AGENDA
Florida Board of Pharmacy
Legislative Committee Meeting
April 2, 2018 – 1:00 p.m.
Residence Inn Tallahassee Universities at the Capitol,
600 West Gaines Street, Tallahassee, Florida 32304, 850-329-9080

Committee Members:
Jeenu Philip, BPharm – Chair
Jonathan Hickman, PharmD
Mark Mikhael, Pharm D
David Wright, BPharm

Board Staff
C. Erica White, MBA, JD - Executive Director
Savada Knight, Regulatory Supervisor

Board Counsel:
David Flynn, Assistant Attorney General
Lawrence Harris, Assistant Attorney General

Note: Participants in this public meeting should be aware that these proceedings are being recorded.

1. Review of Bills from the 2018 Legislative Session (spreadsheet) – (pg.2)
   - HB 21 (pg. 10)
   - HB 675 (pg. 215)

2. Advanced Practice Technician Discussion

3. Old Business / New Business

4. Public Comment

5. Adjourn
TAB #1
## Bills Filed for the 2018 Session for Chapter 465
(last updated March 16, 2018)

<table>
<thead>
<tr>
<th>Bill Number</th>
<th>Companion Bills</th>
<th>Bill Title</th>
<th>Chapters</th>
<th>Summary from Online Sunshine</th>
<th>Notes</th>
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<tbody>
<tr>
<td>CS/SB 8</td>
<td>CS/HB 21</td>
<td>Controlled Substances</td>
<td>456.0301</td>
<td>Controlled Substances; Prohibiting managed care plans and their fiscal agents or intermediaries from imposing certain requirements or conditions on recipients as a prerequisite to receiving medication-assisted treatment (MAT) services to treat substance abuse disorders; authorizing certain boards to require practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial license renewal; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; prohibiting the dispensing of certain controlled substances in an amount that exceeds a 3-day supply or a medically necessary 7-day supply if certain criteria are met, etc. APPROPRIATION: $53,555,360.00 <a href="http://www.flsenate.gov/Session/Bill/2018/00008">http://www.flsenate.gov/Session/Bill/2018/00008</a></td>
<td>03/07/18 - Senate Laid on Table, refer to CS/CS/HB 21</td>
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<td>CS/SB 8</td>
<td>Controlled Substances</td>
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<td>CS/HB 21</td>
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<td>Controlled Substances</td>
<td>456.0301</td>
<td>Controlled Substances; Requires practitioners to complete specified board-approved continuing education course to prescribe controlled substances; defines &quot;acute pain&quot;; provides for adoption of standards of practice for treatment of acute pain; limits prescribing of opioids for acute pain in certain circumstances; requires pain management clinic owners to register approved exemptions with DOH; provides requirements for pharmacists &amp; practitioners for dispensing of controlled substances to persons not known to them; conforms state controlled substances schedule to federal controlled substances schedule; revises &amp; provides definitions; revises requirements for prescription drug monitoring program. <a href="http://www.flsenate.gov/Session/Bill/2018/00021">http://www.flsenate.gov/Session/Bill/2018/00021</a></td>
<td>Signed by Officers and presented to Governor on Wednesday, March 14, 2018</td>
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<td>463.0055 782.04 893.135 921.0022</td>
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<td>CS/HB 431</td>
<td>SB 524</td>
<td>Testing for and Treatment of Influenza and Streptococcus</td>
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<td>Testing for and Treatment of Influenza and Streptococcus; Requires specified licensed pharmacists to report certain information to DOH; authorizes pharmacists to test for &amp; treat influenza &amp; streptococcus; provides requirements with respect thereto; requires that written protocol between pharmacist &amp; supervising physician contain certain information, terms, &amp; conditions; requires that pharmacists provide evidence of current certification by Board of Pharmacy to supervising physician; requires that pharmacists submit their written protocols to board. <a href="http://www.flsenate.gov/Session/Bill/2018/00431">http://www.flsenate.gov/Session/Bill/2018/00431</a></td>
<td>Died in Health &amp; Human Services Committee on Saturday, March 10, 2018.</td>
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<tr>
<td>HB 513</td>
<td>SB 1252</td>
<td>Distributing Pharmaceutical Drugs and Devices</td>
<td>465.027, F.S.</td>
<td>Distributing Pharmaceutical Drugs and Devices; Revises an exception to pharmacy regulations for certain manufacturers &amp; distributors of dialysis drugs or supplies.</td>
<td>Signed by Officers and presented to Governor on Wednesday, March 14, 2018.</td>
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<td>SB 524</td>
<td>CS/HB 431</td>
<td>Influenza Virus and Streptococcal Infections</td>
<td>465.003, F.S. 465.004, F.S. 469.019, F.S. 465.0252, F.S. 499.003, F.S.</td>
<td>Influenza Virus and Streptococcal Infections; Requiring a pharmacist testing for and treating the influenza virus and streptococcal infections to maintain patient records using certain standards and for a specified time; requiring a pharmacist seeking to test for and treat the influenza virus and streptococcal infections to obtain certification through a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine, etc.</td>
<td>Died in Health Policy on Saturday, March 10, 2018</td>
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<td>SB 534</td>
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<td>Regulation of Pharmacy Benefits Managers</td>
<td>465.003, F.S. 465.004, F.S. 469.019, F.S. 465.0252, F.S. 499.003, F.S.</td>
<td>Regulation of Pharmacy Benefits Managers; Redefining the term “administrator” to include pharmacy benefits managers, etc.</td>
<td>Died in Health Policy on Saturday, March 10, 2018</td>
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<tr>
<td>HB 675</td>
<td>SB 1128</td>
<td>Pharmacies</td>
<td>465.003, F.S. 465.004, F.S. 469.019, F.S. 465.0252, F.S. 499.003, F.S.</td>
<td>Pharmacies; <strong>Revises membership of Board of Pharmacy;</strong> establishes Class III institutional pharmacies; provides requirements for such pharmacies; revises notice requirements; authorizes distribution of medicinal drugs &amp; prepackaged drug products without specified permit under certain conditions;</td>
<td>Ordered enrolled on Friday, March 09, 2018</td>
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<td>499.01, F.S.</td>
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<td>Telepharmacy</td>
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<td>removes provision exempting certain drug re-packagers from specified permit requirements.</td>
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<td>CS/CS/HB 679</td>
<td>SB 848</td>
<td>Telepharmacy</td>
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<td>Telepharmacy; Authorizes registered pharmacy technicians to dispense drugs under certain circumstances; provides permit requirements for remote dispensing site pharmacies; provides requirements &amp; prohibitions for remote dispensing site pharmacies; requires the prescription department manager to visit the remote dispensing site pharmacy; requires work experience for registered pharmacy techs; prohibits registered pharmacy techs to perform certain compounding; authorizes Florida licensed pharmacists to be the prescription drug manager at more than one remote dispensing site pharmacy.</td>
<td>Died on Second Reading Calendar on Saturday, March 10, 2018</td>
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<tr>
<td>CS/HB 689</td>
<td>SB 914</td>
<td>Pharmacy</td>
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<td>Pharmacy; Provides licensure requirements for &amp; revising responsibilities of consultant pharmacists.</td>
<td>Died in Health Policy on Saturday, March 10, 2018</td>
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<td>CS/SB 848</td>
<td>CS/HB 679</td>
<td>Remote Dispensing Site Pharmacies</td>
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<td>Remote Dispensing Site Pharmacies; Redefining the term “pharmacy” to include remote dispensing site pharmacies; providing that an offsite pharmacist who supervises a registered pharmacy technician at a remote dispensing site is not considered to be not present or off duty; providing permit requirements for remote dispensing site pharmacies, etc.</td>
<td>Died in Messages on Saturday, March 10, 2018</td>
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<td>SB 914</td>
<td>CS/HB 689</td>
<td>Practice of Pharmacy</td>
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<td>Practice of Pharmacy; Requiring a pharmacist seeking licensure as a consultant pharmacist to complete additional training as required by the Board of Pharmacy; authorizing a pharmacist who is certified to administer vaccines to adults to perform specified services under certain conditions, etc.</td>
<td>Died in Health Policy on Saturday, March 10, 2018</td>
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<td>HB 1047</td>
<td>SB 1486</td>
<td>Department of Health</td>
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<td>Department of Health; Revises and provides provisions relating to DOH, including licensure, registration, inspection, discipline, permits, adverse incidents, education requirements; Repeals provisions related to registration, registration certificates; change of ownership or address, advertising, information, periodic inspections, &amp; equipment &amp; supplies; suspension &amp; revocation &amp; administrative fines, rules, violations, qualifications for licensure as massage therapist.</td>
<td>Died on Second Reading Calendar on Saturday, March 10, 2018</td>
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<td>CS/HB 1099</td>
<td>SB 1564</td>
<td>Advanced Birth Centers</td>
