used in the general population. The ultimate purpose of post-marketing 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 post-marketing surveillance programs.
4. APhA encourages public and private collaboration in the funding and development of post-marketing 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**

**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]

**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]

**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.

[JAPhANS 49(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.1:58 September/October 2000] [JAPhA NS43(5):Suppl. 1:558 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. 1:557 September/October 2003] (Reviewed 2007) (Reviewed 2009) (Reviewed 2010)(Reviewed 2011)(Reviewed 2016)(Reviewed 2016)

## **PRESCRIPTIONS AND PRESCRIPTION ORDERS**

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)

2010, 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 (such as "as directed", unclear use of Latin phrases, confusing abbreviations, etc.) 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.1:58 September/October 2001] (Reviewed 2007)(Reviewed 2009)(Reviewed 2010)(Reviewed 2012)(Reviewed 2017)(Reviewed 2018)

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, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

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**

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 patient-consumer education of consequences of methamphetamine use, misuse, and abuse.
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]

2016, 2003, 1987

### **Substance Use Disorder Education**

APhA supports comprehensive substance use disorder education, prevention, treatment, and recovery programs.

[Am Pharm. NS27(6):424 June 1987] [JAPhA NS43(5): Suppl. 1:558 September/October 2003] (Reviewed 2006)(Reviewed 2011) [JAPhA 56(4); 369 July/August 2016]

## *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.
4. APhA urges the FDA to require the full disclosure of all ingredients in e-cigarettes and other vaporized nicotine products in both the pre-use and vapor states.

[JAPhA 54(4) 358 July/August 2014]

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]

2005, 1968

### **Cigarette Sales in Pharmacies**

APhA recommends that pharmacists not allow smoking in their prescription departments.

[JAPhA NS8:382 July 1968] [JAPhA NS45(5):555-556 September/October 2005] [Reviewed 2009][Reviewed 2014]

1996

### **Exclusion of Alcohol and Tobacco Sales in Pharmacy Practice Settings**

APhA opposes the sale of tobacco products and non-medicinal alcoholic beverages in pharmacies.

[JAPhA NS36(6):396 June 1996] [Reviewed 2005] [Reviewed 2009][Reviewed 2014]

## *Community Awareness and Education*

2014, 2005, 1986

### **Pharmacists' Responsibilities in Community Medication Awareness Programs**

1. APhA supports the development of comprehensive educational programs on the proper use and safe and environmentally responsible disposal of prescription and nonprescription medication.
2. Pharmacists should take a major educational responsibility in proactive programs which optimize therapeutic outcomes and minimize risks from inappropriate medication use.

[Am Pharm NS26(6):419 June 1986] [Reviewed 2005][Reviewed 2009][JAPhA 54(4) 358 July/August 2014]

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]

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] [Reviewed 2005] [Reviewed 2009][Reviewed 2010] [JAPhA NS52(4) 460 July/August 2012][Reviewed 2017]

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]

## *HIV/AIDS*

2005, 1993

### **HIV Testing**

1. APhA opposes mandatory HIV testing of pharmacists, student pharmacists, and pharmacy personnel.
2. APhA supports voluntary and confidential 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 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]

2005, 1993

### **HIV/AIDS Education**

1. APhA encourages pharmacists and student pharmacists to become more knowledgeable about HIV/AIDS.
2. APhA supports the development of cooperative efforts among health care organizations and agencies to facilitate the collection, evaluation, and distribution of information on HIV/AIDS.
3. APhA supports the development of educational programs for pharmacists and student pharmacists that would enable them to assume a service role in the prevention and treatment of HIV/AIDS.

[Am Pharm NS33(7):54 July 1993] [JAPhA NS45(5):556 September/October 2005] [Reviewed 2009][Reviewed 2014]

2005, 1990

### **Needle/Syringe Exchange Programs in the Prevention of the Spread of Human Immunodeficiency Virus (HIV) and Other Infections**

1. APhA supports distribution of educational materials on the risks of sharing needles/syringes with respect to the spread of human immunodeficiency virus (HIV) and other blood-borne infectious diseases.
2. APhA supports the objective gathering and analysis of data and information about the effectiveness of pilot needle/syringe exchange programs in preventing the spread of HIV and other blood-borne infectious diseases.
3. APhA supports needle/syringe exchange programs when part of a comprehensive approach in the prevention of the spread of HIV and other blood-borne infections.

[Am Pharm NS30(6):45 June 1990] [JAPhA NS45(5):556 September/October 2005] [Reviewed 2009][Reviewed 2014]

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]

1996

### **HIV Testing in Pregnant Women**

APhA encourages pharmacists to provide pharmaceutical care to women, including education about the availability and benefits of HIV testing in pregnancy to decrease the risk of HIV transmission to unborn children, APhA encourages pharmacists to provide education about the availability and benefits of HIV testing in pregnancy.

[Am Pharm NS36(6):395 June 1996] [Reviewed 2005] [Reviewed 2009][Reviewed 2014]

## *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 healthcare 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 healthcare 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 (like physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.

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

**2005, 2003, 1996**

### **Pharmacists' 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. 1:557 September/October 2003] [JAPhA NS45(5):556 September/October 2005][Reviewed 2007][Reviewed 2009] [Reviewed 2012][Reviewed 2014]

## *Other Public Health Issues*

**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, post-graduate 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 it 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.

[JPhA 56(4); 369 July/August 2016](Reviewed 2018)

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]

2013, 2008

### **Re-use 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 1966] [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]

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

### **Re-Distribution of Previously Dispensed Medications**

1. As a matter of patient safety, APhA opposes the re-dispensing 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 re-dispensing of a previously dispensed medication once it is out of the control of the healthcare 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’s) 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 and Alternative Medications**

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]

**2005, 2002**

### **Emergency Preparedness**

APhA supports the continuing efforts of the Joint Commission of Pharmacy Practitioners working group on emergency preparedness and response to network with the Office of Homeland Security and with any other relevant governmental and/or military agency.

[JAPhA NS42(5): Suppl. 1:S61 September/October 2002][JAPhA NS45(5):559 September/October 2005][Reviewed 2006][Reviewed 2009][Reviewed 2014]

**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]

**2005, 1972**

### **Prevention and Control of Sexual 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]

**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]

**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 assure 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 which 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]

**1987**

## **Future of Pharmacy**

1. APhA supports programs which plan for the future of pharmacy.
2. APhA supports programs which encourage innovations in the practice of pharmacy in a changing health care environment.
3. APhA supports programs which reflect a positive image of pharmacists.

[Am Pharm NS27(6):422 June 1987] [Reviewed 2002] [Reviewed 2007][Reviewed 2012][Reviewed 2014]

**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

**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, which 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 have an impact on 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]

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 work flow, 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]

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; and
    - 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 over-the-counter medications, and other substances;
    - Participate in the design of the treatment regimen;
    - Understand the treatment regimen and expected outcomes;
    - Adhere to the treatment regimen; and
    - 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; and
    - 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; and
- Be responsive to advances in contemporary practice.

[Am Pharm NS34(6):57 June 1994][JAPhA NS41(5):Suppl.1:59 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 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, non-punitive, easily accessible, and user friendly for all providers within the healthcare system.
6. APhA supports the elimination of hand-written prescriptions or medication orders.

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

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)

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 Web site and state association Web sites, 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, which provide the opportunity to promote the profession and its impact on clinical, economic, and humanistic patient outcomes.

[JAPhA NS41(5):Suppl.1:S8 Sept/Oct.2001] (Reviewed 2003) (Reviewed 2005) (Reviewed 2006) (Reviewed 2008) (Reviewed 2009)(Reviewed 2014)

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 post-graduate 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)

1994

### **Preventing Dispensing-Related Problems**

1. APhA encourages the development of practice guidelines to identify, resolve, and prevent dispensing-related problems.
2. APhA supports the development of electronic systems that confidentially collect information to record dispensing-related problems.
3. APhA believes that pharmacists have a professional responsibility to document and report dispensing-related problems in an ongoing effort to improve the quality of the drug distribution system.
4. APhA will assume a leadership role in the gathering, analysis, and interpretation of the aggregate data regarding dispensing-related problems, and the dissemination of the results, which will enable pharmacists to further improve medication distribution.

[Am Pharm NS34(6):56 June 1994] (Reviewed 2001) (Reviewed 2007) (Reviewed 2009)(Reviewed 2014)

## **RECORD SYSTEMS**

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 between 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]

**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] [2015]

**2015**

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

1. APhA supports nationwide integration 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]

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 non-punitive 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]

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 non-proprietary information systems.

[Am Pharm NS33(7):53 July 1993] (Reviewed 2005) (Reviewed 2009) (Reviewed 2010)(2015)

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)

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.

[JAPhA NS40(4):471 July/August 2010][Reviewed 2012][Reviewed 20..14] [Reviewed 2015]

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]

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]

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 healthcare 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]

**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]

**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]

**1996**

### **Confidentiality of Patient Data**

1. APhA supports the establishment of uniform national privacy protection standards for personally identifiable health information. These standards should:
  - (a) include provisions for patients to access and request modification of their health information, and disclosure of who will have access to the information;
  - (b) establish broad privacy protections for the individual patient without compromising patient care or creating an excessive administrative burden for health care providers; and
  - (c) make a distinction between the clinical information required for communication among health care professionals, and the administrative or financial information required by others (e.g., claims processors and payers).

[JAPhA NS36(6):396 June 1996] [Reviewed 2005] [Reviewed 2009] [Reviewed 2010]

**1994**

### **Implications of On-line 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 On-line Realtime Drug Utilization Review (ORDUR).
4. APhA encourages the development of a standardized method of electronic transfer of patient medical data between all health professionals involved in the care of a patient.

[Am Pharm NS34(6):58 June 1994] [Reviewed 2005] [Reviewed 2009][Reviewed 2014]

**1983**

### **Patient Medication 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] [Revised 2009][Reviewed 2014]

# REIMBURSEMENT AND COMPENSATION

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, which 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 have an impact on 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]

2018, 2013

## Revisions to the Medication Classification System

1. APhA supports the Food and Drug Administration's (FDA's) 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 post graduate 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]

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]

## 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 work flow, 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]

## 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]

**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.

[JAPhANS 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]

**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 which 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]

**2005, 2003, 1996**

### **Pharmacists' 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. 1:557 September/October 2003] [JAPhA NS45(5):556 September/October 2005][Reviewed 2007][Reviewed 2009] [Reviewed 2012][Reviewed 2014]

**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]

**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 the dispensing-related and non-dispensing-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 which 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 which ensures that 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 which are generated by participation in the program.
3. APhA supports those government-operated or -financed, third-party prescription programs which 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 which 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]

**2005, 1969**

### **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]

**2004**

### **Tablet Splitting**

APhA opposes mandatory tablet splitting.

[JAPhA NS44(5):551 September/October 2004] [Reviewed 2010]

**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 (co-payment) which must be paid by the beneficiary when obtaining drugs.
  - (e) To assure patients of receiving 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]

**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]

## *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 which 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]

**1977**

### **National Health Insurance: Pharmaceutical Service Benefit**

1. A National Health Insurance pharmaceutical service benefit must include acceptable methods for ensuring equitable reimbursement to pharmacists for products and services which are to be provided under the program.
2. Reimbursement to pharmacists for dispensed medication and devices under a 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. A NHI, pharmaceutical service benefit must optimize administrative efficiency and minimize administrative costs.

[JAPhA NS17:451 July 1977] [Reviewed 2005] [Reviewed 2009][Reviewed 2014]

## *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 benefits' 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 programs 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]

1994

### **Product and Payment Systems**

1. APhA shall work with public and private sectors in developing timely educational processes which 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 which assure 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 healthcare 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)

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)

1987

### **Compensation for Cognitive Services**

1. APhA recognizes that pharmacists provide to patients cognitive services (i.e., services requiring professional judgment) 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)

**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, which are generated by participating in the program.

[Am Pharm NS21(5):40 May 1981] [Reviewed 2005] [Reviewed 2009][Reviewed 2014]

**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 assure 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**

**2018**

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

1. APhA supports labeling of all prescription and over the counter medications that indicates 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 non-celiac gluten sensitivity.

[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 post graduate 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 PBRNs (practice-based research networks).

[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 healthcare 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) includes all studies, pre and post drug approval, throughout the research period (whether completed, in-progress or discontinued)
- (b) clearly states the size, demographics, limitations and citations, if published, of each study listed
- (c) includes 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) includes warnings to the public regarding inappropriate or incomplete use of the data in making clinical decisions in absence of an interpretive statement
- (e) the sponsor and any supporting company, organization, or partnered institution of each clinical trial listed shall be clearly identified. (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]

## 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 which 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]

## 2005, 1990

### Use of Representative Populations in Clinical Studies

1. APhA supports the use of representative populations in clinical studies, including the use of women, minorities, the elderly, and children when appropriate.
2. APhA encourages the development of research techniques which 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]

## 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 organized pharmacy.

[Am Pharm NS30(6):46 June 1990] [Reviewed 2005] [Reviewed 2009][Reviewed 2014]

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]

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.
  - (c) Encouragement of innovative recruitment programs and curricula to facilitate career development.

[Am Pharm NS29(7):464 July 1989] [Reviewed 2005] [Reviewed 2009][Reviewed 2014]

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]

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]

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]

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]

1966

### **APhA Study Proposal**

APhA should expand its research programs and plans to help the profession find solutions to its problems, discover new opportunities for service, and improve its present practices.

[JAPhA NS6:293 June 1966] [Reviewed 2005][Reviewed 2009][Reviewed 2014]

## *Investigational New Drugs*

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)

## **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**

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)

### *Non-Pharmacists*

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**

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 healthcare 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 healthcare 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 (like physicians, nurses, police, etc.) and prioritize pharmacists to receive medications and immunizations.
- [JAPhA NS45(5):580 September/October 2007] [Reviewed 2009][Reviewed 2014]

- 2005, 2003, 1996**  
**Pharmacists' 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. 1:557 September/October 2003] [JAPhA NS45(5):556 September/October 2005][Reviewed 2007][Reviewed 2009][Reviewed 2012][Reviewed 2014]

- 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]

- 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]

## **VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS AND FOOD**

- 2005, 1997**  
**Complementary and Alternative Medications**
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]

- 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]

**2002, 1986**

### **“Quack” Therapy**

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]

**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 assure 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 which 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]

**1981**

### **Federal Regulation of Salt 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]

**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]

## **WOMEN IN PHARMACY**

**1979**

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

APhA supports efforts to assure equal rights of all persons.

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



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# ARCHIVED POLICY STATEMENTS

## ADMINISTRATIVE POLICIES

1995

### **Administrative Procedures (2004.arc)**

The APhA staff creates an “Administrative Procedures Handbook” which consolidates into one source the various rules and procedures, which this House has adopted.

[Am Pharm NS35(6):38 June 1995]

1995

### **House of Delegates Rules Review Committee (2004.arc)**

A Special Committee on House Rules Procedures of the APhA House of Delegates be appointed annually by the Speaker of the House of Delegates.

[Am Pharm NS35(6):38 June 1995]

## ADVERTISING

### *Drug Names*

1982

### **Misleading Brand Names for Non-prescription Drug Products (2004.arc)**

APhA opposes the use of brand names for non-prescription drug products of different companies.

[Am Pharm NS22(7):32 July 1982]

### *Prescription & Non-Prescription Drugs*

1980

### **Non-Prescription Drug Advertising (2016.arc)**

1. APhA supports a legislative or regulatory requirement that advertising of non-prescription drugs directed to the health care professions identify all active and inactive ingredients, including disclosure of the quantitative amounts of all physiologically active ingredients.
2. APhA supports disclosure of all therapeutically active ingredients of non-prescription drugs in advertising directed to the public

[Am Pharm NS20(7):62 July 1980] (Reviewed 2004) (Reviewed 2006)[Reviewed 2011]

1977

### **Prescription Drug Advertising (2004.arc)**

2. Advertisements about prescription drugs provided to patients, including prescription drug prices, should not encourage or induce the obtaining or use of drugs in excess of a patient’s therapeutic requirements.

[JAPhA NS17:448 July 1977]

1971

### **Non-prescription Drug Advertising (2004.arc)**

1. The committee recommends that APhA urge the development of guidelines for pre-use clearance of non-prescription drug advertising by a government agency or joint government/industry committee to ensure that such advertising does not contain invalid or unsupported claims and that such advertising will not contribute to the drug abuse problem.
2. The committee recommends that APhA not support a flat ban on non-prescription drug advertising at this time.
3. The committee recommends that APhA urge manufacturers to voluntarily comply with guidelines for advertising non-prescription drugs, such as those issued by the National Association of Broadcasters.

[JAPhA NS11:261 May 1971]

1970

### **Non-prescription Drug Advertising (2004.arc)**

1. The committee recommends that APhA adopt a policy condemning misleading and fallacious advertising for non-prescription drugs or any promotional efforts which encourage indiscriminate use of medication.

2. The committee further recommends that APhA assist FTC, FDA, the National Association of Broadcasters, the National Better Business Bureau, the Proprietary Association, and such other involved organizations and agencies in developing responsible advertising and promotional practices for non-prescription medication.
3. Each non-prescription drug product pharmacists carry or intend to carry in stock should be subjected to their critical review. Pharmacists should evaluate products with respect to label, advertised claims, and sound drug therapy.

[JAPhA NS10:356 June 1970]

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

**1988**

### **Computerized and/or Automated Pharmacy Systems (2004.arc)**

1. APhA endorses the development and application of computer and/or automation technology by pharmacists to enhance pharmacy services.
2. APhA recommends that pharmacists maintain authority and responsibility for drug use control in the utilization of computerized and/or automated pharmacy systems.

[Am Pharm NS28(6):395 June 1988] (Reviewed 2001)

## **BIOTECHNOLOGY**

**2012, 2007**

### **Biologic Drug Products (2017.arc)**

1. APhA encourages the development of safe, effective, and affordable therapeutically equivalent generic/biosimilar versions of biologic drug products, including clinical trials that assess safety.
2. APhA encourages the FDA to develop a scientifically based process to approve therapeutically equivalent generic/biosimilar versions of biologic drug products.
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.

[JAPhA NS40(5):Suppl. 1:58 September/October 2000] (Reviewed 2002) (Reviewed 2007)(Reviewed 2012)(Reviewed 2016)(Archived 2017)

## **DISASTER PREPAREDNESS**

**2001**

### **Biological Terrorism, Infectious Diseases, and Pharmacy (2015.arc)**

APhA supports pharmacist involvement in bioterrorism preparedness planning.

[JAPhA NS41(5): Suppl.1:59 September/October 2001] (Reviewed 2006)

**1966**

### **Health Mobilization (2002.arc)**

1. Encourage development of a national drug stockpile program, similar to the Summit plan, to supplement existing programs and continue in our efforts to obtain a contract from the government to study a program of this type since it is the pharmacist's responsibility to provide high quality pharmaceutical services under all types of circumstances.

[JAPhA NS6:328 June 1966]

## **DISPENSING AUTHORITY**

**2005, 2001, 1996**

### **Control of Distribution System (2008.arc)**

APhA supports the pharmacists' authority to control the medication distribution process and maintain the responsibility for all completed medication orders regardless of practice setting

[JAPhA NS36(6):396 June 1996] (Reviewed 2000) [JAPhA NS41(5): Suppl. 1:59 September/October 2001] [JAPhA NS45(5):560 September/October 2005] (Reviewed 2006)

**2004, 1987**

### **Non-pharmacist Dispensing (2010.arc)**

APhA supports the principle that all patients receiving prescription medications are entitled to comprehensive patient care services. These services include, but are not limited to, medication therapy management (MTM), patient counseling, maintaining

patient profiles, and providing the check and balance system with other health professionals to help prevent prescriber errors and adverse drug interactions

[Am Pharm NS27(6):424 June 1987] (JAPhA NS44(5):551 September/October 2004) (Reviewed 2006)

**1987**

### **Non-pharmacist Dispensing (2004.arc)**

2. APhA opposes non-pharmacist dispensing of prescription medications.

[Am Pharm NS27(6):424 June 1987]

**1978**

### **Dispensing Criteria (2004.arc)**

1. APhA supports amendments to laws, where necessary, to require that all those who dispense prescription and non-prescription drugs be subjected to uniform requirements for dispensing.

[Am Pharm NS18(8):42 July 1978]

## **DRUG ABUSE, CONTROL AND EDUCATION**

### *Methadone*

**1972**

### **Methadone Used as Analgesic and Antitussive (2003.arc)**

2. The committee recommends that APhA seek the withdrawal of FDA-approval of methadone for its indications as an analgesic and antitussive.
3. The committee recommends that until FDA-approval of methadone for its indications as an analgesic and antitussive is withdrawn, APhA urge pharmacists to discourage the prescribing of methadone as an analgesic or antitussive.
4. The committee recommends that APhA urge pharmacists receiving prescription orders for methadone to ensure that the drug has been prescribed for a currently acceptable, medical use; and if such insurance can not be obtained, the prescription order should not be dispensed.

[JAPhA NS12:308 June 1972]

**1970**

### **Methadone in Treatment of Narcotic Addiction (2003.arc)**

1. The committee recommends that APhA alert the profession to the basis for using maintenance doses of methadone in the treatment of narcotic addiction.
2. The committee recommends that APhA endorse continued research in the supervised use of methadone in the treatment of narcotic addiction.
3. The committee recommends that APhA urge that methadone treatment programs be conducted only in centers that are capable of meeting federal and state requirements and that methadone treatment not be considered, at this time, as suitable for use by the private medical practitioner in his office practice.
4. The committee recommends that APhA provide assistance in terms of advice on drug control procedures whenever possible to those centers and pharmacists engaging in approved methadone treatment programs.

[JAPhA NS10:355 June 1970]

### *State Drug Laws and Legalization Issues*

**2006**

### **Conversion of Nonprescription Products Into Drugs of Abuse (2016.arc)**

1. APhA supports legislative, regulatory, and private sector efforts that include input from pharmacists to balance the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports consumer sales limits of nonprescription drug products 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 concerning the potential for certain products to be illegally converted into drugs for illicit use.
4. APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.

[JAPhA N46(5):561 September/October 2006][Reviewed 2011]

2005

### **Efforts to Limit Methamphetamine Access (2016.arc)**

1. APhA supports legislation that balances the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports stringent enforcement of criminal laws against individuals who engage in the illegal trafficking of methamphetamine and methamphetamine precursors.
3. APhA supports retail sales limits of non-prescription products that contain methamphetamine precursors to prevent diversion.
4. APhA supports education of employees involved in the distribution chain of methamphetamine precursors about diversion, methamphetamine abuse and prevention of abuse. APhA supports patient/consumer education of consequences of methamphetamine abuse.
5. APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.

[JAPhA NS45(5):555 September/October 2005][Reviewed 2006][Reviewed 2011]

1971

### **Uniform Controlled Substances Act (2002.arc)**

The committee recommends that APhA actively support enactment of the Uniform State Controlled Substances Act, urging that a provision which would ban the mailing of controlled substances in each state be included at the state level.

[JAPhA NS11:268 May 1971]

1966

### **Uniform State Narcotic Act — Exempt Narcotics (2002.arc)**

Requiring that exempt narcotics be sold by a pharmacist will eliminate some of the social and public health problems associated with their use and distribution. But this committee recognizes a need for additional controls. The committee recommends that APhA study the feasibility of legislation requiring that the purchaser properly identify himself to the pharmacist to prevent the use of fictitious names and addresses in the exempt narcotic book, that preparations be labeled with the pharmacy name and address to assist narcotic enforcement officials in quickly ascertaining whether a preparation has been obtained through legitimate channels, and that time and quantity limitations be placed on the sale of exempt preparations to reduce excessive use.

[JAPhA NS6:314 June 1966]

1963

### **Uniform Narcotic Act — Exempt Narcotics (2002.arc)**

APhA proposes that any state narcotic drug act contain within its exempt narcotic section a provision for consumer sales of exempt narcotics being made only in a pharmacy by a pharmacist.

[JAPhA NS3:298 June 1963]

## **DRUG CLASSIFICATION**

2005, 2001

### **Non-Prescription Availability of Nonsedating Antihistamines (2014.arc)**

APhA, as an issue of public safety, encourages manufacturers and the Food and Drug Administration (FDA) to transition nonsedating antihistamines from prescription to nonprescription status.

[JAPhA NS41(5)S:8 September /October 2001] [JAPhA NS45(5):557 September/October 2005] [Reviewed 2009]

## **DRUG PRICING AND DISTRIBUTION**

1991

### **Biotechnology-based Products (2004.arc)**

APhA reaffirms the principle of the 1966 policy that opposed circumvention of the pharmacist in drug distribution. The Association strongly opposes programs and policies by manufactures, governmental agencies, and health groups, which the pharmacist's authority and responsibility to counsel patients regarding biotechnology-based products, dispense those products, and monitor their therapeutic outcome.

[Am Pharm NS31(6):29 June 1991]

1989

### **Patient Education on Medication Storage (2015.arc)**

APhA supports the continued development and use of educational resources for patients regarding the proper storage of drug products.

[Am Pharm NS29(7):464 July 1989] [Reviewed 2004][Reviewed 2006][Reviewed 2010]

1986

### **Nonprofit Institutions Act (2004.arc)**

1. APhA shall actively seek enactment of legislation to eliminate manufacturer and distributor differential pricing of prescription drugs and devices.
2. APhA shall actively seek enactment of legislation to modify the Non-profit Institutions Act to eliminate exemptions for all health care institutions that dispense, issue, or supply prescription drugs.

[Am Pharm NS26(6):420 June 1986]

1983

### **Export of Drugs Manufactured in, But Not Approved for Use in, the US (2011.arc)**

1. APhA supports the export from the U.S. of drug products which have not been approved for use in the U.S. by FDA, except:
  - a. Where a drug product to be exported has not been so approved (or approval has been rescinded) by reasons of an affirmative FDA determination that it is unsafe or is ineffective when used under the conditions prescribed, recommended, or suggested in the labeling with which the drug product would be exported;or
  - b. Where the methods used in, and the facilities and controls used for, the manufacture, processing, and packing of a drug product to be exported are inadequate to preserve its identity, strength, quality, and purity.

[Am Pharm NS23(6):52 June 1983] [Reviewed 2004] [Reviewed 2006]

1968

### **Wholesaler Distribution Functions (2004.arc)**

The current distribution system for drugs in our society relies heavily upon the wholesaling function. Pharmacists find it impossible and frequently uneconomical to purchase all drug supplies directly from pharmaceutical manufacturers. The committee recommends that APhA explore with members of the wholesale drug industry means by which pharmacists can assist them to strengthen and improve their position and services in the drug distribution network.

[JAPhA NS8:363 July 1968]

1967

### **Manufacturers' Distribution Policies (2004.arc)**

The committee has recommended in the past—and recommends again—that APhA seek the assistance of the FDA in preventing the shipment of prescription, legend drugs to institutions that are not qualified by state law to possess drugs. The committee recommends that this also include the shipment of drugs to voluntary health agencies and others who most frequently possess and dispense prescription legend drugs under nominal professional supervision.

[JAPhA NS7:305 June 1967]

1966

### **Manufacturers' Pricing Policies (Discriminatory Pricing) (2004.arc)**

The committee recommends that APhA support the equality of opportunity concept and again urge the pharmaceutical manufacturing industry to eliminate policies and practices which establish de facto discrimination in cost prices, package sizes and services available in the same or interacting markets. The committee believes that the problem is sufficiently acute to justify recourse to the public at large and the legislature if necessary.

[JAPhA NS6:314 June 1966]

1963

### **Manufacturers' Distribution Policies (2004.arc)**

1. APhA, having previously called upon manufacturers to review their distribution policies, recommends those manufacturers whose policies make drugs available to community pharmacies on the same terms and conditions made available to all hospitals and other institutions for medical care which similarly engage in dispensing prescription medication to the public.
2. APhA urges all manufacturers to again review their distribution policies to non-profit, tax-exempt institutions to assure that drug purchases and usage are consistent with the terms and conditions of their sale.

[JAPhA NS3:298 June 1963]

# DRUG PRODUCT PACKAGING

2001

## **Unit-of-Use Packaging (2006.arc)**

APhA encourages the continued development, distribution, and use of unit-of-use packaging to enhance patient safety, patient compliance, and efficiencies in drug distribution.

[JAPhA NS(5):Suppl.1:S10 September/October 2001]

# DRUG PRODUCT SELECTION

1989

## **Uniform Designation for Drug Product Selection Authority (2001.arc)**

2. APhA supports a uniform procedure nationwide for designating the source of the drug product selection decision on a prescription claim.

[Am Pharm NS29(1):67 January 1989]

1972

## **Endorsement of “White Paper on...” — Drug Product Selection, Overview (2004.arc)**

The House of Delegates endorses the “White Paper on... The Pharmacist’s Role in Drug Product election,” with a critique on the paper by the APhA Academy of Pharmaceutical Sciences to be appended.

[JAPhA NS12:280 June 1972]

1970

## **Drug Product Quality Statement (2004.arc)**

The House of Delegates, at a Special Meeting, November 23-24, 1969, adopted the following amended preamble of the Drug Product Quality Statement of the APhA Academy of Pharmaceutical Sciences: “Prior to the initial distribution of a drug product or modification of an existing product, every manufacturer should be obligated to perform tests which are appropriate and sufficient to demonstrate the clinical safety and efficacy claimed for that manufacturer’s product, and to make a summary of this information readily available to the medical and pharmaceutical professions. In particular, in the absence of such tests, it cannot be assumed that the product will exhibit clinical acceptability.”

[JAPhA NS10:90 February 1970]

1970

## **Reference Drug Products (2004.arc)**

1. The committee recommends that APhA adopt a policy favoring the general concept of a reference product for drug dosage forms.
2. The committee further recommends that a careful examination of specifics be made before a particular system to achieve this goal is endorsed.

[JAPhA NS10:347 June 1970]

1969

## **Disclosure of Testing Information (2004.arc)**

The committee recommends that APhA support action by the Congress to require public disclosure of all testing information on the various products purchased by the federal government and other data collected in the procurement process relating to the qualifications of the manufacturer.

[JAPhA NS9:365. July, 1969]

1966

## **Drug Lists for Welfare Prescription Orders (2004.arc)**

The committee reiterates its recommendation that state agencies utilizing a system of listing drugs by generic name, or by cost, or by a combination of these factors, include a printed statement on their prescription order blanks which, when signed by the prescriber, permits the pharmacist to dispense a comparable drug from the approved list. The committee further recommends that all state programs include some provision which would enable a physician to prescribe non-listed drugs when required.

[JAPhA NS6:313 June 1966]

## *Anti-Substitution Laws*

1970

### **Anti-substitution Laws (2004.arc)**

The committee recommends that APhA seek the repeal of anti-substitution laws.

[JAPhA NS10:348 June 1970]

## *Therapeutic Equivalence*

2012, 2007

### **Biologic Drug Products (2017.arc)**

1. APhA encourages the development of safe, effective, and affordable therapeutically equivalent generic/biosimilar versions of biologic drug products, including clinical trials that assess safety.
2. APhA encourages the FDA to develop a scientifically based process to approve therapeutically equivalent generic/biosimilar versions of biologic drug products.
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.

[JAPhA NS40(5):Suppl. 1:58 September/October 2000] (Reviewed 2002) (Reviewed 2007)[Reviewed 2012][Reviewed 2016][Archived 2017]

## **DRUG RECALLS**

1968

### **Clearinghouse Approach (2004.arc)**

The committee reaffirms its endorsement of the “clearinghouse” approach to drug recalls and makes the following recommendations:

1. That a standard recall form and envelope be used which would provide necessary information for easy identification of recalled drugs and precise information on the disposition of the drugs.
2. That a system of record keeping at all levels be developed which would ensure the chain of product identification from the manufacturer to the ultimate consumer. This would include a simpler identity of the lot number on the product label.
3. That a well-defined communications system be implemented to ensure that all pharmacists and wholesalers receive drug recalls.
4. That the seriousness of any recall be established so that appropriate promptness of action can be taken based on the depth and severity of the recall.
5. That an educational program be developed and implemented so that all segments of the industry and health professions are encouraged to comply fully.

[JAPhA NS8:380 July 1968]

1967

### **Reimbursement for Non-prescription Recalls (2004.arc)**

1. The committee recommends that the House of Delegates endorse the drug recall procedure preferred by APhA staff.
2. The committee recommends that APhA adopt a position that when a home remedy is recalled, pharmacists be reimbursed for any cost and expense involved in retrieving these products for the manufacturer.

[JAPhA NS7:307 June 1967]

1967

### **Standard Recall Form (2004.arc)**

1. The obvious implication of drug recalls in public health has prompted the committee to express its concern over the current practice of recalling drugs. Drug recall letters are often confusing and misleading, many times conveying little or no information regarding the recall. Weekly recall bulletins are also confusing. The committee recommends that
  - a. A standard recall form be instituted for all recalls.
  - b. The information contained on this form include the manufacturer and distributor of the drug, the full reason for recall, the control numbers of the lots being recalled, and a reproduction of the label of the product.
  - c. All pharmacists receive a copy of the recall.
  - d. Criteria be established for the depth of recall.

[JAPhA NS7:323 June 1967]

# EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACISTS

## *Competency and Training in Specific Areas*

1989

### **Pharmacy-based Screening and Monitoring Services (2003.arc)**

APhA supports projects that demonstrate and evaluate various pharmacy-based screening and monitoring services.

[Am Pharm NS29(7):463 July 1989]

1986

### **Continuing Competence Assurance (2001.arc)**

2. APhA should assist states in developing standards of practice utilizing the 1979 Standards of Practice for the Profession of Pharmacy as the model.

[Am Pharm NS26(6):419 June 1986]

1986

### **Continuing Competence Assurance (2006.arc)**

1. APhA encourages initiatives which enable pharmacists to maintain competency.

[Am Pharm NS26(6):419 June 1986]

## *Continuing Education*

1983

### **Post-graduate Programs in Distinctive Pharmacy Services (2003.arc)**

APhA encourages the development of post-graduate, structured, continuing education programs, conducted over an extended period of time, to prepare pharmacists to provide distinctive pharmacy services.

[Am Pharm NS23(6):52 June 1983]

1975

### **Measurement of Continuing Competence (2003.arc)**

APhA supports a voluntary system to measure the competence of pharmacy practitioners on a continuing basis.

[JAPhA NS15:336 June 1975]

1974

### **Continuing Education Standards (2003.arc)**

The committee recommends that APhA work with practitioners, educators, and boards of pharmacy members to develop standards for continuing education in pharmacy.

[JAPhA NS14:495 September 1974]

1974

### **Mandatory Continuing Education (2003.arc)**

2. APhA feels the profession in each individual state should make its own decision whether or not to require continuing education consistent with nationally recognized standards if and when such standards are available.
3. APhA should continue to seek better methods of evaluating the benefits of continuing education for pharmacists.

[JAPhA NS14:494 September 1974]

1972

### **National Clearinghouse for Continuing Education (2003.arc)**

1. The committee recommends that APhA function as a national clearinghouse for continuing education.
2. The committee recommends that APhA develop a continuing education accreditation program in cooperation with colleges of pharmacy, state boards of pharmacy, national affiliated organizations, and state pharmaceutical associations.
3. The committee recommends that APhA provide services to aid states in the administration of continuing education relicensure requirements and to facilitate the fulfillment of such requirements by pharmacists.

[JAPhA NS12:298 June 1972]

## *Degree/Designation*

**1991**

### **Doctor of Pharmacy: Equivalency Process (2003.arc)**

APhA supports the assessment of the feasibility of a doctor of pharmacy equivalency process for current baccalaureate pharmacists. The assessment shall be conducted in cooperation with other national pharmacy associations and pharmacy academia.

[Am Pharm NS31(6):28 June 1991]

**1981**

### **A Single Doctoral Degree as the Entry-Level Degree for Pharmacists (2003.arc)**

APhA policy calling for a professional doctoral entry-level degree for pharmacists takes no position on the time period that should be required for awarding such degree.

[Am Pharm NS21(5):40 May 1981]

**1981**

### **Doctor of Pharmacy Degree (2003.arc)**

That the House of Delegates urge the Board of Trustees to immediately work for the establishment of a Task Force charged to devise a plan of action for the most expeditious implementation for the granting, by pharmacy schools, of a uniform doctor of pharmacy degree; this degree to be the sole entry-level degree for the profession.

[Am Pharm NS21(5):41 May 1981]

**1978**

### **Doctor of Pharmacy Degree (2011. arc)**

1. Supports the development of mechanisms other than full-time study that will enable current baccalaureates in pharmacy to attain a professional doctoral degree.
2. The development of mechanisms that will enable current baccalaureates in pharmacy to attain a professional doctoral degree should involve input from various segments of the profession.

[Am Pharm NS18(8):42 July 1978] (Reviewed 2003) (Reviewed 2006)

**1977**

### **Degrees Offered (2001.arc)**

1. APhA endorses a single professional degree in pharmacy.
2. The single degree in pharmacy should be a professional doctoral degree.
3. The educational program leading to a single professional doctoral degree in pharmacy should be pharmacy practice oriented.
4. The educational program leading to single professional doctoral degree in pharmacy should enable pharmacists to qualify for licensure examination upon graduation and to practice immediately upon successful completion of the licensure examination.
5. The development of standards for the curricula leading to the single professional doctoral degree in pharmacy should involve input from various segments of the profession.

[JAPhA NS17:461 July 1977]

## *Internships/Externships and Residencies*

**2008**

### **Experiential Education (2018.arc)**

1. APhA urges state boards of pharmacy, the Accreditation Council for Pharmacy Education (ACPE), the American Association of Colleges of Pharmacy (AACP), and other professional associations; employers; and other stakeholders to collaborate in the development of a blueprint that evaluates, streamlines, and consolidates all student pharmacists' experiential education requirements.

[JAPhA NS48(4):470 July August 2008](Reviewed 2013)

2006

### **Residency Programs (2013.arc)**

APhA encourages active involvement of schools and colleges of pharmacy in the development and advancement of accredited pharmacy practice residency programs.

[JAPhA NS45(5):562 September/October 2006][Reviewed 2008]

2006

### **Residency Programs (2013.arc)**

APhA supports accreditation of all pharmacy residency programs by federally recognized accrediting bodies to ensure quality training experiences.

[JAPhA NS45(5):562 September/October 2006][Reviewed 2008]

2005, 1990

### **Expansion and Recognition of Internship, Externship, and Clerkships (2018.arc)**

1. APhA encourages schools and colleges of pharmacy to establish and maintain experiential education programs in nontraditional areas of practice.
2. APhA encourages state boards of pharmacy to accept, at least on an hour-for-hour basis, hours of experiential education obtained in nontraditional areas of pharmacy practice as fulfilling internship hour requirements.

[Am Pharm NS30(6):45 June 1990][Reviewed 2003][JAPhA NS45(5):560 September/October 2005][Reviewed 2006][Reviewed 2008][Reviewed 2013]

1984

### **Residencies in Community Pharmacy (2013.arc)**

APhA supports the development and implementation of residency programs in community pharmacy which would enable pharmacists to acquire or enhance their practice skills necessary to meet the changing needs of their patients.

[Am Pharm NS24(7):60 July 1984] [Reviewed 2003] [Reviewed 2008]

1982

### **Credit for Non-traditional Practice Experience (2003.arc)**

APhA supports the awarding of credit hours for structured, professionally-related experiences gained outside the traditional dispensing pharmacy environment to partially fulfill the experiential requirements of state boards of pharmacy.

[Am Pharm NS22(7):33 July 1982]

## *Pharmacy School Curriculum*

1992

### **Balanced Education for Pharmacists (2016.arc)**

1. APhA encourages schools and colleges of pharmacy to continue to develop educational requirements to ensure the provision of a balanced, general education in order to graduate educated citizens and competent, health care professionals.
2. APhA supports development of admission processes by schools and colleges of pharmacy that assure that students possess qualities necessary to become educated citizens and competent, health care professionals.

[Am Pharm NS32(6):515 June 1992] [Reviewed 2001] [Reviewed 2003] [Reviewed 2005] [Reviewed 2006][Reviewed 2011]

1991

### **Emerging Technologies (2013.arc)**

APhA encourages schools of pharmacy to include information regarding emerging technologies in their curricula.

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

## **EMPLOYER/EMPLOYEE RELATIONS**

1995

### **Impact of the Pharmacists' Working Conditions on Public Safety (2001.arc)**

4. APhA will convene a task force comprised of employers, pharmacists, technicians, the National Association of Boards of Pharmacy, and other appropriate groups to develop guidelines for working environments conducive to providing effective pharmaceutical care.

[Am Pharm NS35(6):36 June 1995]

## *Other Employment Issues*

**1977**

### **Employers' Use of Lie Detection Tests (2014.arc)**

1. Polygraph tests should not be used as a means of pre-employment screening in pharmacies.
2. Polygraph tests should not be used in pharmacies for routine "security" checking of employees.
3. Polygraph tests should not be used in pharmacies in the course of investigations for cause.