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<td>Advanced Birth Centers; Provides for issuance, renewal, denial, and revocation of licenses to establish advanced birth center by AHCA; provides penalty for operating without a license.</td>
<td>Died in Health &amp; Human Services Committee on Saturday, March 10, 2018</td>
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<td>SB 1128</td>
<td>HB 675</td>
<td>Pharmacy</td>
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<td>Pharmacy; Revising the membership of the Board of Pharmacy; establishing Class III institutional pharmacies; authorizing such pharmacies to dispense, compound, and fill prescriptions, prepare prepackaged drug products, and conduct other pharmaceutical services between certain entities under common control; providing that a prescription drug re-packager permit and a restricted prescription drug distributor permit are not required for the distribution of medicinal drugs or prepackaged drug products between entities under common control under certain circumstances, etc.</td>
<td>Senate Laid on Table, refer to CS/HB 675.</td>
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<td>CS/SB 1252</td>
<td>HB 513</td>
<td>Distributing Pharmaceutical Drugs and Devices</td>
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<td>Home Renal Dialysis; Revising conditions under which manufacturers, or agents thereof, who distribute home dialysis supplies are exempt from the requirements of the Florida Pharmacy Act, etc.</td>
<td>03/06/18 -Senate Laid on Table, refer to HB 513.</td>
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<td>SB 1486</td>
<td>CS/HB 1047</td>
<td>Department of Health</td>
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<td>Department of Health; Requiring the Department of Health to adopt rules to implement a federal program to further encourage qualified physicians to relocate to and practice in underserved areas; revising health care practitioner licensure eligibility requirements for certain members of the armed forces and their spouses; requiring certain pharmacies and outsourcing facilities</td>
<td>Senate Died in Rules on Saturday, March 10, 2018.</td>
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<td>SB 1564</td>
<td>CS/HB 1099</td>
<td>Advanced Birth Centers</td>
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<td>located in this state to obtain a permit in order to create, ship, mail, deliver, or dispense compounded sterile products; revising qualifications for licensure as a massage therapist, etc.</td>
<td><a href="http://www.fl">http://www.fl</a> senate.gov/Session/Bill/2018/01486</td>
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<td>Senate - Withdrawn from further consideration</td>
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An act relating to controlled substances; creating s. 456.0301, F.S.; requiring certain boards to require certain registered practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial license renewal and before a specified date; providing course requirements; providing that the course may be offered in a distance learning format and requiring that it be included within required continuing education hours; prohibiting the Department of Health from renewing the license of a prescriber under specified circumstances; specifying a deadline for course completion; providing an exception from the course requirements for certain licensees; requiring such licensees to submit confirmation of course completion; authorizing certain boards to adopt rules; amending s. 456.072, F.S.; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; amending s. 456.44, F.S.; defining the term "acute pain"; requiring the applicable boards to adopt rules establishing certain guidelines for prescribing controlled substances for acute pain; providing that the failure of a prescriber...
to follow specified guidelines is grounds for disciplinary action; limiting opioid drug prescriptions for the treatment of acute pain to a specified period under certain circumstances; authorizing such prescriptions for an extended period if specified requirements are met; requiring a prescriber who prescribes an opioid drug for the treatment of pain other than acute pain to include a specific indication on the prescription; requiring a prescriber who prescribes an opioid drug for the treatment of pain related to a traumatic injury with a specified Injury Severity Score to concurrently prescribe an emergency opioid antagonist; amending ss. 458.3265 and 459.0137, F.S.; requiring pain management clinics to register with the department or hold a valid certificate of exemption; requiring certain clinics to apply to the department for a certificate of exemption; providing requirements for such certificates; requiring the department to adopt rules necessary to administer such exemptions; amending s. 465.0155, F.S.; providing requirements for pharmacists for the dispensing of controlled substances to persons not known to them; defining the term "proper identification"; amending s. 465.0276, F.S.; prohibiting the dispensing of certain controlled
substances in an amount that exceeds a 3-day supply
unless certain criteria are met; providing an
exception for the dispensing of certain controlled
substances by a practitioner to the practitioner's own
patients for the medication-assisted treatment of
opiate addiction; providing requirements for
practitioners for the dispensing of controlled
substances to persons not known to them; defining the
term "proper identification"; amending s. 893.03,
F.S.; correcting a cross-reference; conforming the
state controlled substances schedule to the federal
controlled substances schedule; amending s. 893.04,
F.S.; authorizing a pharmacist to dispense controlled
substances upon receipt of an electronic prescription
if certain conditions are met; amending s. 893.055,
F.S.; revising and providing definitions; revising
requirements for the prescription drug monitoring
program; authorizing rulemaking; requiring dispensers
to report information to the department for each
controlled substance dispensed; providing
applicability; requiring the department to maintain an
electronic system for certain purposes which meets
specified requirements; requiring certain information
to be reported to the system by a specified time;
specifying direct access to system information;
authorizing the department to enter into reciprocal agreements or contracts to share prescription drug monitoring information with certain entities; providing requirements for such agreements; authorizing the department to enter into agreements or contracts for secure connections with practitioner electronic systems; requiring specified persons to consult the system for certain purposes within a specified time; providing exceptions to the duty of specified persons to consult the system under certain circumstances; requiring the department to issue citations to prescribers or dispensers who fail to meet specified requirements relating to consulting the system; providing a system for discipline of specified persons for failing to meet such requirements; prohibiting a person from failing to report the dispensing of a controlled substance when required to do so; specifying penalties; authorizing the department to enter into agreements or contracts for specified purposes; providing for the release of information obtained by the system; allowing specified persons to have direct access to information for the purpose of reviewing the controlled drug prescription history of a patient; providing prescriber or dispenser immunity from liability for review of
patient history when acting in good faith; providing construction; prohibiting the department from specified uses of funds; requiring the department to conduct or participate in studies for specified purposes; requiring an annual report to be submitted to the Governor and Legislature by a specified date; providing report requirements; authorizing the department to establish a certain direct-support organization for specified purposes; defining the term "direct-support organization"; requiring a direct-support organization to operate under written contract with the department; providing contract requirements; requiring the direct-support organization to obtain written approval from the department for specified purposes; providing for an independent annual financial audit by the direct-support organization; providing that copies of such audit be provided to specified entities; authorizing the department to adopt certain rules relating to resources used by the direct-support organization; providing for future repeal of provisions relating to the direct-support organization; requiring the department to adopt rules to implement the system; amending s. 893.0551, F.S.; revising provisions concerning the release of information held by the prescription drug monitoring program;
program; amending s. 893.13, F.S.; correcting cross-references; increasing the severity of a felony for a
health care practitioner who provides or a person who obtains certain controlled substances that are not medically necessary under certain circumstances;
amending s. 893.147, F.S.; prohibiting any person from possessing, purchasing, delivering, selling, or possessing with intent to sell or deliver a tableting machine, an encapsulating machine, or controlled substance counterfeiting materials with knowledge, intent, or reasonable cause to believe that it will be used to manufacture a controlled substance or counterfeit controlled substance; providing an exception for persons who meet certain criteria; defining terms; providing criminal penalties for persons who violate specified provisions relating to tableting machines, encapsulating machines, and controlled substance counterfeiting materials;
amending ss. 458.331, 459.015, 463.0055, 782.04, 893.135, and 921.0022, F.S.; correcting cross-references; conforming provisions to changes made by the act; providing appropriations; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:
Section 1. Section 456.0301, Florida Statutes, is created to read:

456.0301 Requirement for instruction on controlled substance prescribing.—

(1)(a) The appropriate board shall require each person registered with the United States Drug Enforcement Administration and authorized to prescribe controlled substances pursuant to 21 U.S.C. s. 822 to complete a board-approved 2-hour continuing education course on prescribing controlled substances offered by a statewide professional association of physicians in this state that is accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 Credit or the American Osteopathic Category 1-A continuing medical education credit as part of biennial license renewal. The course must include information on the current standards for prescribing controlled substances, particularly opiates; alternatives to these standards; nonpharmacological therapies; prescribing emergency opioid antagonists; and the risks of opioid addiction following all stages of treatment in the management of acute pain. The course may be offered in a distance learning format and must be included within the number of continuing education hours required by law. The department may not renew the license of any prescriber registered with the United States Drug Enforcement Administration.
Administration to prescribe controlled substances who has failed to complete the course. The course must be completed by January 31, 2019, and at each subsequent renewal. This paragraph does not apply to a licensee who is required by his or her applicable practice act to complete a minimum of 2 hours of continuing education on the safe and effective prescribing of controlled substances.

(b) Each practitioner required to complete the course required in paragraph (a) shall submit confirmation of having completed such course when applying for biennial license renewal.

(c) Each licensing board that requires a licensee to complete an educational course pursuant to this subsection must include the hours required for completion of the course in the total hours of continuing education required by law for such profession unless the continuing education requirements for such profession consist of fewer than 30 hours biennially.

(2) Each board may adopt rules to administer this section.

Section 2. Paragraph (gg) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(gg) Engaging in a pattern of practice when prescribing
medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter or ss. 893.055 and 893.0551, a violation of the applicable practice act, or a violation of any rules adopted under this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

Section 3. Paragraphs (a) through (g) of subsection (1) of section 456.44, Florida Statutes, are redesignated as paragraphs (b) through (h), respectively, a new paragraph (a) is added to that subsection, subsection (3) of that section is amended, and subsections (4), (5), and (6) are added to that section, to read:

456.44 Controlled substance prescribing.—
(1) DEFINITIONS.—As used in this section, the term:
(a) "Acute pain" means the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness. The term does not include pain related to:
2. A terminal condition. For purposes of this subparagraph, the term "terminal condition" means a progressive disease or medical or surgical condition that causes significant...
3. Palliative care to provide relief of symptoms related to an incurable, progressive illness or injury.

4. A traumatic injury with an Injury Severity Score of 9 or greater.

(3) STANDARDS OF PRACTICE FOR TREATMENT OF CHRONIC NONMALIGNANT PAIN.—The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical
indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient is incompetent. The registrant shall use a written controlled
substance agreement between the registrant and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant unless otherwise authorized by the treating registrant and documented in the medical record.

(d) The patient shall be seen by the registrant at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant shall reevaluate the appropriateness of continued treatment. The registrant shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.
(e) The registrant shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or a psychiatrist.

(f) A registrant must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.
2. Diagnostic, therapeutic, and laboratory results.
3. Evaluations and consultations.
4. Treatment objectives.
5. Discussion of risks and benefits.
6. Treatments.
7. Medications, including date, type, dosage, and quantity prescribed.
8. Instructions and agreements.
9. Periodic reviews.

10. Results of any drug testing.


12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant's full name presented in a legible manner.