[JAPhA NS17:450 July 1977] (Reviewed 2004) (Reviewed 2007)(Reviewed 2012)

**1973**

### **Employer/Employee Communications (2001.arc)**

The committee recommends that APhA encourage members to utilize APhA in facilitating meaningful communication between employers and employee pharmacists regarding the application of the APhA Policy Statement on Employment Standards in specific employment situations.

[JAPhA NS13:505 September 1973]

**1967**

### **State Associations' Participation in Employee/Employer Relations (2001.arc)**

The committee commends state associations for their foresight in establishing committees on employer/employee relations. These committees are urged to provide an additional service to their members – that of establishing guidelines for providing fringe benefits, profit-sharing plans, and other related benefits to employee pharmacists. The committee recommends further that all state associations become active in this area and appoint such committees. State associations are urged to place this important subject in their annual meeting programs or seminars.

[JAPhA NS7:321 June 1967]

## *Productivity Requirements*

**2001, 1969**

### **Employer Requirement: Number of Prescriptions Pharmacist Dispenses (2007.arc)**

APhA opposes workload requirements that stifle professional motivation and prerogatives.

[JAPhA NS9:361 July 1969] [JAPhA NS4(5):Suppl. 1:58 September/October 2001]

## *Salary, Wages, Benefits and Retirement*

**1978**

### **Retirement, Mandatory (2001.arc)**

APhA supports the elimination of age-based, mandatory retirement.

[Am Pharm NS18(8):36 July 1978]

**1974**

### **Employees' Pension Plans: Employer Participation (2001.arc)**

The committee recommends that APhA encourage employers to incorporate early vesting rights in pension plans provided as a part of the remuneration of employed pharmacists. Such provisions include a schedule assuring the pharmacist at least 50 percent vesting not later than five years and 100 percent not more than 10 years from the date of employment.

[JAPhA NS14:489 September 1974]

**1969**

### **Payroll Deduction for Employees' Professional Dues (2001.arc)**

The committee recommends that employers and employees investigate the possibility of using a payroll deduction system for paying employees' professional association dues.

[JAPhA NS9:361 July 1969]

**1967**

### **Minimum Wage Law (2001.arc)**

The committee recommends that APhA staff develop suitable guidance and informational materials on the application of the minimum wage law to pharmacies for the information and use of the membership.

[JAPhA NS7:308 June 1967]

## Unionization

1999, 1965

### Unionization of Pharmacists: State Participation in Employer/Employer Relations (2001.arc)

1. The tempo of unionization efforts and interests has noticeably increased in the past year. The committee treated this problem in some detail in its last report and again urges state professional societies to create forums for effective communication between employer and employee pharmacists. We note and commend those few states which have or are now implementing the committee's recommendation that employer/employee relations committees be established to deal with personnel issues facing the practitioners in our profession.
2. The committee further recommends that APhA provide the state professional societies and the colleges of pharmacy with informational materials on the developments in personnel relations and unionization. We further recommend that employer/employee relations be considered as a discussion topic in continuing education or management seminars for pharmacists so that employers and employees alike be encouraged to give more serious consideration to the respective expectations of each other.

[JAPhA NS39(4):447 July/August 1999] [JAPhA NS5:280 May 1965]

1999, 1971

### Unionization of Pharmacists: State Participation in Employer/Employee Relations (2001.arc)

6. The committee recommends that employed pharmacists take active roles in state and local association activities and, when appointed, serve on policy-making committees.

[JAPhA NS39(4):447 July/August 1999] [JAPhA NS11:273 May, 1971]

## ENVIRONMENTAL CONCERNS

2004, 1977

### Fluorinated Hydrocarbons: Utilization in Aerosol Products (2015.arc)

APhA supports legislative or regulatory actions banning the non-essential use of fluorinated hydrocarbons; however, APhA recognizes the essential role played by fluorinated hydrocarbons in some medicinal aerosols and supports the selective exemption of medicinal aerosols.

[JAPhA NS17:446 July 1977] [JAPhA NS44(5):551 September/October 2004] (Reviewed 2010)

2004

### Medication Disposal (2013.arc)

1. APhA encourages the Environmental Protection Agency and other appropriate entities to continue research exploring any connection between the disposal of discarded prescription and OTC medications and contamination of the water supply.
2. APhA encourages the development of programs for safe medication disposal.
3. APhA encourages appropriate government entities to accept responsibility for implementation and associated costs of safe medication disposal programs for consumers.

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

## ETHICAL ISSUES

1997

### Physician Assisted Suicide (2004.arc)

1. APhA reaffirms its 1977 policy that states:  
Each pharmacist, regardless of place or style of practice, must be free to exercise individual professional judgment and must have complete authority for those individual professional responsibilities assumed.
2. APhA reaffirms its 1977 policy that states:  
In cases where group decisions by pharmacists regarding professional matters are indicated, the decision-making process should ensure the opportunity for input by all pharmacists affected by the decisions.

[JAPhA NS37(4):459 July/August 1997]

1995

### Physician Assisted Suicide (2004.arc)

The American Pharmaceutical Association shall appoint a special committee for the purpose of identifying and outlining the questions and concerns facing the profession of pharmacy within the issue of assisted suicide.

[Am Pharm NS35(6):38 June 1995]

1963

### **Pharmacists Misconduct (2010. arc)**

APhA should establish a clear and proper procedure for the handling of any charges of misconduct among pharmacists and that such procedure be recommended as a guideline to the various states for the implementation of similar procedures where they may not now be in existence.

[JAPhA NS3:298 June 1963] [Reviewed 2004]

## **FEDERAL EMPLOYMENT OF PHARMACISTS INCLUDING THE ARMED FORCES**

1986

### **Federal Pharmacy/Quality of Care (2004.arc)**

APhA urges adoption of the U.S. Office of Personnel Management (USOPM) Tentative Standards for the Pharmacist Series, GS-660 revising the classification and qualification standards for Federal civilian pharmacists.

[Am Pharm NS26(6):419 June 1986]

1982

### **Employment Classification for Pharmacists in the Veterans Administration (VA) (2004.arc)**

APhA supports VA reclassification of pharmacists from Title 5, United States Code, to Title 38, United States Code, personnel standards, and procedures.

[Am Pharm NS22(7):32 July 1982]

1973

### **Pharmacists in the Armed Services: Rank as Officer (2004.arc)**

APhA demands of the Department of Defense that pharmacists in the military service serving as pharmacists be elevated to officer status.

[JAPhA NS13:489 September 1973]

1965

### **Pharmaceutical Service in the Armed Services (2004.arc)**

1. APhA should place greater emphasis on its programs which seek to assure that military and other governmental installations maintain the same legal and ethical standards in providing pharmaceutical services to governmental personnel and their dependents as are imposed to preserve the health, safety, and welfare of the civilian population.
2. APhA should establish a permanent staff position to provide concentrated and continuous attention to this objective.
3. APhA should seek to meet with the secretary of the Department of Defense to discuss procedures and policies for providing pharmaceutical services and assigning professional personnel.

[JAPhA NS5:249 May 1965]

## **FEDERAL PROGRAMS AND POLICIES**

1994

### **Small Business Set-Asides (2004.arc)**

1. APhA shall work with the Small Business Administration (SBA) and Congress to guarantee that all contracts involving the expenditure of federal funds for prescription drugs and services comply in full with SBA guidelines as set out by Congress.

[Am Pharm NS34(6):60 June 1994]

1978

### **Intrastate Commerce (2004.arc)**

FDA should fully implement its current inspecting authority over manufacture of drugs in intrastate commerce.

[Am Pharm NS18(8):30 July 1978]

1970

### **Food, Drug, and Cosmetic Act: Delaney Amendment (2004.arc)**

The committee recommends that APhA support revision of the Delaney clause in a manner which would provide for suitable review of scientific data, evaluation by qualified experts, and exercise of judgment by a responsible governmental agency before a decision is made regarding the safety of a food additive.

[JAPhA NS10:345 June 1970]

1970

### **National Formulary and United States Pharmacopoeia (2004.arc)**

2. APhA recommends to its own members and to all U.S. pharmacists a renewed appreciation of the official compendia themselves, as well as the unique standards-setting mechanism which the compendia constitute.
3. APhA urges all American pharmacists to do everything in their power to support and defend the compendia as symbolic of the privilege which Congress, on behalf of the American public, has entrusted to them personally through the profession of pharmacy.

[JAPhA NS10:363 June 1970]

1969

### **Office of Economic Opportunity (OEO) (2004.arc)**

There is a wide spectrum of arrangements for pharmaceutical service that ranges from an “in-house” pharmacy to an exclusive “vendor” system. The possibility of establishing pharmaceutical services within the guidelines of OEO, Model Cities, or other governmental agencies is not excluded. The committee recommends that APhA develop guidelines for pharmacists and their associations in exploring and perhaps utilizing any or all of varied possibilities.

[JAPhA NS9:350 July 1969]

1968

### **Medicare Pharmaceutical Services (2005.arc)**

1. The committee does not think it reasonable to deny those receiving Social Security benefits the essential item of pharmaceutical services so necessary to complete therapy and health care benefits in this modern day society. In this regard, the committee reaffirms its support of the criteria set forth in the 1967 report of the committee on legislation and recommends that APhA continue its support of S.2936.
2. Where a formulary is established, we recommend that APhA insist that the selection of drugs in the formulary be governed by appropriate and qualified health care practitioners guided by the medical needs of the recipients. We further urge that any such formulary provide appropriate procedures to accommodate the need for a non-formulary drug when medical necessity so requires.

[JAPhA NS8:361 July 1968]

1968

### **Medicare Pharmaceutical Services (2005.arc)**

1. S.2936 authorizes the formulary committee to publish and disseminate (at least annually) an alphabetical list of qualified drugs by established names and other representative names by which the drugs are commonly known, along with the benefits allowable, therefore, to pharmacists, physicians, and other interested persons, including the Social Security beneficiaries. The committee recommends that APhA seek revision of this provision to delete “beneficiaries” from the distribution.
2. In its 1967 report, the committee recommended guidelines for use by the APhA Board of Trustees in considering and acting upon proposals in the area of drug costs. The committee believes that S.2936 meets these established criteria. We recommend that the House of Delegates continue its support of these guidelines and endorse S.2936 with the change recommended.

[JAPhA NS8:369 July 1968]

1968

### **Medicare/Medicaid: Standards of Pharmaceutical Service (2005.arc)**

1. The committee reaffirms its admonition that the profession must insist that high standards of pharmaceutical service be available under any government-funded, pharmaceutical service program.
2. The committee reiterates the standards established in 1967 as the proper guide for APhA in future legislative activity for Title XIX.

[JAPhA NS8:361 July 1968]

1967

### **Medicaid: Objectives for State Legislation (2005.arc)**

A number of states have enacted enabling legislation for Title XIX programs during this past year. APhA has been working with state pharmaceutical societies to:

1. Establish freedom of choice provisions in state laws;

2. Have the law incorporate a pharmaceutical advisory committee (or a committee of the medical advisory committee) to review programs and policies dealing with pharmaceutical services in the public assistance program;
3. Attempt to have prescribed drugs included within the authorized services; and
4. Limit payment for prescribed drugs to licensed pharmacist in accordance with HEW guidelines.

[JAPhA NS7:313 June 1967]

**1967**

### **Medicare Formulary Committee (2005.arc)**

S.17 would authorize the Formulary Committee to publish and disseminate (at least annually) an alphabetical list of the qualified drugs along with the allowable expenses established, therefore, to pharmacists, physicians, and other interested persons, including the Social Security beneficiaries. We recommend that APhA seek to have this provision changed to delete “beneficiaries” from the distribution.

[JAPhA NS7:313 June 1967]

**1967**

### **Medicare Reimbursement Procedures (2005.arc)**

We recommend that the House of Delegates endorse S.17 in principle and instruct APhA staff to seek to have some of the details changed to conform to the objectives of the profession. Under S.17, the pharmacist would look to the patient for remuneration in the traditional manner. The allowable cost would be the amount the government would reimburse the patient for prescribed drugs for which the patient had paid the pharmacist. This will provide some pressure for lower cost drugs, of course, but the committee also recognizes that this mechanism will provide some pressure upon the government from patients to establish realistic reimbursement amounts as well. In this context, S.17 does not differ from the financial arrangement provided in major medical insurance contracts under which pharmacists have participated for some years now.

[JAPhA NS7:313 June 1967]

**1967**

### **State Association Relations with Welfare and Health Departments (2005.arc)**

The committee recommends that APhA continue to help state associations improve their working relationships with their respective welfare or health departments so that adequate pharmaceutical service will be provided to eligible recipients and so that pharmacists will receive a reasonable reimbursement for their services.

[JAPhA NS7:311 June 1967]

**1966**

### **Medicaid: State Legislation, Pharmacists' Participation, and Reimbursement (2005.arc)**

1. The committee recommends that APhA assist state associations in establishing, preferably in the authorizing state legislation, pharmaceutical consultant and pharmaceutical advisory committee provision in state plans under title XIX to assist the state in complying with the federal law in the area of pharmaceutical services.
2. The committee repeats its recommendations made in 1964 and again in 1965 that state pharmaceutical societies encourage their state agencies to adopt the professional fee system. The committee further recommends that APhA prepare a detailed explanation of the professional fee system for distribution to state public assistance agencies.

[JAPhA NS6:312 June 1966]

**1966**

### **Office of Economic Opportunity (OEO) (2004.arc)**

APhA should protest the unnecessary expenditure of federal funds by the OEO for facilities and personnel which duplicate existing community pharmacy resources.

[JAPhA NS7:311 June 1967]

**1965**

### **Welfare Programs: Reimbursement for Pharmaceutical Service (2005.arc)**

The committee recommends that continued emphasis be placed on the average professional fee as the method of choice for reimbursing pharmacists for professional services in state welfare programs and simplifying administration aspects of the programs.

[JAPhA NS5:278 May 1965]

# FREEDOM OF ACCESS (FREEDOM OF CHOICE)

1968

## **Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)**

The committee recommends that APhA support a free choice provision in the drug program for veterans comparable to that which now exists under Medicare, Medicaid, and CHAMPUS. The continued expansion of the scope of coverage of the VA programs as result of military conflicts involving the United States assures that the action of the VA will continue to have a substantial drug program.

[JAPhA NS8:366 July 1968]

1967

## **Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)**

The committee recommends that APhA continue its strong opposition to the Veterans Administration mail order provisions so that veterans may exercise their freedom of choice and may elect to have their prescriptions dispensed by their personal pharmacist.

[JAPhA NS7:311 July 1967]

1966

## **Pharmaceutical Service Under Medicaid and Medicare (2004.arc)**

The committee recommends that APhA seek to assure that legislative proposals provide the aged and medically indigent the same freedom and safeguards as are afforded to all the self-paying members of our society. 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.

[JAPhA NS6:312 June 1966]

1966

## **Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)**

APhA should seek legislation to require the Veterans Administration to utilize existing community pharmacy facilities in furnishing pharmaceutical service to veterans and guarantee veteran beneficiaries' freedom to choose their own pharmacist.

[JAPhA NS6:293 June 1966]

1966

## **Veterans Administration Drug Program: Free Choice of Pharmacist/Mail Order Prescriptions (2004.arc)**

1. The Committee recommends that APhA advise state pharmaceutical associations of the importance of including a free choice of practitioner provision in such legislation and further recommends that APhA provide the states with supporting data and material for use in the legislative efforts.
2. The committee further recommends that APhA urge state pharmaceutical societies to obtain representation on the advisory and policy-making committees which advise state agencies responsible for administering government health and welfare programs. This can sometimes be accomplished in the legislative considerations and should be one objective sought in state legislation implementing the federal law.

[JAPhA NS6:300 June 1966]

1964

## **Welfare Programs: Freedom of Choice Principle (2004.arc)**

APhA shall lend its full assistance to the various states to ensure that programs of public welfare are so developed and administered that they preserve the rights and dignity of the individual and fully recognize the need for the principle of freedom of choice of health services based on a sound and equitable appreciation for the costs involved in making such services available.

[JAPhA NS4:428 August 1964]

1963

## **The Principle of Free Choice (2004.arc)**

APhA continues to support the principle of free choice of all professional health practitioners.

[JAPhA NS3:298 June 1963]

# INTERPROFESSIONAL RELATIONS

## *Family Planning*

1973

### **Family Planning Organizations (2004.arc)**

The committee recommends that APhA encourage the voluntary participation of pharmacists in individual or organized activities relating to family planning.

[JAPhA NS13:510 September 1973]

## *General Health Care Organizations*

1975

### **Other Health Care and Professional Organizations (2004.arc)**

2. The committee recommends that active participation of pharmacists in the meetings of related health organizations can best be achieved by involving pharmacists in the programs of existing bodies rather than by establishing special sections on pharmacy.
3. The committee recommends that state pharmaceutical associations develop liaison commissions with their state counterparts of the health-related organizations.

[JAPhA NS15:331-333 June 1975]

1975

### **Professional Standards Review Organizations (PSROs) (2004.arc)**

1. APhA supports amendment of the Social Security Act to make pharmacists eligible for membership in “Professional Standards Review Organizations (PSROs).”
2. APhA advocates active involvement of pharmacists in the development of professional standards review procedures and the review process itself, since the success of such review in maintaining the quality and appropriateness of health care is dependent upon informed participation.
3. Pharmacists should work through their state and/or local pharmaceutical associations to participate in the activities of Professional Standards Review Organizations.
4. APhA should develop programs to assist state and local pharmaceutical associations in their participation with Professional Standards Review Organizations.

[JAPhA NS15:331-333 June 1975]

1968

### **Health Professional Societies (2004.arc)**

The committee recommends that APhA initiate discussions with the professional societies of other health professions such as nursing, optometry, osteopathy, and podiatry.

[JAPhA NS8:379 July 1968]

## *Hospitals*

1966

### **Hospitals: Pharmacist Consultants (2004.arc)**

A number of smaller hospitals will require pharmaceutical consultants to serve on pharmacy and therapeutics committees and to provide and supervise their pharmaceutical service programs. The committee recommends that APhA continue to provide guidance materials to assist practitioners.

[JAPhA NS6:312 June 1966]

## *Mental Health*

1965

### **Mental Health Programs (2004.arc)**

2. APhA should investigate the feasibility of establishing a definite function within the staff to disseminate information and provide guidance to the various state associations with respect to the development of mental health programs.

[JAPhA NS5:274 May 1965]

## *Nursing Homes*

1963

### **Nursing Homes (2004.arc)**

1. APhA urges pharmacists to familiarize themselves with the guidebook, *Pharmaceutical Services in the Nursing Home*, developed with the assistance of APhA, the American Nursing Home Association, the American Society of Hospital Pharmacists, and the U.S. Public Health Service, so that pharmacists can more effectively work with nursing home personnel to institute the proper professional safeguards which are vital to good patient care.
2. APhA urges local and state pharmaceutical associations to consider joint seminars and conferences with nursing home associations.

[JAPhA NS3:299 June 1963]

## *Other Public Health*

1972

### **Prevention and Control of Venereal Disease (2005.arc)**

1. The committee recommends that APhA support the repeal of state and local laws which act to prevent pharmacists from participating with maximum effectiveness in efforts to combat venereal disease by restricting the availability within pharmacies of the prophylactic devices and dissemination of information regarding their use.
2. The committee recommends that APhA support the principle that state and local laws controlling the distribution of prophylactic devices should require that open display and advertising of prophylactic devices be accompanied by the distribution of educational materials relating to venereal disease prevention and control.

[JAPhA NS12:304 June 1972]

## *Pharmacy Specialties*

1964

### **Specialty Organizations in Pharmacy (2004.arc)**

APhA should continue its policy of meeting with any and all specialty organizations in pharmacy to seek mutual understanding and to develop programs to achieve the objectives and policies of APhA.

[JAPhA NS4:428 August 1964]

## *Physician Ownership of Pharmacies*

1970

### **APhA Support of Legislation to Ban Physician Ownership (2004.arc)**

1. The committee recommends that APhA continue to urge passage of the Hart Bill in its present form, but that APhA support any version of the Hart bill which would effectively ban physician ownership, even without a ban on physician dispensing, if the apparent choice is between such a bill or no bill at all.
2. The committee recommends that affirmative efforts be made both by pharmacy organizations and individual pharmacists to establish contact with consumer representative organizations at national, state, and local levels to assure that consumers are aware of their stake in this legislation and are persuaded to work actively in its support.

[JAPhA NS10:340 June 1970]

1963

### **Physician/Pharmacist Code of Understanding (2004.ac)**

State pharmaceutical associations are urged to foster the use of the Physician-Pharmacist Code of Understanding, developed by APhA, as a means of better serving the public through improved and closer relationships between physicians and pharmacists.