(g) A registrant shall immediately refer patients with signs or symptoms of substance abuse to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of
controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

(4) STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The applicable boards shall adopt rules establishing guidelines for
prescribing controlled substances for acute pain, including
evaluation of the patient, creation and maintenance of a
treatment plan, obtaining informed consent and agreement for
treatment, periodic review of the treatment plan, consultation,
medical record review, and compliance with controlled substance
laws and regulations. Failure of a prescriber to follow such
guidelines constitutes grounds for disciplinary action pursuant
to s. 456.072(1)(gg), punishable as provided in s. 456.072(2).

(5) PRESCRIPTION SUPPLY.—
   (a) For the treatment of acute pain, a prescription for an
opioid drug listed as a Schedule II controlled substance in s.
893.03 or 21 U.S.C. s. 812 may not exceed a 3-day supply, except
that up to a 7-day supply may be prescribed if:
   1. The prescriber, in his or her professional judgment,
believes that more than a 3-day supply of such an opioid is
medically necessary to treat the patient's pain as an acute
medical condition;
   2. The prescriber indicates "ACUTE PAIN EXCEPTION" on the
prescription; and
   3. The prescriber adequately documents in the patient's
medical records the acute medical condition and lack of
alternative treatment options that justify deviation from the 3-
day supply limit established in this subsection.
   (b) For the treatment of pain other than acute pain, a
prescriber must indicate "NONACUTE PAIN" on a prescription for
an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812.

(6) EMERGENCY OPIOID ANTAGONIST.—For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II controlled substance listed in s. 893.03 or 21 U.S.C. s. 812 must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1).

Section 4. Effective January 1, 2019, present subsections (2) through (5) of section 458.3265, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3), and paragraph (a) of present subsection (4) of that section are amended, and a new subsection (2) is added to that section, to read:

458.3265 Pain-management clinics.—

(1) REGISTRATION.—

(a)1. As used in this section, the term:

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.
b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

   (I) That advertises in any medium for any type of pain-management services; or

   (II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2).

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m) and must apply to the department for a certificate of exemption unless:

   a. A clinic is licensed as a facility pursuant to chapter 395;

   b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

   c. The clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the
corporation's most recent fiscal quarter exceeded $50 million;

d. A The clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A The clinic that does not prescribe controlled substances for the treatment of pain;

f. A The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A The clinic is wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A The clinic is wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location.
based upon an annual inspection and evaluation of the factors described in subsection (4) (3).

(2) CERTIFICATE OF EXEMPTION.—

(a) A pain management clinic claiming an exemption from the registration requirements of subsection (1) must apply for a certificate of exemption on a form adopted in rule by the department. The form must require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) The department must approve or deny the certificate within 30 days after the receipt of a complete application.

(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A new certificate of exemption is required for a
change of address and is not transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at least 60 days before any anticipated relocation or name change of the pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must notify the department within 3 days after becoming aware that the clinic no longer qualifies for a certificate of exemption and register as a pain management clinic under subsection (1) or cease operations.

(3)(2) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(a) A physician may not practice medicine in a pain-management clinic, as described in subsection (5) (4), if the pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as
long as the physician continues to meet the qualifications set forth in the board rules. A physician who violates this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4) INSPECTION.—
(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the Board of Medicine adopted pursuant to subsection (5) unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Medicine.

(5) RULEMAKING.—
(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.

Section 5. Effective January 1, 2019, present subsections (2) through (5) of section 459.0137, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3), and paragraph (a) of present subsection (4) of that section are amended, and a new subsection (2) is added to that section, to read:

459.0137  Pain-management clinics.
(1) REGISTRATION.—
(a) 1. As used in this section, the term:
   a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.
   b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.
   c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:
      (I) That advertises in any medium for any type of pain-management services; or
      (II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.
   2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2).
   3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m) and must apply to the department for a certificate of exemption unless:
a. A clinic is licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A clinic is owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A clinic is affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A clinic does not prescribe controlled substances for the treatment of pain;

f. A clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A clinic is wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A clinic is wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or who are also board-certified
in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location based upon an annual inspection and evaluation of the factors described in subsection (4) (3).

(2) CERTIFICATE OF EXEMPTION.—

(a) A pain management clinic claiming an exemption from the registration requirements of subsection (1) must apply for a certificate of exemption on a form adopted in rule by the department. The form must require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) The department must approve or deny the certificate within 30 days after the receipt of a complete application.
(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A new certificate of exemption is required for a change of address and is not transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at least 60 days before any anticipated relocation or name change of the pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must notify the department within 3 days after becoming aware that the clinic no longer qualifies for a certificate of exemption and register as a pain management clinic under subsection (1) or cease operations.

(3) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be
registered in subsection (1).

(a) An osteopathic physician may not practice medicine in a pain-management clinic, as described in subsection (5) (4), if the pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Osteopathic Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as long as the physician continues to meet the qualifications set forth in the board rules. An osteopathic physician who violates this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4) (3) INSPECTION.—

(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the Board of Osteopathic Medicine adopted pursuant to subsection (5) (4) unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Osteopathic Medicine.

(5) (4) RULEMAKING.—

(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.
Section 6. Section 465.0155, Florida Statutes, is amended to read:

465.0155 Standards of practice.—

(1) Consistent with the provisions of this act, the board shall adopt by rule standards of practice relating to the practice of pharmacy which shall be binding on every state agency and shall be applied by such agencies when enforcing or implementing any authority granted by any applicable statute, rule, or regulation, whether federal or state.

(2)(a) Before dispensing a controlled substance to a person not known to the pharmacist, the pharmacist must require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the pharmacist may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

(b) This subsection does not apply in an institutional setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which patients are admitted.

(c) As used in this subsection, the term "proper
identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 7. Paragraph (b) of subsection (1) of section 465.0276, Florida Statutes, is amended, and paragraph (d) is added to subsection (2) of that section, to read:

465.0276 Dispensing practitioner.—

(1)

(b) A practitioner registered under this section may not dispense a controlled substance listed in Schedule II or Schedule III as provided in s. 893.03. This paragraph does not apply to:

1. The dispensing of complimentary packages of medicinal drugs which are labeled as a drug sample or complimentary drug as defined in s. 499.028 to the practitioner's own patients in the regular course of her or his practice without the payment of a fee or remuneration of any kind, whether direct or indirect, as provided in subsection (4).

2. The dispensing of controlled substances in the health care system of the Department of Corrections.

3. The dispensing of a controlled substance listed in Schedule II or Schedule III in connection with the performance of a surgical procedure.

   a. For an opioid drug listed as a Schedule II controlled
substance in s. 893.03 or 21 U.S.C. s. 812:

(I) For the treatment of acute pain, the amount dispensed pursuant to this subparagraph may not exceed a 3-day supply, or a 7-day supply if the criteria in s. 456.44(5)(a) are met.