[JAPhA NS3:298 June 1963]

## *Podiatry*

1967

### **Podiatrist Organizations (2004.arc)**

The committee recommends increased liaison with podiatrists on a national and state level.

[JAPhA NS7:320 June 1967]

## *Public Health*

1968

### **American Public Health Association (2004.arc)**

The committee reviewed the pharmacy public health meeting which was sponsored jointly by APhA and the American Association of Colleges of Pharmacy at the annual meeting of the American Public Health Association. The committee recommends that APhA continue to support such meetings and urges that, when possible, pharmacists make an effort to participate in these meetings.

[JAPhA NS8:382 July 1968]

1968

### **Voluntary Health Agencies (2004.arc)**

The committee recommends that state and local pharmacy organizations make an effort to establish communications with the state and local counterparts of the national voluntary health agencies.

[JAPhA NS8:382 July 1968]

## *State Pharmacy Associations*

1963

### **State Organizations of the Professions (2004.arc)**

APhA should encourage state pharmaceutical associations to participate in the formation of state organizations of the professions.

[JAPhA NS3:298 June 1963]

## *Veterinary Medicine*

1988

### **Pharmacists' Relationship to Veterinarians (2004.arc)**

1. APhA should re-establish a liaison with the American Veterinary Medical Association and other appropriate groups to explore mutual goals and interests.

[Am Pharm NS28(6):395 June 1988]

## **LABELING**

### *Expiration Dating and Drug Storage Instructions*

1970

### **Expiration Dating and Drug Storage (2004.arc)**

1. The committee recommends that manufacturers of prescription and non-prescription drugs include on the package label adequate directions as to storage conditions and the date after which the products should not be used.
2. The foregoing applies only to products distributed by manufacturers in their container and does not consider prescription medication dispensed by pharmacists.

[JAPhA NS10:360 June 1970]

1968

### **Expiration Date (2004.arc)**

The committee recommends that pharmacists place the expiration date of all time-dated drugs on the prescription labels of those drugs.

[JAPhA NS8:380 July 1968]

## *Identification of Drug and Manufacturer*

**2004, 1971**

### **Drug Name and Strength (2010.arc)**

APhA supports the practice of placing the name and strength of the drug on the prescription label; however, APhA opposes any requirement that the name and strength of the drug be included on the prescription label in any case in which the prescriber objects to or waives the inclusion of such information on the prescription label.

[JAPhA NS11:260 May 1971] [JAPhA NS44(5):551 September/October 2004]

**1981**

### **NDA or ANDA Number on Drug Product Label (2004.arc)**

APhA supports legislation to require that the labels of prescription drug products distributed to pharmacists include evidence that FDA has approved the marketing of the product or that FDA has exempted the drug from approval requirements.

[Am Pharm NS21(5):40 May 1981]

**1978**

### **Labeling of Non-prescription Drug Products (2004.arc)**

APhA urges the manufacturers of non-prescription drug products to help increase patient awareness of the role of the pharmacist as a health care professional and a readily available information source on drug actions and interactions by including an appropriate statement in the labeling and advertising of non-prescription drug products.

[Am Pharm NS18(8):3-36 July 1978]

**1970**

### **Drug Labeling Information (2004.arc)**

The committee recommends that the following guidelines be adopted for use by APhA on pending drug code legislation:

1. Legislation should provide that the name of the manufacturer of the final dosage form be made part of the approved labeling of all prescription drug products.
2. The code authorized by the legislation should be relevant to professional practice in identifying individual commercial packages and administered doses.
3. Drugs, when dispensed on prescription, generally should be exempt from the requirement that the prescription label bear the code.
4. Pharmacists, when performing professional duties in providing medication on prescription orders, should be exempt from the packager and labeler provisions.

[JAPhA NS10:343 June 1970]

**1970**

### **Drug Labeling Information (2004.arc)**

APhA no longer opposes the practice of placing the name and strength of the drug on the prescription label as a routine matter, unless otherwise indicated by the prescriber.

[JAPhA NS10:343 June 1970]

**1969**

### **National Drug Code: Prescription Capsule and Tablet Codes (2004.arc)**

Recognizing the benefit to the health of the public that would accrue if all tablets and capsules of prescription medications were so coded, the committee encourages all manufacturers to code their capsules and tablets in this fashion.

[JAPhA NS9:361 July 1969]

**1969**

### **Prescription Drug Inventory: Selection by Pharmacist/Brand vs. Generic Names (2004.arc)**

The committee urges pharmacists to exercise the same professional judgment and care in selecting their prescription drug inventory as they do in dispensing that inventory. Because of the importance of the identity of the actual manufacturer of the drug product in the purchasing process, the committee recommends that APhA seek appropriate legislation to require such information as part of the drug product label.

[JAPhA NS9:363 July 1969]

## *Ingredients*

1970

### **Disclosure of Active Ingredients (2004.arc)**

1. The committee recommends that supports for APhA efforts to obtain full disclosure of the quantity of active ingredients in the labeling of all non-prescription drugs be sought from all concerned organizations, including government agencies, other health professionals, and lay consumer groups.
2. The committee also recommends that APhA undertake an education program directed at all segments of the health professions, as well as an education program directed to the public and Congress, on the need for full disclosure of the active ingredients of all non-prescription drugs.

[JAPhA NS10:349 June 1970]

1969

### **Disclosure of Active Ingredients (2004.arc)**

The committee reaffirms its statement made in its 1968 report that pharmacists choose non-prescription drug products for recommendation from among those drugs on which the quantitative amounts of active ingredients are known (either from the label or the Handbook of Non-prescription Drugs.)

[JAPhA NS9:334 June 1969]

## **LICENSURE, REGISTRATION AND REGULATION**

### *Licensure and Registration of Personnel*

2008

### **Pharmacy Technician Education and Training (2018.arc)**

1. APhA reaffirms the 2005/2001/1996 Control of Distribution System policy, which states that APhA supports pharmacists' authority to control the distribution process and personnel involved and the responsibility for all completed medication orders, regardless of practice setting.
2. APhA supports nationally recognized standards and guidelines for the accreditation of pharmacy technician education and training programs.
3. APhA supports the continued growth of accredited education and training programs that develop qualified pharmacy technicians who will support pharmacists in ensuring patient safety and enhancing patient care.
4. APhA supports the following minimum requirements for all new pharmacy technicians by the year 2015:
  - a. successful completion of an accredited education and training program and
  - b. certification by the Pharmacy Technician Certification Board (PTCB).
5. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, and certification. APhA also encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians.

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

2004

### **Pharmacy Technicians (2008.arc)**

1. APhA supports certification of pharmacy technicians by the Pharmacy Technician Certification Board to advance the position as a career within pharmacy practice.
2. APhA urges pharmacists to provide guidance and training to pharmacy technicians. Pharmacists and employers are urged to provide on-going training support opportunities.
3. APhA supports state boards of pharmacy regulating all pharmacy technicians. Such regulations must require pharmacist oversight of personnel involved in pharmacy services.

[JAPhA NS44(5):551 September/October 2004]

1993

### **Universal Unique Identifier Numbering System (2015.arc)**

APhA supports the development and use of a universal unique identifier numbering system that identifies all health care professionals involved with medication use.

[Am Pharm NS33(7):56 July 1993] (Reviewed 2004) (Reviewed 2010)

1991

### **Development of Internship/Preceptor Guidelines (2008.arc)**

1. APhA encourages state boards of pharmacy to review existing internship program objectives and to update or develop quality assurance procedures regarding internship.
2. APhA supports efforts by NABP and national pharmacy associations to identify, review, update, and publish pharmacy internship guidelines as they pertain to all practice environments.

[Am Pharm NS31(6):28 June 1991] (Reviewed 2003) (Reviewed 2005)

1977

### **Licensure Qualifications for Foreign Students (2002.arc)**

APhA supports the adoption of a uniform system of evaluation that permits objective determination of the educational qualifications of graduates of foreign colleges of pharmacy who wish to qualify for state licensure examinations.

[JAPhA NS17:459 July 1977]

1972

### **National Pharmacy Examination (2002.arc)**

1. The committee recommends that APhA assist NABP in developing a streamlined procedure for direct licensure in any state. The procedure should provide for a national pharmacy examination and make it possible for a pharmacist who has passed the examination to apply only to the state in which he wishes to be licensed.
2. The committee recommends that APhA develop techniques and methodologies that could be used in ensuring the continued competency of pharmacy practitioners.

[JAPhA NS12:309 June 1972]

## *Licensure, Registration and Inspection of Facilities*

2001

### **Regulatory Compliance/Regulatory Burden (2008.arc)**

APhA, in conjunction with the Occupational Safety and Health Administration and other appropriate regulators, shall educate employers and employee groups and the public about applicable regulations.

[JAPhA NS41(5)Suppl.1:59 September/October 2001]

1971

### **National Pharmacy Examination (2002.arc)**

1. The committee recommends that APhA endorse the use of a national pharmacy examination by all boards of pharmacy.
2. The committee recommends that a candidate who passes the national examination be eligible for licensure in any state after demonstrating to the satisfaction of that state's board of pharmacy that he meets the state's requirements for character qualifications and knowledge of state pharmacy and drug law.

[JAPhA NS11:276 May 1971]

## *Pharmacy Law and Practice Acts*

1970

### **Model State Pharmacy Law (2002.arc)**

1. The committee recommends that APhA proceed as promptly as possible to develop a new model state pharmacy law.
2. The committee recommends that pharmacists contact their state legislators and urge postponement of legislation to consolidate existing narcotic and drug abuse control laws, pending enactment of a federal controlled drug law and completion of a state bill by the National Conference of Commissioners on Uniform State Laws.

[JAPhA NS10:352 June 1970]

## MISCELLANEOUS POLICIES

1993

### **Endorsement of Preferred Vendors by APhA (2004.arc)**

APhA shall not endorse as a preferred vendor any corporation that mandates an exclusive contract for pharmaceutical services for that particular company's employees or retirees. This motion shall be understood to require freedom of choice for the beneficiaries of that vendor when it offers a prescription drug benefit program.

[Am Pharm NS33(7):56 July 1993]

1990

### **A White Paper on the Pharmacist's Clinical Roles in Managed Health Care Programs (2004.arc)**

APhA, by action of the Board of Trustees, should commission publication of "A White Paper on the Pharmacist's Clinical Roles in Managed Health Care Programs."

[Am Pharm NS30(6):46 June 1990]

1986

### **Rationing of Expensive Health Care Services (2004.arc)**

1. APhA shall be active in developing criteria with other health care associations regarding rationing of health care services in order to represent pharmacy's interest.

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

1984

### **Center for Human Organ Acquisition (2004.arc)**

4. APhA urges the establishment of facilities for the identification and matching of donors and recipients so that the benefits of organ transplantation techniques may be available to all persons.

[Am Pharm NS24(7):61 July 1984]

1970

### **Industry-Sponsored APhA Projects (2004.arc)**

1. The committee recommends a continuation of current APhA policies relating to industry-sponsored APhA programs and activities, including advertising and exhibit standards, sustaining funds, publications, and slide talks.
2. The committee recommends that responsible subdivisions of APhA and staff review objectives, guidelines, value, and effectiveness of all award programs sponsored by grants from industry, as well as clarify the responsibilities and obligations of award recipients, staff, and officers to the sponsors of the awards.

[JAPhA NS10:335 June, 1970]

## NEW DRUG APPLICATIONS AND INVESTIGATIONAL NEW DRUGS

1984

### **Abbreviated New Drug Applications (ANDAs) for Post-1962 Drugs (2004.arc)**

APhA supports legislation and/or regulations that would serve to permit the filing, consideration, and approval of ANDAs for products containing drug entities initially approved since 1962, when such drug entities have been demonstrated through post-marketing experience to be safe and effective for continued use. Such legislation and/or regulation is not to affect or infringe on the patent life that may relate to the drug.

[Am Pharm NS24(7):61 July 1984]

1980

### **Therapeutic Orphans (2004.arc)**

1. APhA supports the adoption of policies in the new drug application (NDA) process that would result in pre-marketing, clinical testing of the applicant drug in those population groups and for the major indicated uses for which the drug could reasonably be expected to achieve a substantial degree of use.

[Am Pharm NS20(7):73 July 1980]

1978

### **Drugs for Phase IV Experimental Uses (2004.arc)**

1. APhA supports the concept of limited investigational marketing of new drugs as part of the drug approval process and supports legislation that would provide for such marketing under the Federal Food, Drug, and Cosmetic Act.
2. APhA supports conditions precedent to limited investigational marketing of new drugs to ensure patients know that a drug is in Phase IV, marketed with limitations, that the drug is a new drug or is being used for a new indication, and that FDA has found the drug safe for its intended use(s).
3. Limited investigational marketing of new drugs should not restrict professional practice of pharmacy or medicine and should not limit patient access to drugs generally. Such marketing should not impose any general restrictions as to who can prescribe and who can dispense drugs that are approved for marketing on a non-investigational basis.

[Am Pharm NS18(8):30 July 1978]

## *New Drug Applications*

1982

### **Utilization of Institutional Review Boards for Expediting New Drug Approval (2004.arc)**

APhA favors efforts to expedite the drug approval process, without changing the standards of human subject protection, by supporting the actions which would provide an option to move review responsibility for certain elements of drug investigation to properly constituted and certified Institutional Review Boards.

[Am Pharm NS22(7):32 July 1982]

## **PATIENT/PHARMACIST RELATIONSHIPS**

1989

### **Patient Education on Medication Storage (2015.arc)**

APhA supports the continued development and use of educational resources for patients regarding the proper storage of drug products.

[Am Pharm NS29(7):464 July 1989] [Reviewed 2004][Reviewed 2006][Reviewed 2010]

1968

### **Patient (2004.arc)**

The committee recommends that the individual recipient of pharmaceutical services be referred to as “the patient.” The committee recognizes that pharmacists referring to “their patients” might initially cause confusion in the minds of the public and other health practitioners but the fact remains that the recipient of pharmaceutical services is the patient.

[JAPhA NS8:379 July 1968]

1966

### **Privileged Communications (2004.arc)**

The committee recommends that APhA not advocate enactment of patient/pharmacist privilege statutes.

The confidential obligations imposed upon pharmacists by ethics and civil legal remedies are adequate to protect the public.

[JAPhA NS6:301 June 1966]

## **PHARMACY CRIME AND SECURITY**

1980

### **Pharmacy Robberies (2004.arc)**

APhA supports legislation to provide for a specific federal income tax credit for the purchase and installation of security devices to meet each pharmacy’s unique, individual needs for security against robberies and burglaries.

[Am Pharm NS20(7):62 July 1980]

# PHARMACY PRACTICE

2007

## **Medication Reconciliation the Pharmacists' Responsibility (2010.arc)**

1. APhA recognizes pharmacists as the health care team member responsible for the medication reconciliation process when patients move between practice settings within the continuum of care.

[JAPhA NS45(5):580 September-October 2007]

2007

## **Pharmacist Primary Care (2013.arc)**

1. APhA recommends the use of pharmacists as primary care providers, alone or in collaboration with other providers, in community pharmacy based health clinics.

[JAPhA NS45(5):580 September-October 2007] (Reviewed 2008) (Reviewed 2009)(Reviewed 2011)(Reviewed 2012)

2005, 1987

## **Drug Regimen Review (DRR) (2009.arc)**

APhA endorses appropriate compensation to pharmacists for performing drug regimen review.

[Am Pharm NS27(6):422 June 1987] (JAPhA NS45(5):557 September/October 2005)

2001

## **Regulatory Compliance/Regulatory Burden (2008.arc)**

APhA, in conjunction with the Occupational Safety and Health Administration and other appropriate regulators, shall educate employers and employee groups and the public about applicable regulations.

[JAPhA NS41(5)Suppl.1:S9 September/October 2001]

1993

## **Commitment to Pharmaceutical Care (2004.arc)**

APhA believes that in order to reform the payment system, individual pharmacists must commit themselves to the provision of pharmaceutical care.

[Am Pharm NS33(7):54 July 1993]

1993

## **Patient Compliance: Industry Programs (2015.arc)**

1. APhA supports the development of patient compliance programs that adhere to the principles of pharmaceutical care and are intended to improve the patient's health.
2. APhA should exert a leadership position in a collaborative effort with industry, the medical profession, and other organizations to develop guidelines for patient compliance programs.
3. APhA opposes patient compliance programs that compromise a pharmacist's ability to provide pharmaceutical care to a patient.

[Am Pharm NS33(7):56 July 1993] (Reviewed 2004) (Reviewed 2010)

1993

## **Patient Compliance: Pharmacists' Responsibilities (2015.arc)**

1. APhA affirms that pharmacists are responsible for assisting patients to become active, informed, decision makers regarding compliance with their prescribed therapeutic plans.
2. APhA will convey to the public, employee benefit managers, third-party payers, and other health care decision makers, the value and cost-effectiveness of the role of the pharmacist in comprehensive medication-use management.

[Am Pharm NS33(7):55 July 1993] (Reviewed 2004) (Reviewed 2010)

1992

## **Compounding Activities of Pharmacists (2008.arc)**

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.

[Am Pharm NS32(6):515 June 1992] (Reviewed 2004)

1991

### **Biotechnology (2004.arc)**

APhA reaffirms the pharmacist's traditional authority and responsibility for achieving optimal therapeutic outcomes by assuring appropriate use of all medications, devices, and associated services, including the unique biotechnology-based products.

[Am Pharm NS31(6):29 June 1991]

1979

### **Endorsement of Standards of Practice (2004.arc)**

APhA endorses the recommended standards of practice resulting from the 1978 APhA/AACP A National Study of the Practice of Pharmacy and recommends that pharmacists voluntarily implement these standards in their professional practices.

[Am Pharm NS19(7):67 June 1979]

1979

### **Proposal on Drug Regimen Review (DRR) by Pharmacists (2004.arc)**

1. APhA endorses drug regimen review as an appropriate role for pharmacists in all settings where drug therapy is used.

[Am Pharm NS19(7):61 June 1979]

1978

### **Definition of Pharmacy Practice (2002.arc)**

APhA advocates that pharmacy practice be defined as a patient-oriented health service that applies a scientific body of knowledge to improve and promote health through assurances of safety and efficacy in drug use and drug-related therapy.

[Am Pharm NS18(8):42 July 1978]

## **PHARMACY TECHNICIANS**

2008

### **Pharmacy Technician Education and Training (2018.arc)**

1. APhA reaffirms the 2005/2001/1996 Control of Distribution System policy, which states that APhA supports pharmacists' authority to control the distribution process and personnel involved and the responsibility for all completed medication orders, regardless of practice setting.
2. APhA supports nationally recognized standards and guidelines for the accreditation of pharmacy technician education and training programs.
3. APhA supports the continued growth of accredited education and training programs that develop qualified pharmacy technicians who will support pharmacists in ensuring patient safety and enhancing patient care.
4. APhA supports the following minimum requirements for all new pharmacy technicians by the year 2015:
  - a. successful completion of an accredited education and training program and
  - b. certification by the Pharmacy Technician Certification Board (PTCB).
5. APhA supports state board of pharmacy regulations that require pharmacy technicians to meet minimum standards of education, training, and certification. APhA also encourages state boards of pharmacy to develop a phase-in process for current pharmacy technicians.

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

2005, 2001, 1996

### **Control of Distribution System (2008.arc)**

APhA supports the pharmacists' authority to control the distribution process and personnel involved and the responsibility for all completed medication orders regardless of practice setting.

[JAPhA NS39(6) June 1996] [JAPhA NS4(5): Suppl. 1:58 September/October 2001] [JAPhA NS45(5):560 September/October 2005]

2004

### **Pharmacy Technicians (2008.arc)**

1. APhA supports certification of pharmacy technicians by the Pharmacy Technician Certification Board to advance the position as a career within pharmacy practice.
2. APhA urges pharmacists to provide guidance and training to pharmacy technicians. Pharmacists and employers are urged to provide on-going training support opportunities.
3. APhA supports state boards of pharmacy regulating all pharmacy technicians. Such regulations must require pharmacist oversight of personnel involved in pharmacy services.

[JAPhA NS44(5):551 September/October 2004]

1997

### **Pharmacy Technician Membership (2008.arc)**

APhA should establish a membership category and services for pharmacy technicians.

[JAPhA NS37(4):460 July/August 1997] [Reviewed 2001] [Reviewed 2007]

1996

### **Technician Licensure and Registration (2004.arc)**

2. APhA supports the role of the State Boards of Pharmacy in protecting the public in its interaction with the profession, including the Boards' oversight of pharmacy technicians, through their control of pharmacists and pharmacy licenses.
3. In States where the Board of Pharmacy chooses to exercise some direct oversight of technicians, APhA recommends a registration system.
4. APhA reaffirms its opposition to licensure of pharmacy technicians by statute or regulation.

[JAPhA NS36(6):396 June 1996] [Reviewed 2001]

1988

### **Pharmacy Technicians (2001.arc)**

1. The American Pharmaceutical Association supports the pharmacists' authority to control the distribution process and the responsibility for all completed medication orders regardless of practice setting.
2. APhA supports the voluntary certification of pharmacy technicians by pharmacy profession.
3. APhA supports the voluntary accreditation of pharmacy technician training programs by the pharmacy profession.

[Am Pharm NS28(6):395 June 1988]

1988

### **Pharmacy Technicians (2001.arc)**

1. APhA endorses the use of the term "pharmacy technicians" to describe those individuals who assist pharmacists in the performance of selected professional duties.
2. APhA endorses the appropriate use of pharmacy technicians in various types of pharmacy practices.
3. APhA advocates that pharmacists maintain supervisory control over pharmacy technicians.
4. APhA advocates the training of pharmacy technicians via programs developed and administered under the guidance of pharmacists.
5. APhA advocates that pharmacists develop written guidelines for pharmacy technicians which specify functions and supervisory controls.

[Am Pharm NS28(6):395 June 1988]

1971

### **Subprofessionals: Functions, Standards and Supervision (2001.arc)**

2. The committee recommends that APhA endorse the report of the Task Force on Practitioners' and Subprofessional's Roles in Pharmacy as an initial guide to the profession regarding the functions that can be performed by supportive personnel and that continued study be directed toward functions, standards of performance, and supervision of supportive personnel.
3. The committee recommends that APhA assure that criteria for interservice training programs for supportive personnel be developed and disseminated.

[JAPhA NS11:277 May 1971]

1971

### **Subprofessionals: Functions, Standards and Supervision (2004.arc)**

The committee recommends that APhA endorse the use of properly supervised supportive personnel in pharmacy practice as a positive step toward improving the quality and quantity of pharmaceutical services provided by the profession.

[JAPhA NS11:277 May 1971] [Reviewed 2001]

## **POISON PREVENTION**

1973

### **Poison Prevention Packaging Act (2004.arc)**

The committee recommends that APhA endorse and support enactment of the National Drug Trade Conference Model State Poison Prevention Packaging Act.

[Am Pharm NS13:511 September 1973]

1970

### **Safety Packaging (2004.arc)**

1. The committee recommends that APhA continue to support in principle the voluntary use of safety closures by pharmacists where feasible and urge the profession to exert every effort to educate patients on the proper storage and use of drug products.
2. The committee recommends that, at this time, APhA not endorse legislation which would require the routine use of safety closures for all medication because technological and other issues of concern to pharmacists are not yet resolved.

[JAPhA NS10:341 June 1970]

1969

### **Syrup of Ipecac (2004.arc)**

The committees recommend that pharmacists make distribution of Syrup of Ipecac, USP, part of their National Poison Prevention Week activities. The committees urge all wholesalers to make one ounce containers of properly labeled Syrup of Ipecac, USP, available as a service to the profession of pharmacy and the public.

[JAPhA NS9:333 July 1969]

1968

### **Poison Control, Information, and Treatment: Pharmacists' Responsibility (2004.arc)**

3. The committee also recommends that manufacturers label fluid extract of ipecac as a poison.
4. The committee recommends that APhA consult with poison prevention and treatment authorities and prepare an acceptable publication that pharmacists can use in their poison prevention activities.
5. In view of the above, the committee recommends that any publication describing poisoning procedures distributed by pharmacists for home use should only provide first-aid instructions for accidental poisoning. The only antidotes listed in this publication should be syrup of ipecac and activated charcoal. In addition, the public should be informed in this publication that these antidotes should be used only after consultation with proper authorities.

[JAPhA NS8:383 July 1968]

1967

### **Insecticides: State Laws (2004.arc)**

The committee recognizes a danger and inequality in many state laws regulating poisons and insecticides.

In many areas, an individual must obtain certain poisons only from a pharmacist after registering for the poison while other, more powerful poisons may be obtained from unsupervised sources. The committee recommends that pharmacists urge the various state agencies to review their poison laws which, in many cases, are antiquated.

[JAPhA NS7: 321 June 1967]

1966

### **Aspirin Packaging (2004.arc)**

The committee endorses in principle the suggestion that children's aspirin (1 1/4 grs.) be packaged in containers of not more than 25 tablets. A legislative review of pending bills that would effect this change is needed. The committee recommends that the Pharmaceutical Manufacturers Association and the Proprietary Association consider voluntary compliance before legislation is encouraged. Limiting the package size of children's aspirin would markedly reduce the number of accidental deaths from self poisoning.

[JAPhA NS6:333 June 1966]

1966

### **Syrup of Ipecac (2004.arc)**

Pharmacists who supply ipecac syrup as an emergency emetic should take special precautions to avoid the possibility of confusion with fluid extract of ipecac. Although some have recommended the removal of fluid extract of ipecac from commerce, distinctive labeling that would serve as a means of clear differentiation between the syrup and the fluid extract seems a better alternative.

The fluid extract is a convenience for those pharmacists who prepare the syrup in quantity for distribution in their community. Manufacturers are urged to consider new labeling for the fluid extract.

[JAPhA NS6:32 June 1966]

## POST-MARKETING SURVEILLANCE

2004, 1967

### Adverse Drug Reactions: Pharmacists' Responsibilities (2009.arc)

APhA urges pharmacists to take an active role in reporting adverse drug reactions.

[JAPhA NS7:324 June 1967] [JAPhA NS44(5):551 September/October 2004]

1986, 1982

### Post-marketing Surveillance (2004.arc)

1. APhA supports the concept of post-marketing drug surveillance.
2. APhA recognizes the spontaneous adverse drug reaction reporting system as the basic foundation of post-marketing drug surveillance; as such, APhA believes that this spontaneous reporting system should be maintained and strengthened.
3. APhA recommends the use of definitive post-marketing drug surveillance methods as indicated by a priori information or data gathered through spontaneous reporting.
4. APhA believes that by virtue of their skills and practice settings, pharmacists are well suited to participate in and to advance post-marketing drug surveillance; hence, APhA fosters the utilization of pharmacists in these activities.

[Am Pharm NS26(6):420 June 1986] [Am Pharm NS22(7):32 July 1982]

## PRESCRIBING AUTHORITY

2012, 1987

### Pharmacists' Authority to Select Medications (2018.arc)

APhA supports authority for pharmacists to select nonprescription and prescription medications as part of pharmacists' responsibilities to design, implement, and monitor drug regimens for patients, in consultation with practitioners when appropriate.

[Am Pharm NS27(6):422 June 1987][Reviewed 2003] [Reviewed 2007][Reviewed 2008][Reviewed 2009][Reviewed 2011][JAPhA NS52(4) 460 July/August 2012][JAPhA 53(4):366 July/August 2013]

## PRESCRIPTIONS AND PRESCRIPTION ORDERS

1997

### Red "C" Stamp Regulations (2011.arc)

APhA supports the repeal of laws and rules requiring the red "C" stamp on all hard copy schedule prescriptions.

[JAPhA NS37(4):460 July/August 1997] [Reviewed 2006]

1993

### Access to Patient Information (2010.arc)

1. APhA supports the right of pharmacists, in all practice environments, to have access to patient-specific information necessary to achieve optimal therapeutic outcomes.
2. APhA encourages the prescriber's assessment of the patient's disease state and desired or intended therapeutic outcome to accompany the prescription order.

[Am Pharm NS33(7):54 July 1993] [Reviewed 2001] [Reviewed 2007]

1990

### Facsimile (Fax) Transmission of Prescription Orders (2007.arc)

APhA encourages state boards of pharmacy and DEA to develop regulations governing the use of facsimile devices in pharmacy practice settings, with regard to such issues as verification of source of order, quality of facsimile transmission, and appropriate use with prescription orders for controlled substances.

[Am Pharm NS30(6):46 June 1990] [Reviewed 2001]

1979, 1978

### Prescription Transfer Authorization (2006.arc)

1. APhA endorses the FDA view that "the only safe and proper course for a pharmacist who receives a copy of a prescription order (from a patient) is to call the prescribing physician for authorization to renew (dispense) the prescription."
2. APhA does not endorse the use of written copies of prescription orders as a means of transferring renewal authorizations among pharmacists and holds that copies should serve only as informational documents.

3. APhA recommends that, where legally permissible, pharmacists utilize a “verbal transfer order” procedure for prescription renewals in necessary situations. A verbal transfer order is a telephone or other verbal communication between two pharmacists by which one pharmacist transfers to another pharmacist a prescriber’s prescription order to dispense a prescription drug. This procedure requires that:
  - a. The receiving pharmacist prepare a transfer document that indicates the location and file number of the original prescription order, the dates of original dispensing and of the most recent dispensing, and the number of valid renewals remaining;
  - b. The transferring pharmacist mark the original prescription order to indicate to whom a verbal transfer order had been issued, the date of issuance, and the extent of authorization, and;
  - c. The transferring pharmacist apprise the pharmacist receiving the verbal transfer order of pertinent patient medication information.

[Am Pharm NS19(7):56 June 1979] [Am Pharm NS18(8):30 July 1978]

**1976**

### **Prescription: Identification of Prescriber (2001.arc)**

Agencies which regulate the prescribing and dispensing of prescription drugs must assure that all prescription orders contain sufficient legible information to permit the pharmacist to identify and communicate with the prescriber.

[JAPhA NS16:340 June 1976]

**1974**

### **Diagnosis on Prescription Orders and Labels (2001.arc)**

The committee recommends that APhA initiate discussions with organizations representing prescribers in the interest of including information regarding intended use or intended effect of medication or diagnosis on prescription orders and labels.

[JAPhA NS14:499 September 1974]

**1973**

### **Prescription Order Forms: Guidelines (2001.arc)**

1. The committee recommends that APhA at this time not endorse the multiline prescription order form concept.
2. The committee recommends that APhA have its Academy of General Practice of Pharmacy work with representatives of the prescribing professions to develop several prototype designs of medication orders and patient record systems for use in various health care environments.

[JAPhA NS13:512 September 1973]

**1969**

### **Uniform Prescription Order Forms (2001.arc)**

The committee recommends that APhA call a meeting of representatives from all professions licensed to prescribe, for the purposes of discussing the hazards involved with current prescription writing and detailing those steps which might result in a uniform prescription order form which could be used by all prescribing professions.

[Am Pharm NS9:361 July 1969]

**1967**

### **Authority for Prescription Order Renewals (2001.arc)**

The committee wishes to emphasize the fact that only a physician may authorize a renewal of a prescription; he may do this personally or authorize another to convey his authorization to the pharmacist. This is an area of intense interest and misinformation on the part of physicians and pharmacists. The committee recommends increased activity by local pharmaceutical groups to foster more discussion of this problem with physicians. Physicians and pharmacists should jointly review applicable laws and professional ethics so that a common understanding can be achieved.

[JAPhA NS7:320 June 1967]

**1963**

### **Confidentiality of Prescription Orders (2001.arc)**

APhA, recognizing the confidentiality of prescription order information from a legal and ethical standpoint, should develop procedures for making prescription order information available consistent with a proper pharmacist-patient-prescriber relationship when the disclosure of such information is for the purpose of serving the patient’s interest.

[JAPhA NS3:298 June 1963]

# PUBLIC HEALTH

## *Alcohol and Tobacco*

1987

### **AIDS (2005.arc)**

1. APhA encourages pharmacists to become more knowledgeable about AIDS.
3. APhA supports the development of educational programs for pharmacists which would enable them to assume a service role in the prevention and treatment of AIDS.
3. APhA supports the development of educational programs for pharmacists and student pharmacists that would enable them to assume a service role in the prevention and treatment of HIV/AIDS.

[Am Pharm NS27(6):422 June 1987]

1973

### **Smoking in APhA's Public Meetings (2009.arc)**

Many persons, including many of our colleagues, object to being subjected to the smoking of others. Those in attendance should not smoke in public meetings of the APhA.

[JAPhA NS13:489 September 1973] (Reviewed 2005)

1970

### **Cigarette Sales in Pharmacies (2005.arc)**

1. The committee commends those pharmacists who have ceased selling cigarettes in their pharmacies and urges other pharmacists to initiate similar action. The main issue concerning smoking and health is not whether pharmacists discontinue selling cigarettes, but whether the public discontinues smoking them. The key, therefore, is public education and the committee urges pharmacists to take active roles in smoking and health education programs.
2. The committee is concerned over the developing trend of tobacco companies to compensate pharmacists who provide space for self-service cigarette racks in their pharmacies. In the committee's view, mass display of cigarettes in pharmacies is in direct contradiction to the role of the pharmacy as a public health facility.

[JAPhA NS10:357 June 1970]

1969

### **Cigarette Sales in Pharmacies (2005.arc) (2018.arc)**

Since the sale of cigarettes in pharmacies can be considered to be inconsistent with their functions as health institutions, the committee recommends that pharmacists examine what effect the sale of tobacco products in pharmacies has on public health.

[JAPhA NS9:334 June 1969]

1968

### **Cigarette Sales in Pharmacies (2005.arc)**

1. The committee recommends that, if feasible, APhA prepare a sign for use by those pharmacies which do not sell cigarettes, stating this fact.
2. The committee also recommends that APhA distribute to its members a list containing the tar and nicotine content of various brands of cigarettes.
3. The committee urges pharmacists to display this list in their pharmacies.

[JAPhA NS8:382 June 1968]

1964

### **Dangers in Smoking: Public Education (2005.arc)**

APhA encourages pharmacists to educate young adults on the medical evidence implicating cigarette smoking as a causative factor in certain diseases and illnesses.

[JAPhA NS4:429 August 1964]

## *Community Awareness and Education*

**2005, 1986**

### **Pharmacists' Responsibilities in Community Medication Awareness Programs (2014.arc)**

1. APhA supports the development of a comprehensive educational program on the proper use of prescription and non-prescription medication.

[AM Pharm NS26(6):419 June 1986] [Reviewed 2005] [Reviewed 2009]

**1972**

### **Public Health Education: Proper Drug Use (2005.arc)**

1. The committee recommends that APhA seek to establish, with the cooperation and support of the drug industry, a public education fund to produce educational materials, particularly for broadcast use, which would develop public awareness of proper drug use and of the dangers inherent in improper drug use and which would emphasize the necessity for professional consultation for a supervision of drug therapy.
2. The committee recommends that APhA work to ensure that labeling and promotional materials for proprietary drug products direct attention to instructions regarding precautions and proper use of such products and identify the pharmacist as a source of information and advice regarding self medication.

[JAPhA NS12:304 June 1972]

**1970**

### **Public Health Education (2005.arc)**

1. The committee recommends the following priorities for APhA in developing educational programs using all vehicles and mechanisms available:
  - a. a "Respect for Drugs" (including Drug Abuse Education) programs
  - b. a "Venereal Disease Education" program
  - c. a "Poison Prevention" program.

[JAPhA NS10:350 June 1970]

## *Other Public Health Issues*

**2006**

### **Conversion of Nonprescription Products Into Drugs of Abuse (2016.arc)**

1. APhA supports legislative, regulatory, and private sector efforts that include input from pharmacists to balance the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports consumer sales limits of nonprescription drug products 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 concerning the potential for certain products to be illegally converted into drugs for illicit use.
4. APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.

[JAPhA N46(5):561 September/October 2006][Reviewed 2011]

**2005**

### **Efforts to Limit Methamphetamine Access (2016.arc)**

1. APhA supports legislation that balances the need for patient/consumer access to medications for legitimate medical purposes with the need to prevent diversion and abuse.
2. APhA supports stringent enforcement of criminal laws against individuals who engage in the illegal trafficking of methamphetamine and methamphetamine precursors.
3. APhA supports retail sales limits of non-prescription products that contain methamphetamine precursors to prevent diversion.
4. APhA supports education of employees involved in the distribution chain of methamphetamine precursors about diversion, methamphetamine abuse and prevention of abuse. APhA supports patient/consumer education of consequences of methamphetamine abuse.
5. APhA supports public and private initiatives that result in increased funding to address the escalating needs for drug abuse treatment and prevention.

[JAPhA NS45(5):555 September/October 2005][Reviewed 2006][Reviewed 2011]

- 1986**  
**Reye Syndrome (2006.arc)**
2. APhA supports the voluntary inclusion of Reye Syndrome warnings in the labeling of oral and rectal salicylate-containing products.
- [Am Pharm NS26(6):419 June 1986]

## PUBLIC RELATIONS

- 1971**  
**Promotion of Pharmacists' Value (2002.arc)**
1. The committee recommends the following specific activities: That APhA develop informational materials designed to provide the public factual information concerning pharmacy practice and charges for pharmaceutical services and that such materials be distributed by APhA, state associations, and individual pharmacists.
- That APhA hold a national meeting for consumer groups, government officials, the press, and others for the purpose of airing the needs for cost information and problems involved in providing it. Such a meeting should also seek to inform attendees of the nature and scope of pharmaceutical services.
- [JAPhA NS11:264 May 1971]

- 1969**  
**APhA and Pharmacists' Role (2002.arc)**
- The committee recommends that APhA continue the public relations and public information programs and projects it now conducts and that, as time, staff, funds, and opportunities permit, it build upon this program foundation to better inform the public about APhA and profession. The committee continues to believe that all public relations begin with the individual pharmacist and on the community level and that APhA should continue to provide pharmacists and their associations with public relations tools for local and personal implementation.
- [JAPhA NS9:357 July 1969]

## QUALITY ASSURANCE

- 2012, 1995**  
**Assuring Pharmacists' Continuing Competence in Contemporary Practice (2017.arc)**
1. APhA reaffirms its policy, adopted in 1975, which advocates that pharmacists maintain their professional competence throughout their professional careers.
  2. APhA recommends that employers evaluate prospective and current pharmacist employees based on demonstrated competencies in patient care and experience, in addition to education.
  3. APhA will develop and implement curricular-based continuing education programs leading to certificates of competence in patient care.
  4. APhA will convene a task force to develop and implement a voluntary program which enables pharmacists to assess and improve their continuing professional competence.
- [Am Pharm NS35(6):36 June 1995] [Reviewed 2001] [Reviewed 2007][Reviewed 2011] [JAPhA NS52(4) 460 July/August 2012]

- 2000**  
**Quality Assessment (2015.arc)**
- APhA reaffirms the 2000, 1980 and 1995 policy statements on quality assessment and improvement and supports the expanded implementation of those statements.
- [JAPhA NS40(5):Suppl.1:58 September/October 2000]

- 1995**  
**Measuring the Quality of Pharmaceutical Care (2006.arc)**
1. APhA should appoint a task force charged with the development of quality assessment measures used for the evaluation and continuous improvement of the quality of pharmaceutical care services. The foundation for developing these measures should be the 1994 APhA House of Delegates adopted guidelines for Pharmacist's Responsibilities in Appropriate Drug Use and other relevant documents.
- [Am Pharm NS35(6):37 June 1995]

# RECLASSIFICATIONS OF DRUGS

**2005, 1970, 1969, 1968, 1967, 1964**

## **Four Classes of Drugs (2006.arc)**

1. APhA supports continuing efforts to classify drugs into the four classes:
  - a. Drugs to be dispensed on prescription order and renewable at the prescriber's discretion only;
  - b. Drugs to be dispensed initially on prescription order, but renewable at the pharmacist's discretion;
  - c. Drugs to be dispensed personally by the pharmacist without prescription at the patient's request; and;
  - d. Drugs to be directly available to the public without professional supervision or control.

[JAPhA NS4(9) September 1964] [JAPhA NS7(6) June 1967] [JAPhA NS8(7) July 1968] [JAPhA NS9(7) July 1969] [JAPhA NS10:358 June 1970] [JAPhA NS45(5):557 September/October 2005]

**2005, 1987**

## **Transition Class of Drugs/Prescription to Non-prescription Switch (2006.arc)**

1. APhA supports federal and state legislation that would establish a "transition class of drugs" and a process to facilitate the transition of suitable legend drug products to non-prescription status by, among other things:
  - a. Authorizing FDA to designate that such drug products be dispensed without prescription orders.;
  - b. Requiring that such drug products be dispensed by pharmacists.;
  - c. Requiring that drug products remain in this transitional category until FDA determines, within a specified time period (e.g. five years) that the drug product can be moved into non-prescription status.;
  - d. Requiring that during this time period, studies be conducted to assess the appropriateness of such drug products for non-prescription drug use.
2. APhA recognizes the need for the identification of those drugs or classes of drugs which might be candidates for a transition class of drugs and shall initiate a process to identify such drugs in cooperation with other organizations.
3. APhA recognizes the necessity for pharmacists to play an active role in consultation, monitoring, and reporting problems associated with the use of drugs included in a transition class of drugs.