(II) For the treatment of pain other than acute pain, a practitioner must indicate "NONACUTE PAIN" on a prescription.

(III) For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a practitioner must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1).

b. For a controlled substance listed in Schedule III, the amount dispensed pursuant to this subparagraph may not exceed a 14-day supply.

c. The exception in this subparagraph does not allow for the dispensing of a controlled substance listed in Schedule II or Schedule III more than 14 days after the performance of the surgical procedure.

d. For purposes of this subparagraph, the term "surgical procedure" means any procedure in any setting which involves, or reasonably should involve:

(I) Perioperative medication and sedation that allows the patient to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal or tactile stimulation and makes intra- and postoperative monitoring necessary; or
(II)  The use of general anesthesia or major conduction anesthesia and preoperative sedation.

4. The dispensing of a controlled substance listed in Schedule II or Schedule III pursuant to an approved clinical trial. For purposes of this subparagraph, the term "approved clinical trial" means a clinical research study or clinical investigation that, in whole or in part, is state or federally funded or is conducted under an investigational new drug application that is reviewed by the United States Food and Drug Administration.

5. The dispensing of methadone in a facility licensed under s. 397.427 where medication-assisted treatment for opiate addiction is provided.

6. The dispensing of a controlled substance listed in Schedule II or Schedule III to a patient of a facility licensed under part IV of chapter 400.

7. The dispensing of controlled substances listed in Schedule II or Schedule III which have been approved by the United States Food and Drug Administration for the purpose of treating opiate addictions, including, but not limited to, buprenorphine and buprenorphine combination products, by a practitioner authorized under 21 U.S.C. s. 823, as amended, to the practitioner's own patients for the medication-assisted treatment of opiate addiction.

(2) A practitioner who dispenses medicinal drugs for human
consumption for fee or remuneration of any kind, whether direct or indirect, must:

(d)1. Before dispensing a controlled substance to a person not known to the dispenser, require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the dispenser may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

2. This paragraph does not apply in an institutional setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which patients are admitted.

3. As used in this paragraph, the term "proper identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 8. Paragraph (c) of subsection (1) and subsections (2) through (5) of section 893.03, Florida Statutes, are amended to read:

893.03 Standards and schedules.—The substances enumerated
in this section are controlled by this chapter. The controlled substances listed or to be listed in Schedules I, II, III, IV, and V are included by whatever official, common, usual, chemical, trade name, or class designated. The provisions of this section shall not be construed to include within any of the schedules contained in this section any excluded drugs listed within the purview of 21 C.F.R. s. 1308.22, styled "Excluded Substances"; 21 C.F.R. s. 1308.24, styled "Exempt Chemical Preparations"; 21 C.F.R. s. 1308.32, styled "Exempted Prescription Products"; or 21 C.F.R. s. 1308.34, styled "Exempt Anabolic Steroid Products."

(1) SCHEDULE I.—A substance in Schedule I has a high potential for abuse and has no currently accepted medical use in treatment in the United States and in its use under medical supervision does not meet accepted safety standards. The following substances are controlled in Schedule I:

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation that contains any quantity of the following hallucinogenic substances or that contains any of their salts, isomers, including optical, positional, or geometric isomers, homologues, nitrogen-heterocyclic analogs, esters, ethers, and salts of isomers, homologues, nitrogen-heterocyclic analogs, esters, or ethers, if the existence of such salts, isomers, and salts of isomers is possible within the specific chemical
designations or class description:

1. Alpha-Ethyltryptamine.
2. 4-Methylaminorex (2-Amino-4-methyl-5-phenyl-2-oxazoline).
4. DOB (4-Bromo-2,5-dimethoxyamphetamine).
5. 2C-B (4-Bromo-2,5-dimethoxyphenethylamine).
7. Cannabis.
8. Cathinone.
9. DET (Diethyltryptamine).
10. 2,5-Dimethoxyamphetamine.
11. DOET (4-Ethyl-2,5-Dimethoxyamphetamine).
12. DMT (Dimethyltryptamine).
14. JB-318 (N-Ethyl-3-piperidyl benzilate).
15. N-Ethylamphetamine.
16. Fenethylline.
17. 3,4-Methylenedioxy-N-hydroxyamphetamine.
18. Ibogaine.
19. LSD (Lysergic acid diethylamide).
20. Mescaline.
22. 5-Methoxy-3,4-methylenedioxyamphetamine.
23. PMA (4-Methoxyamphetamine).
24. PMMA (4-Methoxymethamphetamine).
25. DOM (4-Methyl-2,5-dimethoxyamphetamine).
26. MDEA (3,4-Methylenedioxy-N-ethylamphetamine).
27. MDA (3,4-Methylenedioxyamphetamine).
28. JB-336 (N-Methyl-3-piperidyl benzilate).
29. N,N-Dimethylamphetamine.
30. Parahezyl.
31. Peyote.
32. PCPY (N-(1-Phenylcyclohexyl)-pyrrolidine) (Pyrrolidine analog of phencyclidine).
33. Psilocybin.
34. Psilocyn.
35. Salvia divinorum, except for any drug product approved by the United States Food and Drug Administration which contains Salvia divinorum or its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, if the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation.
36. Salvinorin A, except for any drug product approved by the United States Food and Drug Administration which contains Salvinorin A or its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, if the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation.
876  37. Xylazine.
877  38. TCP (1-[1-(2-Thienyl)-cyclohexyl]-piperidine)
878 (Thiophene analog of phencyclidine).
879  39. 3,4,5-Trimethoxyamphetamine.
880  40. Methylone (3,4-Methylenedioxymethcathinone).
881  41. MDPV (3,4-Methylenedioxypyrovalerone).
882  42. Methylenecathinone.
883  43. Methoxymethcathinone.
884  44. Fluoromethcathinone.
885  45. Methylmethcathinone.
886  46. CP 47,497 (2-(3-Hydroxycyclohexyl)-5-(2-methyloctan-2-
887 yl)phenol) and its dimethyloctyl (C8) homologue.
888  47. HU-210 [(6aR,10aR)-9-(Hydroxymethyl)-6,6-dimethyl-3-
889 (2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-
890 ol].
891  48. JWH-018 (1-Pentyl-3-(1-naphthoyl)indole).
892  49. JWH-073 (1-Butyl-3-(1-naphthoyl)indole).
893  50. JWH-200 (1-[2-(4-Morpholinyl)ethyl]-3-(1-
894 naphthoyl)indole).
895  51. BZP (Benzylpiperazine).
896  52. Fluorophenylpiperazine.
897  53. Methylphenylpiperazine.
898  54. Chlorophenylpiperazine.
899  55. Methoxyphenylpiperazine.
900  56. DBZP (1,4-Dibenzylpiperazine).
57. TFMPP (Trifluoromethylphenylpiperazine).
58. MBDB (Methylbenzodioxolylbutanamine) or (3,4-Methylenedioxo-N-methylbutanamine).
59. 5-Hydroxy-AMT (5-Hydroxy-alpha-methyltryptamine).
60. 5-Hydroxy-N-methyltryptamine.
61. 5-MeO-MiPT (5-Methoxy-N-methyl-N-isopropyltryptamine).
62. 5-MeO-AMT (5-Methoxy-alpha-methyltryptamine).
63. Methyltryptamine.
64. 5-MeO-DMT (5-Methoxy-N,N-dimethyltryptamine).
65. 5-Me-DMT (5-Methyl-N,N-dimethyltryptamine).
66. Tyramine (4-Hydroxyphenethylamine).
67. 5-MeO-DiPT (5-Methoxy-N,N-Diisopropyltryptamine).
68. DiPT (N,N-Diisopropyltryptamine).
69. DPT (N,N-Dipropyltryptamine).
70. 4-Hydroxy-DiPT (4-Hydroxy-N,N-diisopropyltryptamine).
71. 5-MeO-DALT (5-Methoxy-N,N-Diallyltryptamine).
72. DOI (4-Iodo-2,5-dimethoxyamphetamine).
73. DOC (4-Chloro-2,5-dimethoxyamphetamine).
74. 2C-E (4-Ethyl-2,5-dimethoxyphenethylamine).
75. 2C-T-4 (4-Isopropylthio-2,5-dimethoxyphenethylamine).
76. 2C-C (4-Chloro-2,5-dimethoxyphenethylamine).
77. 2C-T (4-Methylthio-2,5-dimethoxyphenethylamine).
78. 2C-T-2 (4-Ethylthio-2,5-dimethoxyphenethylamine).
79. 2C-T-7 (4-(n)-Propylthio-2,5-dimethoxyphenethylamine).
80. 2C-I (4-Iodo-2,5-dimethoxyphenethylamine).
81. Butylone (3,4-Methylenedioxy-alpha-methylaminobutyrophenone).
82. Ethcathinone.
83. Ethylone (3,4-Methylenedioxy-N-ethylcathinone).
84. Naphyrone (Naphthylpyrovalerone).
85. Dimethyline (3,4-Methylenedioxy-N,N-dimethylcathinone).
86. 3,4-Methylenedioxy-N,N-diethylcathinone.
87. 3,4-Methylenedioxy-propiophenone.
88. 3,4-Methylenedioxy-alpha-bromopropiophenone.
89. 3,4-Methylenedioxy-propiophenone-2-oxime.
90. 3,4-Methylenedioxy-N-acetylcathinone.
91. 3,4-Methylenedioxy-N-acetylmethcathinone.
92. 3,4-Methylenedioxy-N-acetylethylenechathinone.
93. Bromomethcathinone.
95. Eutylone (3,4-Methylenedioxy-alpha-ethylaminobutyrophenone).
96. Dimethylcathinone.
97. Dimethylmethcathinone.
98. Pentyline (3,4-Methylenedioxy-alpha-methylaminovalerophenone).
99. MDPBP (3,4-Methylenedioxy-alpha-pyrrolidinopropiophenone).
100. MDPBP (3,4-Methylenedioxy-alpha-
pyrrolidinobutyrophenone).

101. MOPPP (Methoxy-alpha-pyrrolidinopropiophenone).

102. MPHP (Methyl-alpha-pyrrolidinoheptanophenone).

103. BTCP (Benzothiophenylcyclohexylpiperidine) or BCP (Benocyclidine).

104. F-MABP (Fluoromethylaminobutyrophenone).

105. MeO-PBP (Methoxypyrrolidinobutyrophenone).

106. Et-PBP (Ethylpyrrolidinobutyrophenone).

107. 3-Me-4-MeO-MCAT (3-Methyl-4-Methoxymethcathinone).