[Am Pharm NS27(6):423 June 1987] [JAPhA NS45(5):557 September/October 2005]

**1984**

## **Prescription to Non-prescription Switch (2005.arc)**

1. APhA supports federal and state legislation that would establish a category of drug products and a process to facilitate the transition of suitable, legend, drug products to non-prescription status by, among other things:
  - a. Authorizing FDA to designate that such drug products be dispensed without prescription orders.
  - b. Requiring that such drug products be dispensed by pharmacists.
  - c. Requiring that drug products remain in this transitional category until FDA determines, within a specified time period (e.g., five years) that the drug product can be moved into non-prescription status.
  - d. Requiring that during this time period, studies be conducted to assess the appropriateness of such drug products for non-prescription use.

[Am Pharm NS24(7):60 July 1984]

**1968**

## **Nitroglycerin: Patient Information if Reclassified (2005.arc)**

The committee recommends that, should nitroglycerin be made available without prescription, APhA provides pharmacists with an appropriate pamphlet outlining the information patients should receive about pharmacology, toxicology, dosage, stability, and storage requirements.

[JAPhA NS8:382 July 1968]

**1968**

## **Nitroglycerin: Proposed Reclassification as Non-prescription Drug (2005.arc)**

The committee recommends that APhA staff seek active support for its position on nitroglycerin from the National Association of Retail Druggists (NARD) and the state associations.

[JAPhA NS8:372 July 1968]

**1968**

## **Nitroglycerin: Reclassified as Non-prescription Drug (2005.arc)**

1. The committee also endorses and commends the positive action of APhA in supporting the proposed reclassification of nitroglycerin sublingual tablets published by FDA. We concur that the wide use of nitroglycerin tablets coupled with

the inherent dangers and other factors outlined in the statement submitted to FDA by APhA requires that pharmacists personally accept responsibility for the distribution of this drug when it is removed from the prescription legend category of the Federal Food, Drug and Cosmetic Act.

2. The committee reaffirms its belief that the public health and safety will be best served by a classification of drugs which are available at the request of a patient, but personally dispensed by a pharmacist. We urge APhA to continue to seek a unified position of support for its proposal from state and local professional societies of pharmacists and national pharmaceutical organizations.

[JAPhA NS8:362 July 1968]

**1967**

### **Third Class of Drugs, Dispensed by Pharmacist (2005.arc)**

The committee recommends that state pharmaceutical societies discuss and be prepared to vote on a direct proposition that they and their members will support an all-out effort on the principle that this third class of drugs be dispensed personally by a pharmacist.

[JAPhA NS7:308 June 1967]

**1966**

### **Proposal and Promotion of Reclassification (2005.arc)**

The committee reviewed the progress of the APhA reclassification of drugs proposal. We urge APhA to continue its discussions with legislators, governmental officials and other national health organizations to promote an understanding of what the proposal is and why it is needed. The committee reiterates its view that the profession of pharmacy has the manpower and resources to provide professional guidance on products for self-medication.

[JAPhA NS6:314 June 1966]

## **RECORD SYSTEMS**

**1993**

### **Professional Association-Driven Unique Identification System (2008.arc)**

APhA supports the development of a universal unique identifier numbering system for prescribers that relies on voluntary adoption of identifiers that are created by associations of health care professionals;enhances current activities and commitments of professional associations to manage and maintain data on their professions' constituencies;is centralized into a non-governmental national directory by an organization that is mutually agreeable to the affected associations;and assures open access to legitimate users and accuracy, security, and confidentiality of the information.

[Am Pharm NS33(7):56 July 1993] [Reviewed 2005]

**1981**

### **Access to Medical Records (2009.arc)**

APhA supports pharmacists' access to patient medical record information, when such access is required by the pharmacist for the purpose of providing professional service to a patient.

[Am Pharm NS21(5):40 May 1981] [Reviewed 2005]

**1979, 1965**

### **Proposal on Application of Privacy Concepts to Health Care Records (2005.arc)**

1. APhA opposes any survey or audit of confidential patient information which results in disclosure of the name of the patient and/or the prescribing physician, without the express authorization of the patient or physician, or both, if both are to be identified.
2. APhA does not oppose pharmacists providing information on the prescribing of a particular drug product if the patient and/or the prescriber is not identified.
3. APhA believes that providing patient or prescriber identity and prescription order details to third party payers for the purpose of submitting a third-party payment program service claim is in the patient's best interest.
4. APhA opposes allowing unauthorized personnel to extract information from confidential patient records.

[JAPhA NS5:273 June 1965] [Am Pharm NS19(7):68 June 1979]

1976

### **Computerization in Pharmacy Practice (2001.arc)**

APhA supports regulatory changes at the national and state levels that would provide for computerized patient and prescription records as an alternative to manually prepared record systems.

[JAPhA NS16:344 June 1976]

1974

### **Patient Medication Profiles (2001.arc)**

1. The committee recommends that APhA not endorse mandating by state law or board regulation that pharmacists keep patient medication profiles.
2. The committee recommends that APhA continue to urge pharmacists to utilize patient medication profiles in providing a positive contribution to total patient care.
3. The committee recommends that APhA continue to publicize to the public, fiscal intermediaries, and the health professions the significant contributions to public health that pharmacists provide by using patient medication profiles.
4. The committee recommends that APhA develop programs that encourage more practitioners to utilize patient medication profiles.
5. The committee recommends that APhA initiate and encourage studies of the effectiveness of patient medication profiles in improving patient care.

[JAPhA NS14:496 September 1974]

1970

### **Patient Medication Profiles (2001.arc)**

1. The committee urges pharmacists to make use of a profile system in their practices because patient medication profile systems are an indispensable element of pharmaceutical services in total health care.
2. The committee recommends that APhA prepare guidelines to assist pharmacists in developing efficient patient medication profile systems for their practices.
3. The committee recommends that APhA initiate a comprehensive study to make available to pharmacists information on drug interactions. Attention should be given to organizing and making this information available in a concise form which will include an explanation of the mechanism and clinical significance of specific drug interactions.

[JAPhA NS10:361 June 1970]

1965

### **Patient Record Systems: Pharmacists' Responsibilities (2001.arc)**

The committee recommends that pharmacists implement a patient record system to facilitate retrieval of the information needed to fill out claim forms for patients. Every pharmacist is familiar with the task of searching his prescription files over a period of several months to assist patients in complying with the insurer's claim requirements. Such a system would minimize this burden on pharmacists and be a valuable assist in properly serving his patients in other professional areas as well.

[JAPhA NS5:273 May 1965]

## **REIMBURSEMENT AND COMPENSATION**

2005, 1987

### **Drug Regimen Review (DRR) (2009.arc)**

APhA endorses appropriate compensation to pharmacists for performing drug regimen review.

[Am Pharm NS27(6):422 June 1987] [JAPhA NS45(5):557 September/October 2005]

2004, 1979

### **Proposal on Drug Regimen Review (DRR) by Pharmacists (2005.arc)**

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):65 June 1979] [JAPhA NS44(5):551 September/October 2004]

## *Claim Forms and Procedures*

1971

### **Universal Claim Form (2001 arc.)**

The committee recommends that APhA endorse the concept of the universal claim for use in all third-party payment prescription programs.

[JAPhA NS11:278 May 1971]

1969

### **Metric System and Third-party Payment (2001 arc.)**

Recognizing that APhA has gone on record as supporting routine use of the metric system, the committee recommends that pharmacists use the metric system in their practice and when submitting claims for third-party payment.

[JAPhA NS9:362 July 1969]

## *Federal Programs*

2005, 1969

### **Medicare and Pharmaceutical Service (2012 arc)**

APhA believes that the current Medicare (a federal program of hospital and medical insurance for nearly all people 65 and over) is grossly deficient in that it fails to provide a drug benefit to non-institutionalized patients. The committee, therefore, strongly recommends that APhA continue to support federal legislation to eliminate this deficiency.

[JAPhA NS9:363 July 1969] [JAPhA NS45(5):558 September/October 2005 (Reviewed 2009)]

## *Federal Programs*

2005, 1978

### **Medicare Prescription Drug Benefits (2013.arc)**

1. APhA endorses extension of Medicare coverage to include a Medicare prescription drug benefit.
2. A Medicare prescription drug benefit should:
  - a. Place drug product cost reimbursement on an actual acquisition cost basis;
  - b. Ensure a dispensing fee comparable to that charged the self-paying public;
  - c. Allow for professional discretion in identification of drug products in the labeling of dispensed prescriptions;
  - d. Prevent dispensing by physicians under this program; and
  - e. Remove the price-posting requirement as a condition of participation in the program.

[Am Pharm NS18(8):30 July 1978] [JAPhA NS45(5):558 September/October 2005] (Reviewed 2009)

## *National Health Insurance*

1963

### **National Health Insurance (NHI): APhA Opposition (2005. arc)**

1. The basic position of APhA opposing compulsory national health insurance was adopted by this House of Delegates in 1949. In keeping with this position, officers of APhA have testified on numerous occasions before Congressional committees. In the 87th Congress, APhA strongly opposed the King-Anderson legislation because of its compulsory characteristics and inadequacies.
2. It is the recommendation of this committee, however, that APhA now review its basic position. While considerable progress has been made since 1949 through voluntary programs, the profession must satisfy itself that all is being done that can be done to serve the public. In some instances, for example, remedial legislation could accelerate voluntary programs.

[JAPhA NS3:324 June 1963]

## *Professional Fees*

1975

### **Professional Fees in Federal Program: Maximum Allowable Cost (MAC) (2005 arc.)**

Prompt and equitable adjustments of pharmacist professional fees in federally-supported health care programs must be undertaken concurrently with implementation of HEW's maximum allowable cost regulations, or any similar regulations.

[JAPhA NS15:330 June 1975]

1966

### **Professional Fee System (2005.arc)**

The methods used to determine prescription charges continue to be a subject of some controversy. The committee recommends that all pharmacists consider the value of the professional fee system as the most logical means of determining charges for pharmaceutical services. Whatever method is used, pharmacists should be prepared to discuss their fees with their patrons. To encourage this candid discussion, a plaque that announces the pharmacist's willingness to discuss his fees will be prepared and offered to those pharmacists who elect to display it. Some pharmacists who have adopted the professional fee method have used this as a competitive advertising advantage. This practice is to be discouraged. Methods of determining charges must be considered at the community level in light of local conditions and fixed costs.

[JAPhA NS6:332 June 1966]

## *Third Party and Prepaid Programs*

1994

### **Third-party Prescription Drug Programs (2001 arc.)**

1. APhA shall establish, publish, and promote criteria which any pharmacy benefits' administrator must meet in order to secure the endorsement of this Association;and
2. APhA shall define the scope of those endorsements it is to provide.

[Am Pharm NS29(7):464 July 1994]

1989

### **Pharmacists' Participation in Influencing Third-party Program Policies (2001 arc.)**

1. APhA believes that pharmacists must participate in the legislative and regulatory processes and in the development of policies related to third-party programs.
2. APhA supports the development of programs and materials for the pharmacist to educate legislators, third-party payers, and benefits managers about the value of comprehensive pharmaceutical services.
3. APhA supports the development of programs and materials to assist pharmacists in educating patients about pharmaceutical benefits included in their health-insurance programs.

[Am Pharm NS23(6):52 June 1989]

1983

### **Third-party Differentials (2001 arc.)**

APhA opposes third-party payment differentials for drugs based on their therapeutic use.

[Am Pharm NS23(6):52 June 1983]

1971

### **Third-party Negotiations (2001 arc.)**

1. The committee recommends that APhA pursue all lawful means to obtain authorization for pharmacists to negotiate through their state associations with regard to reimbursement for pharmaceutical services from all third-party prescription benefit programs.
2. The committee recommends that such efforts be undertaken on a cooperative basis by all national organizations representing practicing pharmacists.

[JAPhA NS11:268 May 1971]

1968

### **Prepaid Programs (2001 arc.)**

The committee reiterates APhA policy that it is not the function of APhA to underwrite or necessarily to endorse any particular prepayment or pharmaceutical insurance plan.

[JAPhA NS8:362 July 1968]

1967

### **Prepaid Programs (2001 arc.)**

The committee urges that the following points be considered as indispensable to a working prepayment program:

1. Free choice of pharmacists
2. That standard forms be used for all programs
3. That the professional fee be used as a means of reimbursement
4. That proof of eligibility of the recipient be readily established.

[JAPhA NS7:321 June 1967]

1967

### **Prepaid Programs: Guidelines for Reimbursement (2001 arc.)**

1. The committee recommends that the House of Delegates reaffirm the policy that the APhA should not assume the role of underwriter in any such program. The committee further recommends that the House establish the following guidelines for use in APhA work on pre-payment programs:
  - a. Patients must be given free choice of pharmacy.
  - b. Pharmacists should be paid for their professional services on the basis of an equitable professional fee in addition to the cost of the drug dispensed.
  - c. Programs should be a service type benefit program rather than a reimbursement type insurance program in its practical applications and administration.

[JAPhA NS7:306 June 1967]

1966

### **Prepaid Pharmaceutical Service (2001 arc.)**

The committee recommends that APhA continue to study alternative methods of financing and administering a plan to provide prepaid pharmaceutical services and that it continues to make its findings and assistance available upon request to state associations.

[JAPhA NS6:314 June 1966]

1964

### **Insurance to Cover Catastrophic Illness (2005.arc)**

APhA recognizes and is most concerned with the problems that can occur with the unfortunate advent of catastrophic illness and, therefore, encourages the health insurance industry to provide coverage which would specifically meet the costs associated with such catastrophic illnesses.

[JAPhA NS4:429 August 1964]

## **RESEARCH**

1986

### **Therapeutic Drug Testing in Children (2005.arc)**

1. APhA supports the inclusion of children in clinical investigations of drug products where appropriate safeguards are instituted to ensure the safety of children, where the use of the drug has significant indications (need for use) in children and where there is prior experience with the drug in the adult population.

[Am Pharm NS26(6):420 June 1986]

1985

### **Genetic Research and its Application (2010.arc)**

1. APhA recommends the establishment of a privately-funded, voluntary body representing the public and private sectors to review genetic research and, in cooperation with existing public agencies, to develop uniform standards for all laboratories involved in such studies.
2. APhA recognizes the need for maintaining high levels of scientific and corporate social responsibility to assure public health and safety with regard to the consequences of genetic research.

[Am Pharm NS25(5):51 May 1985] [Reviewed 2005]

1985

### **Testing Drugs in Elderly Patients (2005.arc)**

1. APhA recommends that, for drugs intended for use in both elderly and non-elderly populations, age per se be eliminated as an exclusion criterion in clinical investigations.
2. APhA supports the inclusion of elderly populations in clinical investigations of drug products.
3. APhA favors development of research techniques which would identify possible problems not readily detected in clinical investigations to aid in the more effective use of drugs in the elderly.

[Am Pharm NS25(5):51 May 1985]

1975

### **Prisoners in Human Experimentation (2005.arc)**

1. APhA fully supports all reasonable procedures, including use of institutional review committees, informed consent, and other procedures as described in HEW's 1971 guide and the May 30, 1974, regulations on this subject, for the protection of all classes of human subjects, who are to be used for any form of human experimentation.
2. Future regulations which are promulgated should permit the continued effective use of prisoners in experimentation in a manner which is not substantially different from non-institutionalized human subjects.

[JAPhA NS15:319 June 1975]

## **SAMPLING**

1970

### **Manufacturers' Sampling Programs (2002.arc)**

1. The committee recommends that APhA commend Roche Laboratories for its initiative in phasing out its system of traditional physician sampling.
2. The committee recommends further that APhA offer Roche Laboratories assistance in evaluating the results of their decision.
3. The committee recommends that those pharmacists who serve on pharmacy advisory panels of other pharmaceutical manufacturers familiarize themselves with the Roche program and recommend that these other companies take similar steps to phase out their sampling programs.

[JAPhA NS10:354 June 1970]

1969

### **Manufacturers' Sampling Programs (2002.arc)**

1. The committee offers the following guidelines to pharmacists and manufacturers for consideration in developing sampling programs involving pharmacists:
  - a. Control of medication should be maintained by those who are authorized by law to control and possess prescription medication.
  - b. Confidentiality of the prescription should be preserved.
  - c. Administrative paper work by pharmacists should be kept to a minimum.
  - d. Pharmacists should be reimbursed a monetary fee which is commensurate with their professional services.
  - e. The amounts of drug involved should be sufficient for starter doses only.
  - f. Any programs involving starter dosage sampling which will involve pharmacists should be as extensive in terms of variety and quantity as in any comparable physician sampling program.

[JAPhA NS9:362 June 1969]

1968

### **Mailing of Prescription Drug Samples (2002.arc)**

The committee concludes that the mailing of prescription drug samples is not in the best interests of public health and recommends that the committee on legislation consider appropriate action.

[JAPhA NS8:383 July 1968]

1966

### **Mailing of Prescription Drug Samples (2002.arc)**

1. APhA shall lend its support and assistance to enactment of legislation which would prohibit the mailing of unsolicited drug samples.
2. Unsolicited mailings of samples of legend drugs continues to be a serious problem and public health hazard. Manufacturers are asked to review their current policies and pharmacists are reminded that they should report promptly any evidence of the abuse of sampling to the state boards of pharmacy, FDA, and APhA for appropriate action.

[JAPhA NS6:293 July 1966]

1964

### **Professional Samples (2002.arc)**

APhA should enlist the cooperation of the American Medical Association and the Pharmaceutical Manufacturers Association in developing a code of understanding to serve as a guide in the distribution and dispensing of professional samples.

[JAPhA NS4:428 August 1964]

# SPECIALTIES IN PHARMACY

1997

## Criteria for the Recognition of a Specialized Area of Pharmacy Practice (2007.arc)

APhA strikes in its entirety the 1975 Criteria for the Recognition of a Specialized Area of Pharmacy Practice, replacing it with the following

The following criteria should be utilized by the Board of Pharmaceutical Specialties in the determination of whether or not to afford official recognition to an area of specialization in pharmacy

CRITERION A. The area of specialization shall be one for which specifically trained practitioners are needed to fulfill the responsibilities of the profession of pharmacy in improving the health and welfare of the public, which responsibilities may not otherwise be effectively fulfilled.;

CRITERION B. The area of specialization in the practice of pharmacy shall be one in which there exists a significant and clear health demand to provide the necessary public reason for certification.;

CRITERION C. The area of specialization shall include a reasonable number of individuals who devote most of the time of their practice to the specialty area.;

CRITERION D. The area of specialization shall be based on specialized knowledge of one or more of the pharmaceutical sciences and the biological, physical, and behavioral sciences which underlie them. Administrative, managerial, procedural, or technical services and the environment in which pharmacy is practiced, are not applicable to this criterion.;

CRITERION E. The area of specialization shall represent an identifiable field of pharmacy practice which requires specialized functioning by the practitioner and which is distinct from other recognized pharmacy specialties.;

CRITERION F. The area of specialization shall be one in which schools and colleges of pharmacy and/or other organizations offer recognized education and training programs to those seeking advanced knowledge and skills in the area of specialty practice so that they may perform more competently.;

CRITERION G. The area of specialization shall be one in which there is an adequate transmission of specialized knowledge through professional, scientific, and technical literature immediately related to the specialty.

[JAPhA NS37(4):459-60 July/August 1997] (Reviewed 2001)

1973

## Clinical Pharmacy and Pharmacy Practice (2001.arc)

1. The committee recommends that APhA endorse the Report of the Task Force on the Pharmacist's Clinical Role (Drug-Related Studies Program, National Center for Health Services, Research and Development, DHEW, September 1971) as containing worthwhile goals toward which all pharmacists should strive in rendering patient oriented pharmaceutical service.
2. The committee recommends that the APhA recognize that there are pharmacy practitioners who have additional clinical education, training, or experience and who are primarily involved in practicing expanded, clinical functions described in the Task Force Report.

While these pharmacists are most often referred to as clinical pharmacists, they do not constitute an officially recognized specialty at this time.

3. The committee recommends that the House of Delegates rescind its action taken in 1972 adopting the Report of the Task Force on the Definition of Clinical Pharmacy, Institutional Pharmacy, and Group Practice and the statement on pharmacy practice.
4. The committee recommends that APhA adopt the following definition of pharmacy practice  
"Pharmacy practice is defined as that personal health service that assures safety and efficacy in the procuring, storing, prescribing, compounding, dispensing, delivering, administering and use of drugs and related articles."

[JAPhA NS13:517 September 1973]

# TITLES/DESIGNATIONS

## *Non-Pharmacists*

1988

### **Pharmacy Technicians (2001.arc)**

1. APhA endorses the use of the term “pharmacy technicians” to describe those individuals who assist pharmacists in the performance of selected professional duties.
2. APhA endorses the appropriate use of pharmacy technicians in various types of pharmacy practices.
3. APhA advocates that pharmacists maintain supervisory control over pharmacy technicians.
4. APhA advocates the training of pharmacy technicians via programs developed and administered under the guidance of pharmacists.
5. APhA advocates that pharmacists develop written guidelines for pharmacy technicians which specify functions and supervisory controls.

[Am Pharm NS28(6):395 June 1988]

# VACCINES

1981

### **Vaccine Liability Programs (2014.arc)**

APhA supports legislative action to create a joint pharmaceutical industry/government program which would compensate victims and reduce the liability of vaccine manufacturers and health care professionals arising from adverse effects associated with the appropriate administration of properly manufactured vaccines.

[Am Pharm NS21(5):41 May 1981] [Reviewed 2005] [Reviewed 2009]

# WOMEN IN PHARMACY

1984

### **Female Health Professional Draft Registration (2009.arc)**

APhA supports the enactment of legislation to amend the Military Selective Service Act to provide for the specific registration and induction of members of the pharmacy profession, both male and female, in times of national need for their professional services provided, however, that such support is limited to legislation which would grant commissions to pharmacists inducted by the authority of such legislation.

[AmPharm NS24(7):60 July 1984] [Reviewed 2005]

1977

### **Equal Employment Opportunities (2005.arc)**

APhA shall take positive action to make women equally visible as members of this esteemed profession including but not limited to: advertising depicting pharmacists and recruiting material.

[JAPhA NS17:463 July 1977]





# Historical APhA Policies: Rescinded – Statements 1963-2018

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# RESCINDED POLICY STATEMENTS

## DRUG ABUSE, CONTROL AND EDUCATION

### *Marijuana*

1974

#### **Marijuana Law Reform (2003.res)**

The committee recommends that APhA support removal of marijuana from the federal Controlled Substances Act and related state and local laws and support the establishment of uniform controls for marijuana which more appropriately balance the potential public health hazards of marijuana with its current, social use.

[JAPhA NS14:492 September 1974]

## DRUG PRODUCT SELECTION

1986

#### **“Quack” Therapy (2002.res)**

1. APhA encourages FDA and FTC to increase their efforts to eliminate “quack products.”
2. APhA encourages pharmacists not to stock any “quack products.”

[Am Pharm NS26(6):420 June 1986]

1974

#### **Anti-substitution Laws: Elimination of Brand Names (2004.res)**

The committee recommends that APhA undertake efforts, including support of legislation, to eliminate the use of brand names for prescription, legend drug products.

[JAPhA NS14:492 September 1974]

## EDUCATION, CURRICULUM AND COMPETENCE FOR PHARMACISTS

### *Continuing Education*

1975

#### **Standards for Continuing Competence (2003.res)**

APhA supports programs designed to established valid standards of competence for pharmacy practice and reliable means of measuring and evaluating such competence.

[JAPhA NS15:336 June 1975]

## EMPLOYER/EMPLOYEE RELATIONS

1969

#### **Employee Participation in Continuing Education: Employer Responsibility (2001.res)**

The committee is concerned about the increasing number of complaints from the more recent graduates about the lack of interest by their employers in providing time and financial assistance to attend continuing education meetings. In some instances, the newer practitioners are being penalized, and, in other instances, the opportunity is being denied. The committee recognizes that there are many enlightened employers who contribute to the development of the profession and their practices by encouraging and assisting the pharmacists they employ in participating in educational and professional meetings. The committee recommends that APhA encourage consideration of this subject in articles and conferences on the subject of employer/employee relations.

[JAPhA NS9:336 July 1969]

## *Unionization*

1999, 1971

### **Unionization of Pharmacists: State Participation in Employer/Employee Relations (2001.res)**

5. The committee recommends that APhA reiterate its condemnation of local and state association membership requirements and privileges based on employer or employee status.

[JAPhA NS39(4):447 July/August 1999] [JAPhA NS11:273 May 1971]

## **FEDERAL PROGRAMS AND POLICIES**

1970

### **National Formulary and United States Pharmacopoeia (2004.res)**

1. APhA exhorts all state pharmacy board officials to actively support requirements pertaining to the maintaining of the current official NF and USP in each pharmacy in the United States as a condition of licensure.

[JAPhA NS10:363 June 1970]

## **LICENSURE, REGISTRATION AND REGULATION**

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

1967

### **Institutional Pharmacy: State Law Requirements (2002.res)**

The committee recommends that APhA consider the possibility and effect of special institutional pharmacy permits which would allow an institution to establish a pharmacy under applicable state law but yet not meet all of the requirements of the state pharmacy practice act with a limitation that the pharmaceutical services rendered would be limited to institutionalized patients.

[JAPhA NS7:305 June 1967]

## **MAIL ORDER PRESCRIPTIONS**

1991, 1977

### **Pharmacist/Patient Communication (2001.res)**

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.

[JAPhA NS17:464 July 1977] [AmPharm NS31(6):28 June 1991]

1970

### **APhA Opposition (2001.res)**

1. The committee recommends that APhA continue in its opposition to plans which offer prescription services by mail order on the grounds that such practice by its very nature constitutes a threat to public health and welfare, because it eliminates or interferes with the physician/patient/pharmacist relationship and also because such practice violates pharmacy laws and regulations of many states.
2. The committee recommends further that APhA continue its efforts to assist pharmacy groups in litigation against mail order operations offering prescription services.

[JAPhA NS10:354 June 1970]

1965

### **APhA Opposition (2001.res)**

1. APhA unequivocally opposes the circumvention of state pharmacy laws, the destruction of the physician-patient-pharmacist relationship and the obvious opportunity for diversion of drugs to illegitimate uses presented by all prescription mail order schemes.
2. APhA shall provide guidance to the several state societies to assist them in protecting the welfare of the public from such mail order operations.

3. APhA shall again encourage the Congress to review the problems associated with the improper distribution and use of drugs obtained by mail order.

[JAPhA NS5:273 May 1965]

## PATIENT/PHARMACIST RELATIONSHIPS

1991, 1977

### Pharmacist/Patient Communication (2001.res)

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.

[JAPhA NS17:464 July 1977] [AmPharm NS31(6):28 June 1991]

## PHARMACY TECHNICIANS

1991, 1988

### Pharmacy Technicians (2001.res)

1. APhA reaffirms its policy, adopted in 1988, which opposes the licensure, registration, or certification of pharmacy technicians by statute or regulation.

[Am Pharm NS(6):28 June 1988] [Am Pharm NS(6):28 June 1991]

1971

### Supportive Personnel: Functions, Standards and Supervision (2001.res)

4. The committee recommends that supportive personnel not be licensed, certified, or registered by statute or regulation.

[JAPhA NS11:277 May 1971]

1968

### Subprofessionals: Training for Pharmacy Technicians (2001.res)

It seems obvious that, unless need can be demonstrated and the duties of technicians clearly defined, no training for technicians should be instituted. It is imperative, therefore, that pharmacists throughout the country discourage the establishment of such programs in junior and community colleges for the present. The committee recommends that state pharmaceutical associations—and, through them, their county associations—be advised of this problem and that they be asked to be on the alert against any misguided steps to initiate such programs. The executive director of APhA should be notified should any institution in the country announce plans to train such personnel.

[JAPhA NS8:388 July 1968]

1966

### Subprofessionals (2001.res)

The committee would be opposed to any assumption of the pharmacist's professional functions by subprofessionals or technicians. There is a need to determine exactly what these functions are and the relative position of the pharmacy intern. Under no circumstance should a subprofessional program in pharmacy create an individual such as the former "qualified assistant" still practicing in some states.

[JAPhA NS6:332 June 1966]

## PRESCRIBING AUTHORITY

1976

### Prescribing Drugs — Authority (2009.res)

APhA opposes granting independent drug prescribing authority to Physician Assistants and Nurse Practitioners.

[JAPhA NS16:341 June 1976] [Reviewed 2007]

# REIMBURSEMENT AND COMPENSATION

## *Federal Programs*

1970

### **Medicare, Medicaid, and Other Third-party Payment Programs (2005.res)**

1. The committee recommends that no changes be made in APhA policy favoring out-of-hospital, prescription benefits under Medicare.

[JAPhA NS10:346 June 1970]

1969

### **Veterans Administration Hometown Prescription Program (2005.res)**

The committee recommends that VA adopt the professional fee method for its Hometown Prescription Program.

[JAPhA NS9:352 July 1969]

## *Professional Fees*

1967

### **Fee for Service Guidelines (2005.res)**

Obviously, this committee or APhA cannot recommend or set a fee, but we do recommend that APhA collect information on pharmacists serving as consultants to extended-care facilities and hospitals and make it available to the membership as a guide.

[JAPhA NS7:305 June 1967]

1967

### **Pharmaceutical Service Cost Information (2005.res)**

The committee recommends that APhA, if invited to testify at these hearings, not presume that it has the facts and information to explain these wide pricing differences, this is data that the individual manufacturers will have to provide themselves. On the other hand, APhA should undertake to explain and document the charges pharmacists make to the public for their own professional services if called upon to do so.

[JAPhA NS7:316 June 1967]

# TITLES/DESIGNATIONS

## *Non-Pharmacists*

1988

### **Pharmacy Technicians (2001.res)**

6. APhA opposes the licensure, registration, or certification of pharmacy technicians by statute or regulation.

[Am Pharm NS28(6):395 June 1988]

1976

### **Pharmacy Aide (2001.res)**

1. APhA endorses the term "pharmacy aide" as the accepted term to designate that category of supportive personnel most frequently utilized in pharmacy practice who are trained to perform routine, non-judgmental functions under the supervision of a pharmacist.
2. APhA advocates the training of pharmacy aides via in-service or on-the-job training programs.
3. APhA advocates that pharmacy aides function under written procedures which specify functions and supervisory controls and which assure the efficiency of pharmacy practice, while not compromising the quality of pharmaceutical service, and further, that no more than one non-pharmacist (excluding registered intern pharmacist) be involved in the non-judgmental, prescription dispensing functions under the direct supervision of a pharmacist at any given time.

[JAPhA NS16:343 June 1976]

# APPENDICES

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# American Pharmacists Association Bylaws as amended through April 22, 2014.

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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  
5 information, education, and advocacy to help all pharmacists  
6 improve medication use and advance patient care.

7 **Section 2. Membership Benefits and Services.** In  
8 furtherance of its lawful purposes and within its corporate  
9 powers, this ASSOCIATION shall conduct such programs and  
10 activities and shall provide such other membership benefits  
11 and services as may be established from time to time by its  
12 members or Board of Trustees.

13 **Section 3. Code of Ethics.** This ASSOCIATION shall provide  
14 and maintain a Code of Ethics for pharmacists.

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## ARTICLE III. MEMBERSHIP

15 **Section 1. Classes of Membership.** This ASSOCIATION  
16 shall have Member, Student Pharmacist Member, Pharmacy  
17 Technician Member, and Honorary Member classes of  
18 membership and such other classes of membership as may  
19 be established from 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  
32 enrolled in a school or college of pharmacy holding membership  
33 in the American Association of Colleges of Pharmacy or  
34 accredited by ACPE, or a student enrolled in a pre-pharmacy  
35 program, shall be eligible for membership as a Student  
36 Pharmacist Member. A Student Pharmacist Member shall also be  
37 a member of the ASSOCIATION's student pharmacist  
38 membership organization group. A Student Pharmacist Member  
39 shall have full voting rights in the student pharmacist  
40 membership organization group and may hold office only in the  
41 ASSOCIATION's student pharmacist membership organization  
42 group, provided, however, that a Student Pharmacist Member  
43 shall have full voting rights as a member of an  
44 ASSOCIATION committee or as a delegate in the  
45 ASSOCIATION House of Delegates. Student Pharmacist  
46 Members representing the student pharmacist membership  
47 organization group in the APhA House of Delegates shall have

48 the right to vote in that year's annual election for at-large APhA  
49 Board of Trustees members and APhA President-Elect, as well  
50 as any additional issues that may be placed on the ballot from  
51 time to time.

52 **Section 4. Pharmacy Technician Member.** Any individual  
53 who is a pharmacy technician shall be eligible for membership as  
54 a Pharmacy Technician Member. A Pharmacy Technician  
55 Member shall have full voting rights in a selected Association  
56 membership organization group and may hold office only in that  
57 selected membership organization group, provided, however,  
58 that a Pharmacy Technician Member shall have full voting rights  
59 as a member of an ASSOCIATION committee or as a delegate  
60 in the ASSOCIATION House of Delegates.

61 **Section 5. Honorary Membership.** Any individual may be  
62 granted Honorary membership by the Board of Trustees. An  
63 Honorary Member shall have no voting rights and may not hold  
64 office in this ASSOCIATION or any of its membership  
65 organization groups unless entitled to do so under another class  
66 of membership.

67 **Section 6. Admission to Membership.** Any individual shall  
68 be admitted to membership in the appropriate class of  
69 membership upon completion of administrative processing of  
70 any required application accompanied by required dues,  
71 provided, however, that the Board of Trustees may deny any  
72 individual membership for cause, meaning conduct tending to  
73 damage the public reputation of this ASSOCIATION.

74 **Section 7. Membership Benefits and Services.**  
75 Membership benefits and services for each class of membership  
76 shall be those established from time to time by the Board of  
77 Trustees. The Board of Trustees may add, delete, or adjust  
78 membership benefits and services as it deems necessary or  
79 desirable in furtherance of ASSOCIATION purposes. No  
80 addition, deletion, or adjustment of membership benefits or  
81 services shall require any adjustment of dues for the  
82 membership period during which the addition, deletion, or  
83 adjustment of membership benefits or services occurs.

84 **Section 8. Termination of Membership.** Any member may  
85 voluntarily terminate membership by notice to this  
86 ASSOCIATION. Termination of membership shall be effective  
87 upon completion of administrative processing of such notice.  
88 No such voluntary termination of membership shall be effective  
89 to avoid any debt to this ASSOCIATION. This ASSOCIATION  
90 may terminate the membership of any member for failure to pay  
91 required dues. Such termination of membership shall be  
92 effective at the convenience of this ASSOCIATION.  
93 Termination of membership shall terminate the right of any  
94 member to all membership benefits and services.

95 **Section 9. Dues.** Each member shall pay such dues as may be  
96 required from time to time by the Board of Trustees for each  
97 class of membership. The Board of Trustees may establish from  
98 time to time such administrative policies and procedures as it  
99 deems necessary or desirable to facilitate the payment and  
100 receipt of required dues. The Board of Trustees may also  
101 establish from time to time special dues within established  
102 classes of membership.

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## ARTICLE IV. OFFICERS

103 **Section 1. Officers.** The officers of the ASSOCIATION shall  
104 be the President, the President-elect, the Immediate Past  
105 President, the Treasurer, and the Executive Vice President.

106 **Section 2. President, President-elect and Immediate  
107 Past President.** The President shall be a pharmacist from the  
108 ASSOCIATION's Member category and the principal elected  
109 officer of the ASSOCIATION and shall serve as a Trustee of  
110 this ASSOCIATION.

111 The President shall first be elected as President-elect, and  
112 the year thereafter shall serve as President with the third year  
113 of service as Immediate Past President. The President shall  
114 preside at meetings of this ASSOCIATION and shall appoint,  
115 with the approval of the Board of Trustees, all ASSOCIATION  
116 committees other than the ASSOCIATION House of Delegates  
117 Committees.

118 The President shall perform such other duties as may be  
119 assigned from time to time by the Board of Trustees, but shall  
120 have no individual duties or responsibility for administrative  
121 decisions or actions with regard to the continuing management  
122 of ASSOCIATION affairs.

123 No individual shall serve as President-elect immediately  
124 following a term as President or Immediate Past President. A  
125 vacancy in the office of President shall be filled by the President-  
126 elect. A vacancy in the office of President-elect or Immediate  
127 Past President may be filled by a pharmacist from the  
128 ASSOCIATION's Member category appointed by the Board of  
129 Trustees, except that any appointment of a President-elect will  
130 be effective only until the next regular election at which time  
131 the membership shall elect both a President-elect and a  
132 President.

133 **Section 3. Executive Vice President.** The Executive Vice  
134 President shall be a pharmacist from the ASSOCIATION's  
135 Member category appointed by the Board of Trustees and  
136 employed by the ASSOCIATION as chief executive officer on  
137 such terms and conditions as are approved by the Board of  
138 Trustees. The Executive Vice President shall be responsible to  
139 the Board of Trustees in the exercise of assigned duties and  
140 authorities for executive and administrative decisions or actions  
141 with regard to the continuing management of the  
142 ASSOCIATION's affairs. The Executive Vice President shall  
143 serve as Secretary of the ASSOCIATION and as Secretary of  
144 the House of Delegates. A vacancy in the office of Executive  
145 Vice President shall be filled by a pharmacist from the  
146 ASSOCIATION's Member category appointed by the Board of  
147 Trustees.

148 **Section 4. Treasurer.** The Treasurer shall be a Member  
149 appointed by the Board of Trustees and shall serve for a term of  
150 three (3) years from the effective date of the appointment. No  
151 individual shall serve more than two (2) consecutive full three-  
152 year terms as Treasurer. A vacancy in the office of Treasurer  
153 shall be filled for the unexpired term by a Member appointed by  
154 the Board of Trustees.

155 **Section 5. Removal.** An Officer of the ASSOCIATION  
156 (except for the Executive Vice President) may be removed  
157 from office for any reason by a two-thirds (2/3) vote in favor  
158 of removal by the whole Board of Trustees, excluding the vote  
159 of the affected Officer. Trustees may only vote in person at an  
160 assembled meeting, face-to-face. No proxies, mail, telephone or  
161 other indirect means of voting shall be permitted. The vote shall  
162 be taken by secret written ballot. Counsel to the  
163 ASSOCIATION shall tally the ballots and shall announce only  
164 the result.

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## ARTICLE V. BOARD OF TRUSTEES

165 **Section 1. Composition.** Six (6) Elected Trustees, the  
166 Officers, the Speaker of the House of Delegates, and the  
167 Presidents of the membership organization groups of this  
168 ASSOCIATION shall constitute the Board of Trustees.

169 **Section 2. Duties and Authority.** The Board of Trustees  
170 shall be responsible for the general supervision and management  
171 of ASSOCIATION affairs, including, but not limited to, the  
172 specific duties and authority stated in these Bylaws. It shall have,  
173 in addition to the specific duties and authority stated in these  
174 Bylaws, such duties and authority which from time to time are  
175 imposed on or recognized by law as being applicable to  
176 nonprofit corporations. It shall adopt Bylaws and rules or  
177 procedures for the conduct of its business.

178 It shall act with regard to matters of ASSOCIATION policy for  
179 the House of Delegates in the interim between House of  
180 Delegates meetings and shall make an annual report to the  
181 membership regarding the programs and activities of this  
182 ASSOCIATION.

183 **Section 3. Election of Trustees.** Elected Trustees shall be  
184 elected as provided for in the Article on elections in these  
185 Bylaws.

186 **Section 4. Term of Office.** Elected Trustees shall be elected  
187 for a term of three (3) years and shall serve until their  
188 successors have been duly elected and installed. No individual  
189 shall serve more than two (2) successive full terms as an Elected  
190 Trustee. However, nothing in this Article shall prevent a  
191 Trustee who has served two full successive terms from being  
192 elected as President-elect or President.

193 **Section 5. Vacancies.** A vacancy among Elected Trustees shall  
194 be filled by a pharmacist from the ASSOCIATION's Member  
195 category selected by the Board of Trustees to serve the  
196 remainder of the unexpired term. A vacancy among Officer  
197 Trustees shall be filled as provided for in the Article on Officers  
198 in these Bylaws. A vacancy in the Office of Speaker or the  
199 Office of Speaker-elect of the House of Delegates shall be filled  
200 as provided for in the Article on the House of Delegates in  
201 these Bylaws.

202 **Section 6. Meetings.** The Board of Trustees shall meet at the  
203 call of the President or on the call of a quorum of the Board of  
204 Trustees. The time and place of Board of Trustees meetings  
205 shall be established by the President.

206 **Section 7. Quorum.** A majority of Trustees plus one shall  
207 constitute a quorum for the transaction of business.

208 **Section 8. Removal.** A Trustee of the ASSOCIATION may  
209 be removed from office for any reason by a two-thirds (2/3)  
210 vote in favor of removal by the whole Board of Trustees,  
211 excluding the vote of the affected Trustee. Trustees may only  
212 vote in person at an assembled meeting, face-to-face. No  
213 proxies, mail, telephone or other indirect means of voting shall  
214 be permitted. The vote shall be taken by secret written ballot.  
215 Counsel to the ASSOCIATION shall tally the ballots and shall  
216 announce only the result.

---

## ARTICLE VI. HOUSE OF DELEGATES

217 **Section 1. Composition.** The House of Delegates shall  
218 consist of delegates from states, ASSOCIATION membership  
219 organization groups, Recognized National Organizations,  
220 Delegates Ex Officio, and Speaker-appointed delegates. Each  
221 delegate and Delegate Ex Officio must be a member of this  
222 ASSOCIATION.

223 Section 2. Apportionment of Delegates.

224 **A.** States: each shall have two (2) delegates plus one (1) delegate  
225 for each two hundred (200) Members of this ASSOCIATION,  
226 or major fraction thereof, who are members of this  
227 ASSOCIATION residing in the state. Delegates and alternate  
228 delegates from each state should reflect the demographic  
229 diversity represented by the ASSOCIATION membership  
230 residing in that state.

231 **B.** ASSOCIATION membership organization groups: each shall  
232 have twenty-eight (28) delegates.

233 **C.** Recognized National Organizations: each shall have two (2)  
234 delegates, delegates who are members of the recognized  
235 organization.

236 **D.** Delegates Ex Officio: shall be each Trustee, ASSOCIATION  
237 Former Presidents, and Former Speakers of the House of  
238 Delegates.

239 **E.** The Speaker shall appoint up to 10 delegates from House  
240 committee members not appointed as delegates from other  
241 delegations.

242 **F.** Each appointing organization shall have the right to appoint  
243 one (1) alternate delegate for up to five (5) delegates that it  
244 appoints, plus one (1) alternate delegate for each additional  
245 five (5) delegates, or major fraction there-of, that it appoints.

246 **G.** Delegations that have one or more seats unfilled during both  
247 House sessions for 3 consecutive years shall have those seats  
248 removed from their delegate allocation. Delegations shall be  
249 notified 60 days prior to the removal of delegate seats and  
250 may petition the Secretary of the House for reappointment of  
251 those seats.

252 **Section 3. Duties and Authority.** The House of Delegates  
253 shall serve as a legislative body in the development of  
254 ASSOCIATION policy. It shall act on such policy  
255 recommendations as shall come before it and shall adopt  
256 rules or procedures for the conduct of its business.

257 **Section 4. Appointment of Delegates.** Affiliated State  
258 Organizations, Recognized National Organizations, and  
259 ASSOCIATION membership organization groups will appoint  
260 the delegates and alternate delegates to which they are entitled.  
261 Delegates and alternate delegates are appointed to serve from  
262 June 1 through May 31 of each year. Delegates representing the  
263 student pharmacist membership organization group shall be  
264 appointed in accordance with procedures and length of terms  
265 established by the student pharmacist membership organization  
266 group. Those delegates unable to attend the regular meeting of  
267 the House of Delegates will be replaced with 30 days' notice  
268 prior to the meeting. Appointing organizations shall notify the  
269 Secretary of the House of Delegates at least thirty (30) days  
270 before the June 1 appointment date of the name and address of  
271 each of its delegates and alternate delegates. The Speaker shall  
272 appoint up to 10 delegates from House committee members  
273 not appointed as delegates from other delegations. All delegates  
274 and alternate delegates other than Delegates Ex Officio shall  
275 serve until their successors have been appointed. Delegates Ex  
276 Officio shall serve for life or, in the case of Trustees serving  
277 as Delegates Ex Officio, until their successors have been duly  
278 appointed or elected and installed.

279 **Section 5. Officers.** The Officers of the House of Delegates  
280 shall be a Speaker, a Speaker-elect, and a Secretary. The  
281 Speaker shall appoint delegates and Committees as provided in  
282 these Bylaws, shall preside at meetings of the House of  
283 Delegates, and shall be responsible for a report of the actions of  
284 the House of Delegates to the members of this ASSOCIATION.  
285 The Speaker-elect shall assist the Speaker in the performance of  
286 the Speaker's duties and/or perform such duties as specified by  
287 the House of Delegates. In the event of a vacancy in the Office  
288 of Speaker, or in the event the Speaker is unable to perform the

289 duties of the office during a meeting of the House of Delegates,  
290 the Speaker-elect shall assume the duties of the Speaker. In the  
291 event of a vacancy in both the Office of Speaker and the Office  
292 of Speaker-elect, or in the event both the Speaker and the  
293 Speaker-elect are unable to perform the duties of the offices  
294 during a meeting of the House of Delegates, the House of  
295 Delegates shall elect a Speaker pro tem, at which time a  
296 Speaker and a Speaker-elect shall be elected. The Secretary of  
297 the House of Delegates shall be responsible for the  
298 administrative functions of the House of Delegates.

299 **Section 6. Elections.** The Speaker-elect shall be elected  
300 during the Annual Meeting of the ASSOCIATION by the House  
301 of Delegates from among a slate of delegates nominated by the  
302 House of Delegates Committee on Nominations and as  
303 otherwise may be provided for in rules or procedures adopted  
304 by the House of Delegates. Speaker-elect elections will be held  
305 every other year. The Speaker-elect shall serve until the end of  
306 the next Annual Meeting of the ASSOCIATION following  
307 election at which time the Speaker-elect shall be installed in the  
308 Office of Speaker. The Speaker shall serve for two years. The  
309 Speaker shall serve until a successor is duly elected and/or  
310 installed. The Executive Vice President of the ASSOCIATION  
311 shall serve as Secretary of the House of Delegates.

312 **Section 7. Meetings.** The House of Delegates shall hold a  
313 regular meeting during the Annual Meeting of this  
314 ASSOCIATION, this regular meeting to consist of such sessions  
315 and to have an order of business as specified in the official  
316 program of the Annual Meeting. The House of Delegates may  
317 hold special meetings at the call of the Speaker with the  
318 approval of the Board of Trustees, or upon written petition of a  
319 majority of authorized delegates. The time and place of special  
320 meetings of the House of Delegates shall be established by the  
321 Speaker with the approval of the Board of Trustees.

322 **Section 8. Quorum.** A majority of the delegates registered at  
323 any regular or special meeting of the House of Delegates shall  
324 constitute a quorum for the transaction of business.

325 **Section 9. Committees.** The House of Delegates shall have  
326 committees as established by the Speaker and the Board of  
327 Trustees. Such Committees shall be appointed by the Speaker  
328 of the House of Delegates. The House of Delegates shall have  
329 the following standing committees:

- 330 Committee on Nominations
- 331 Canvassers Committee
- 332 Policy Committees.

333 Committees shall have such number of members as the Board  
334 of Trustees may establish and shall consider subjects only on  
335 agendas approved by the Board of Trustees. The House of  
336 Delegates Committee on Nominations shall nominate  
337 candidates for Speaker of the House of Delegates in accordance  
338 with such Bylaws, rules, or procedures as the House of  
339 Delegates deems necessary or desirable to facilitate its business.  
340 The House of Delegates Canvassers Committee shall certify the  
341 results of the House of Delegates elections.

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## ARTICLE VII. RECOGNIZED AND AFFILIATED ORGANIZATIONS

342 **Section 1. Recognized National Organizations.** Any  
343 national organization representing pharmacy, the purposes of  
344 which are consistent with the purposes of this ASSOCIATION,  
345 may be designated a Recognized National Organization by the  
346 Board of Trustees. The status of such an organization as a  
347 Recognized National Organization may be terminated by the

348 Board of Trustees.  
349 **Section 2. Affiliated State Organizations.** A State  
350 Organization may be designated as an Affiliated State  
351 Organization by the Board of Trustees in its discretion.

---

## ARTICLE VIII. ORGANIZATION OF MEMBERS

352 **Section 1. Organization.** The Association shall have a  
353 membership organization group representing at least the  
354 following segments of members: pharmacy practitioners,  
355 student pharmacists, and pharmaceutical scientists. Each group  
356 shall have an Executive Committee consisting of a President, a  
357 President-elect, and such additional members as the Board of  
358 Trustees may establish from time to time. Each Executive  
359 Committee shall be elected by the members of the group  
360 pursuant to procedures established by the Board of Trustees.  
361 Section 2. Additional membership organization groups. The  
362 Board may, from time to time, establish additional membership  
363 organization groups reflecting the diverse professional needs of  
364 the membership.  
365 **Section 3. Programming.** Each membership organization  
366 group shall conduct such programs as may be established from  
367 time to time for the benefit of its members, the profession, or  
368 the public. Programs are subject to the approval of the Board of  
369 Trustees. The student pharmacist organization group may  
370 recognize an affiliated student pharmacist chapter at any  
371 ACPE-accredited or American Association of Colleges of  
372 Pharmacy recognized school or college of pharmacy.

---

## ARTICLE IX. MEETINGS

373 **Section 1. Annual Meeting.** This ASSOCIATION shall hold  
374 an Annual Meeting each calendar year at a time and place  
375 established by the Board of Trustees. The Annual Meeting shall  
376 consist of such sessions and shall have an order of business  
377 as specified in the official program for the Annual Meeting.  
378 **Section 2. Special Meetings.** The ASSOCIATION may hold  
379 special meetings at the call of the President with the approval of  
380 the Board of Trustees. The time and place of special meetings  
381 shall be established by the President. The order of business for a  
382 special meeting shall be as specified in the call, notice or agenda  
383 of the special meeting.

---

## ARTICLE X. ELECTIONS

384 **Section 1. Nominations.** Candidates for election as  
385 ASSOCIATION President-elect and Elected Trustees shall be  
386 from among pharmacists in the Member category. A slate of  
387 two (2) candidates shall be nominated for each Elected Trustee  
388 slot and President-Elect.  
389 **Section 2. Nominating Committee.** The Committee on  
390 Nominations shall nominate all candidates for President-elect  
391 and Elected Trustees as provided for in this Article. The  
392 Committee on Nominations shall consist of the most recent  
393 nonincumbent Former President, the immediate former Speaker  
394 of the House of Delegates, and three (3) other members  
395 appointed by the President. No individual shall serve on the  
396 Committee on Nominations in more than three (3) consecutive  
397 calendar years.

398 **Section 3. Election Procedure.** Except as may otherwise be  
399 provided in these Bylaws, the names of candidates for election  
400 and a mail ballot shall be provided all members entitled to vote.  
401 Executed ballots must be received by the date published on the  
402 ballot.  
403 The Committee of Canvassers shall certify the results of all  
404 ASSOCIATION elections, except for elections in the House of  
405 Delegates. The Committee of Canvassers shall meet following a  
406 tally of timely, valid ballots and shall review the election  
407 procedure for compliance with these Bylaws. It shall certify to  
408 the Board of Trustees the results of the election for each  
409 position. The names of candidates elected shall be made public  
410 following certification of the election by the Committee of  
411 Canvassers. Once certified, the results of any election shall not  
412 be subject to challenge.  
413 **Section 4. Time of Election.** Except as may otherwise be  
414 provided in these Bylaws, the ASSOCIATION nomination and  
415 election process shall be conducted pursuant to a schedule  
416 established by the Executive Vice President with the approval of  
417 the Board of Trustees, which will permit candidates elected to  
418 assume office as provided in these Bylaws.  
419 **Section 5. Installation.** Except as may otherwise be provided  
420 in these Bylaws, Officers and Elected Trustees of the  
421 ASSOCIATION and the elected officers of the membership  
422 organization groups shall assume office at the conclusion of  
423 business on the last day of the Annual Meeting of the  
424 ASSOCIATION following the year in which they are elected.  
425 **Section 6. Honorary President.** When nominated by the  
426 Board of Trustees, an Honorary President of the  
427 ASSOCIATION shall be elected pursuant to the election  
428 procedures established in these Bylaws. The Honorary  
429 President shall be a member of the ASSOCIATION, shall have  
430 made significant contributions to the ASSOCIATION, and shall  
431 serve for a one-year term commencing on the first day of the  
432 Annual Meeting following the year in which elected.

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## ARTICLE XI. FINANCES

433 **Section 1. Financial and Investment Policy.** The financial  
434 and investment policy of this ASSOCIATION shall be as  
435 established from time to time by the Board of Trustees with the  
436 advice of the Treasurer, Executive Vice President, and such  
437 other financial advisors as the Board of Trustees may deem  
438 necessary or desirable. Investments shall not be restricted to  
439 those approved by law by the District of Columbia or any other  
440 jurisdiction.  
441 **Section 2. Financial Administration.** The Executive Vice  
442 President, with the approval of the Treasurer, shall be  
443 responsible for the continuing management of the financial  
444 affairs of this ASSOCIATION. The Board of Trustees shall  
445 approve any bank intended to serve as a repository of  
446 ASSOCIATION assets and a public accounting firm that shall be  
447 retained to conduct an annual audit of ASSOCIATION  
448 accounts. All disbursements of ASSOCIATION funds shall be  
449 pursuant to such policies and procedures as may be  
450 established from time to time by the Board of Trustees and  
451 are to be monitored and reviewed on a regular basis by the  
452 Treasurer and the Executive Vice President or by the Executive  
453 Vice President alone.  
454 **Section 3. Bonds.** The Treasurer, the Executive Vice  
455 President, and such other members, employees, or agents of  
456 this ASSOCIATION as the Board of Trustees may direct  
457 shall be bonded for proper care and disposition of

458 ASSOCIATION property in their possession or custody. Such  
459 bonds shall be in amounts and subject to such conditions as  
460 the Board of Trustees shall direct. The expense of such bonds  
461 shall be borne by the ASSOCIATION.  
462 **Section 4. Financial Report.** The Treasurer shall make an  
463 annual financial report to the membership that includes an  
464 audited financial statement for the preceding fiscal year.

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## ARTICLE XII. BOARD OF PHARMACY SPECIALTIES

465 **Section 1. Purposes.** The Board of Pharmacy Specialties shall  
466 exist for the following purposes:

- 467 A. To grant recognition of appropriate pharmacy practice  
468 specialties based on criteria established by the Board of  
469 Pharmacy Specialties.
- 470 B. To establish standards for certification and  
471 recertification  
472 in recognized pharmacy practice specialties.
- 473 C. To grant qualified pharmacists certification and  
474 recertification in recognized pharmacy practice  
475 specialties.
- 476 D. To serve as a coordinating agency and informational  
477 clearinghouse for organizations and pharmacists in  
478 recognized pharmacy practice specialties.

479 **Section 2. Bylaws and Composition.** The Board of  
480 Pharmacy Specialties shall operate under Bylaws (and  
481 subsequent amendments) approved by the ASSOCIATION's  
482 Board of Trustees. The composition of the Board of Pharmacy  
483 Specialties shall be outlined in the approved Bylaws.

484 **Section 3. Finances.** The ASSOCIATION shall act as fiscal  
485 agent for the Board of Pharmacy Specialties in accordance with  
486 procedures established by the ASSOCIATION's Board of  
487 Trustees. The ASSOCIATION shall prepare an annual audited  
488 financial report of Board of Pharmacy Specialties activities.

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## ARTICLE XIII. PARLIAMENTARY AUTHORITY AND PRECEDENCE

489 **Section 1. Parliamentary Authority.** The rules contained in  
490 the current edition of Robert's Rules of Order shall govern this  
491 ASSOCIATION in all cases to which they are applicable. The  
492 Executive Vice President may retain the services of a qualified  
493 parliamentarian for any meeting when such services are deemed  
494 necessary or desirable and shall do so for all deliberative  
495 meetings of the House of Delegates.

496 **Section 2. Precedence.** In any case of conflict between these  
497 Bylaws and any other bylaws, parliamentary authority, or rules  
498 or procedures of any membership organization group, these  
499 Bylaws shall prevail. All such apparent conflicts shall be resolved  
500 by the Board of Trustees whose decision shall be binding on all  
501 interested parties.

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## ARTICLE XIV. AMENDMENTS

502 **Section 1. Bylaws.** Every proposed amendment of these  
503 Bylaws, following the approval of counsel and the Board of  
504 Trustees, shall be submitted with a mail ballot to all members  
505 entitled to vote. Executed ballots must be received by this  
506 ASSOCIATION by the date published on the ballot. A proposed

507 amendment of these Bylaws shall become effective upon  
508 receiving a two-thirds (2/3) affirmative vote certified by the  
509 Committee of Canvassers to the Board of Trustees. Once  
510 certified, the results of any vote on a proposed Bylaw  
511 amendment shall not be subject to challenge.

512 **Section 2. Code of Ethics.** Every proposed amendment of the  
513 Code of Ethics, with the approval of counsel and the Board of  
514 Trustees, shall be submitted with a mail ballot to all members  
515 entitled to vote. Executed ballots must be received by this  
516 ASSOCIATION by the date published on the ballot. A proposed  
517 amendment of the Code of Ethics shall become effective upon  
518 receiving a two-thirds (2/3) affirmative vote certified by the  
519 Committee of Canvassers to the Board of Trustees.

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## ARTICLE XV. NOTICE

520 **Section 1. Previous Notice.** Any previous notice required to  
521 be provided any member of this ASSOCIATION may be given  
522 by printing the notice in a publication regularly provided the  
523 member entitled to notice or by mailing the notice to each  
524 member entitled to notice at the member's mailing address then  
525 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.*

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## **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 to increase 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 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 attached document. The guidelines are a dynamic document and will be periodically reviewed as the health care arena changes. The guidelines were last reviewed in 2012.

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

## American Pharmacists Association

### **Guideline 1 – Prevention – Pharmacists should protect their patients' health by being vaccine advocates.**

- (a) Pharmacists should adopt one of three levels of involvement in vaccine advocacy:
  - (1) Pharmacist as educator (motivating people to be immunized);
  - (2) Pharmacist as facilitator (hosting others who immunize);
  - (3) Pharmacist as immunizer (protecting vulnerable people, consistent with state law).
- (b) Pharmacists should focus their immunization efforts on diseases that are the most significant sources of preventable mortality among the American people, such as influenza, pneumococcal, and hepatitis B infections.
- (c) Pharmacists should routinely determine the immunization status of patients, then refer patients to an appropriate provider for immunization.
- (d) Pharmacists should identify high-risk patients in need of targeted vaccines and develop an appropriate immunization schedule.
- (e) Pharmacists should protect themselves and prevent infection of their patients by being appropriately immunized themselves.

### **Guideline 2 – Partnership – Pharmacists who administer immunizations do so in partnership with their community.**

- (a) Pharmacists should support the immunization advocacy goals and other educational programs of health departments in their city, county, and state.
- (b) Pharmacists should collaborate with community prescribers and health departments.
- (c) Pharmacists should assist their patients in maintaining a medical home, including care such as immunization delivery.
- (d) Pharmacists should consult with and report immunization delivery, as appropriate, to primary-care providers, state immunization registries, and other relevant parties.
- (e) Pharmacists should identify high-risk patients in hospitals and other institutions and assure that appropriate vaccination is considered either before discharge or in discharge planning.
- (f) Pharmacists should identify high-risk patients in nursing homes and other facilities and assure that needed vaccinations are considered either upon admission or in drug regimen reviews.

**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 responses to adverse events and should provide this service only in settings equipped with epinephrine and related supplies.
- (c) Before immunization, pharmacists should question patients and/or their families about contraindications and inform them in specific terms about the risks and benefits of immunization.
- (d) Pharmacists should receive additional education and training on current immunization recommendations, schedules, and techniques at least annually.

**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 report adverse events following immunization to appropriate primary care providers and to the Vaccine Adverse Event Reporting System (VAERS).

**Guideline 5 – Empowerment – Pharmacists should educate patients about immunizations and respect patients’ rights.**

- (a) Pharmacists should encourage appropriate vaccine use through information campaigns for health care practitioners, employers, and the public about the benefits of immunizations.
- (b) Pharmacists should educate patients and their families about immunization in readily understood terms.
- (c) Before immunizing, pharmacists should document any patient education provided and informed consent obtained, consistent with state law.

**References**

CDC. Standards for pediatric immunization practices. *MMWR*. 1993;42 (RR-5): 1-13.  
National Coalition for Adult Immunization. Bethesda,MD: *NCAI* 1995.

Approved by the APhA Board of Trustees, August 1997. Reviewed in 2012.



# 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 1912-2018

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	Joseph T. Mattingly	T.E. Menighan

## 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