108. Me-EABP (Methylethylaminobutyrophenone).


110. PPP (Pyrrolidinopropiophenone).

111. PBP (Pyrrolidinobutyrophenone).

112. PVP (Pyrrolidinovalerophenone) or (Pyrrolidinopentiophenone).

113. MPPP (Methyl-alpha-pyrrolidinopropiophenone).

114. JWH-007 (1-Pentyl-2-methyl-3-(1-naphthoyl)indole).

115. JWH-015 (1-Propyl-2-methyl-3-(1-naphthoyl)indole).

116. JWH-019 (1-Hexyl-3-(1-naphthoyl)indole).

117. JWH-020 (1-Heptyl-3-(1-naphthoyl)indole).

118. JWH-072 (1-Propyl-3-(1-naphthoyl)indole).

119. JWH-081 (1-Pentyl-3-(4-methoxy-1-naphthoyl)indole).

120. JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl)indole).

121. JWH-133 ((6aR,10aR)-6,6,9-Trimethyl-3-(2-methylpentan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).
122. JWH-175 (1-Pentyl-3-(1-naphthylmethyl)indole).
123. JWH-201 (1-Pentyl-3-(4-methoxyphenylacetyl)indole).
124. JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl)indole).
125. JWH-210 (1-Pentyl-3-(4-ethyl-1-naphthoyl)indole).
126. JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl)indole).
127. JWH-251 (1-Pentyl-3-(2-methylphenylacetyl)indole).
128. JWH-302 (1-Pentyl-3-(3-methoxyphenylacetyl)indole).
129. JWH-398 (1-Pentyl-3-(4-chloro-1-naphthoyl)indole).
130. HU-211 ((6aS,10aS)-9-(Hydroxymethyl)-6,6-dimethyl-3-
(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-
ol).
131. HU-308 ([1R,2R,5R]-2-[2,6-Dimethoxy-4-(2-
methyloctan-2-yl)phenyl]-7,7-dimethyl-4-bicyclo[3.1.1]hept-3-
enyl] methanol).
132. HU-331 (3-Hydroxy-2-[(1R,6R)-3-methyl-6-(1-
methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-2,5-cyclohexadiene-
1,4-dione).
133. CB-13 (4-Pentyloxy-1-(1-naphthoyl)naphthalene).
134. CB-25 (N-Cyclopropyl-11-(3-hydroxy-5-pentylphenoxy)-
undecanamide).
135. CB-52 (N-Cyclopropyl-11-(2-hexyl-5-hydroxyphenoxy)-
undecanamide).
136. CP 55,940 (2-[3-Hydroxy-6-propanol-cyclohexyl]-5-(2-
methyloctan-2-yl)phenol).
137. AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl)indole).
138. AM-2201 (1-(5-Fluoropentyl)-3-(1-naphthoyl)indole).
139. RCS-4 (1-Pentyl-3-(4-methoxybenzoyl)indole).
140. RCS-8 (1-(2-Cyclohexylethyl)-3-(2-
methoxyphenylacetyl)indole).
141. WIN55,212-2 ((R)-(-)[2,3-Dihydro-5-methyl-3-(4-
morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl]-1-
naphthalenylmethylacetyl)indole).
142. WIN55,212-3 (((3S)-2,3-Dihydro-5-methyl-3-(4-
morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl]-1-
naphthalenylmethylacetyl)indole).
143. Pentedrone (alpha-Methylaminovalerophenone).
144. Fluoroamphetamine.
145. Fluoromethamphetamine.
146. Methoxetamine.
147. Methiopropamine.
148. Methylbuphedrone (Methyl-alpha-
methyaminobutyrophenone).
149. APB ((2-Aminopropyl)benzofuran).
150. APDB ((2-Aminopropyl)-2,3-dihydrobenzofuran).
151. UR-144 (1-Pentyl-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).
152. XLR11 (1-(5-Fluoropentyl)-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).
153. Chloro UR-144 (1-(Chloropentyl)-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).
154.  AKB48 (N-Adamant-1-yl 1-pentylindazole-3-carboxamide).
155.  AM-2233(1-[(N-Methyl-2-piperidinyl)methyl]-3-(2-iodobenzoyl)indole).
156.  STS-135 (N-Adamant-1-yl 1-(5-fluoropentyl)indole-3-carboxamide).
157.  URB-597 ((3’-(Aminocarbonyl)[1,1’-biphenyl]-3-yl)-cyclohexylcarbamate).
158.  URB-602 ([1,1’-Biphenyl]-3-yl-carbamic acid, cyclohexyl ester).
159.  URB-754 (6-Methyl-2-[(4-methylphenyl)amino]-1-benzoaxin-4-one).
160.  2C-D (4-Methyl-2,5-dimethoxyphenethylamine).
161.  2C-H (2,5-Dimethoxyphenethylamine).
162.  2C-N (4-Nitro-2,5-dimethoxyphenethylamine).
163.  2C-P (4-(n)-Propyl-2,5-dimethoxyphenethylamine).
164.  25I-NBOMe (4-Iodo-2,5-dimethoxy-[N-(2-methoxybenzyl)]phenethylamine).
165.  MDMA (3,4-Methylenedioxymethamphetamine).
166.  PB-22 (8-Quinolinyl 1-pentylindole-3-carboxylate).
167.  Fluoro PB-22 (8-Quinolinyl 1-(fluoropentyl)indole-3-carboxylate).
168.  BB-22 (8-Quinolinyl 1-(cyclohexylmethyl)indole-3-carboxylate).
169.  Fluoro AKB48 (N-Adamant-1-yl 1-
(fluoropentyl)indazole-3-carboxamide).
170. AB-PINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-pentylinazole-3-carboxamide).
171. AB-FUBINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).
172. ADB-PINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentylinazole-3-carboxamide).
173. Fluoro ADBICA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(fluoropentyl)indole-3-carboxamide).
174. 25B-NBOMe (4-Bromo-2,5-dimethoxy-[N-(2-methoxybenzyl)]phenethylamine).
175. 25C-NBOMe (4-Chloro-2,5-dimethoxy-[N-(2-methoxybenzyl)]phenethylamine).
176. AB-CHMINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).
177. FUB-PB-22 (8-Quinolinyl 1-(4-fluorobenzyl)indole-3-carboxylate).
178. Fluoro-NNEI (N-Naphthalen-1-yl 1-(fluoropentyl)indole-3-carboxamide).
179. Fluoro-AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-(fluoropentyl)indazole-3-carboxamide).
180. THJ-2201 (1-(5-Fluoropentyl)-3-(1-naphthoyl)indazole).
181. AM-855 ((4aR,12bR)-8-Hexyl-2,5,5-trimethyl-1,4,4a,8,9,10,11,12b-octahydronaphtho[3,2-c]isochromen-12-ol).
182. AM-905 ((6aR,9R,10aR)-3-[(E)-Hept-1-enyl]-9-
  (hydroxymethyl)-6,6-dimethyl-6a,7,8,9,10,10a-
  hexahydrobenzo[c]chromen-1-ol).
183. AM-906 ((6aR,9R,10aR)-3-[(Z)-Hept-1-enyl]-9-
  (hydroxymethyl)-6,6-dimethyl-6a,7,8,9,10,10a-
  hexahydrobenzo[c]chromen-1-ol).
184. AM-2389 ((6aR,9R,10aR)-3-(1-Hexyl-cyclobut-1-yl)-
  6a,7,8,9,10,10a-hexahydro-6,6-dimethyl-6H-dibenzo[b,d]pyran-1,9
diol).
185. HU-243 ((6aR,8S,9S,10aR)-9-(Hydroxymethyl)-6,6-
  dimethyl-3-(2-methyloctan-2-yl)-8,9-ditritio-7,8,10,10a-
  tetrahydro-6aH-benzo[c]chromen-1-ol).
186. HU-336 ((6aR,10aR)-6,6,9-Trimethyl-3-pentyl-
  6a,7,10,10a-tetrahydro-1H-benzo[c]chromene-1,4(6H)-dione).
187. MAPB ((2-Methylaminopropyl)benzofuran).
188. 5-IT (2-(1H-Indol-5-yl)-1-methyl-ethylamine).
189. 6-IT (2-(1H-Indol-6-yl)-1-methyl-ethylamine).
190. Synthetic Cannabinoids.—Unless specifically excepted
  or unless listed in another schedule or contained within a
  pharmaceutical product approved by the United States Food and
  Drug Administration, any material, compound, mixture, or
  preparation that contains any quantity of a synthetic
  cannabinoid found to be in any of the following chemical class
  descriptions, or homologues, nitrogen-heterocyclic analogs,
  isomers (including optical, positional, or geometric), esters,
ethers, salts, and salts of homologues, nitrogen-heterocyclic analogs, isomers, esters, or ethers, whenever the existence of such homologues, nitrogen-heterocyclic analogs, isomers, esters, ethers, salts, and salts of isomers, esters, or ethers is possible within the specific chemical class or designation. Since nomenclature of these synthetically produced cannabinoids is not internationally standardized and may continually evolve, these structures or the compounds of these structures shall be included under this subparagraph, regardless of their specific numerical designation of atomic positions covered, if it can be determined through a recognized method of scientific testing or analysis that the substance contains properties that fit within one or more of the following categories:

a. Tetrahydrocannabinols.—Any tetrahydrocannabinols naturally contained in a plant of the genus Cannabis, the synthetic equivalents of the substances contained in the plant or in the resinous extracts of the genus Cannabis, or synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity, including, but not limited to, Delta 9 tetrahydrocannabinols and their optical isomers, Delta 8 tetrahydrocannabinols and their optical isomers, Delta 6a,10a tetrahydrocannabinols and their optical isomers, or any compound containing a tetrahydrobenzo[c]chromene structure with substitution at either or both the 3-position or 9-position, with or without substitution at the 1-position with
hydroxyl or alkoxy groups, including, but not limited to:

(I) Tetrahydrocannabinol.

(II) HU-210 ((6aR,10aR)-9-(Hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol).

(III) HU-211 ((6aS,10aS)-9-(Hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol).

(IV) JWH-051 ((6aR,10aR)-9-(Hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).

(V) JWH-133 ((6aR,10aR)-6,6,9-Trimethyl-3-(2-methylpentan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).

(VI) JWH-057 ((6aR,10aR)-6,6,9-Trimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).

(VII) JWH-359 ((6aR,10aR)-1-Methoxy-6,6,9-trimethyl-3-(2,3-dimethylpentan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromene).

(VIII) AM-087 ((6aR,10aR)-3-(2-Methyl-6-bromohex-2-yl)-6,6,9-Trimethyl-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol).

(IX) AM-411 ((6aR,10aR)-3-(1-Adamantyl)-6,6,9-trimethyl-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol).

(X) Parahexyl.

b. Naphthoylindoles, Naphthoylindazoles, Naphthoylcarbazoles, Naphthylmethylindoles, Naphthylmethylindazoles, and Naphthylmethylcarbazoles.—Any
compound containing a naphthoylindole, naphthoylindazole, naphthoylcarbazole, naphthylmethylin
dole, naphthylmethylindazole, or naphthylmethylcarbazole structure, with or without substitution
on the indole, indazole, or carbazole ring to any extent, whether or not substituted on the
naphthyl ring to any extent, including, but not limited to:
(I) JWH-007 (1-Pentyl-2-methyl-3-(1-naphthoyl)indole).
(II) JWH-011 (1-(1-Methylhexyl)-2-methyl-3-(1-
naphthoyl)indole).
(III) JWH-015 (1-Propyl-2-methyl-3-(1-naphthoyl)indole).
(IV) JWH-016 (1-Butyl-2-methyl-3-(1-naphthoyl)indole).
(V) JWH-018 (1-Pentyl-3-(1-naphthoyl)indole).
(VI) JWH-019 (1-Hexyl-3-(1-naphthoyl)indole).
(VII) JWH-020 (1-Heptyl-3-(1-naphthoyl)indole).
(VIII) JWH-022 (1-(4-Pentenyl)-3-(1-naphthoyl)indole).
(IX) JWH-071 (1-Ethyl-3-(1-naphthoyl)indole).
(X) JWH-072 (1-Propyl-3-(1-naphthoyl)indole).
(XI) JWH-073 (1-Butyl-3-(1-naphthoyl)indole).
(XII) JWH-080 (1-Butyl-3-(4-methoxy-1-naphthoyl)indole).
(XIII) JWH-081 (1-Pentyl-3-(4-methoxy-1-naphthoyl)indole).
(XIV) JWH-098 (1-Pentyl-2-methyl-3-(4-methoxy-1-
naphthoyl)indole).
(XV) JWH-116 (1-Pentyl-2-ethyl-3-(1-naphthoyl)indole).
(XVI) JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl)indole).
(XVII) JWH-149 (1-Pentyl-2-methyl-3-(4-methyl-1-
naphthoyl)indole).

(XVIII) JWH-164 (1-Pentyl-3-(7-methoxy-1-
naphthoyl)indole).

(XIX) JWH-175 (1-Pentyl-3-(1-naphthylmethyl)indole).

(XX) JWH-180 (1-Propyl-3-(4-propyl-1-naphthoyl)indole).

(XXI) JWH-182 (1-Pentyl-3-(4-propyl-1-naphthoyl)indole).

(XXII) JWH-184 (1-Pentyl-3-[(4-methyl)-1-
naphthylmethyl]indole).

(XXIII) JWH-193 (1-[2-((4-Morpholinyl)ethyl]-3-(4-methyl-1-
naphthoyl)indole).

(XXIV) JWH-198 (1-[2-((4-Morpholinyl)ethyl]-3-(4-methoxy-1-
naphthoyl)indole).

(XXV) JWH-200 (1-[2-((4-Morpholinyl)ethyl]-3-(1-
naphthoyl)indole).

(XXVI) JWH-210 (1-Pentyl-3-(4-ethyl-1-naphthoyl)indole).

(XXVII) JWH-387 (1-Pentyl-3-(4-bromo-1-naphthoyl)indole).

(XXVIII) JWH-398 (1-Pentyl-3-(4-chloro-1-
naphthoyl)indole).

(XXIX) JWH-412 (1-Pentyl-3-(4-fluoro-1-naphthoyl)indole).

(XXX) JWH-424 (1-Pentyl-3-(8-bromo-1-naphthoyl)indole).

(XXXI) AM-1220 (1-[1-Methyl-2-piperidinyl)methyl]-3-(1-
naphthoyl)indole).

(XXXII) AM-1235 (1-(5-Fluoropentyl)-6-nitro-3-(1-
naphthoyl)indole).

(XXXIII) AM-2201 (1-(5-Fluoropentyl)-3-(1-

naphthoyl)indole).

(XXXIV) Chloro JWH-018 (1-(Chloropentyl)-3-(1-
naphthoyl)indole).

(XXXV) Bromo JWH-018 (1-(Bromopentyl)-3-(1-
naphthoyl)indole).

(XXXVI) AM-2232 (1-(4-Cyanobutyl)-3-(1-naphthoyl)indole).

(XXXVII) THJ-2201 (1-(5-Fluoropentyl)-3-(1-
naphthoyl)indole).

(XXXVIII) MAM-2201 (1-(5-Fluoropentyl)-3-(4-methyl-1-
naphthoyl)indole).

(XXXIX) EAM-2201 (1-(5-Fluoropentyl)-3-(4-ethyl-1-
naphthoyl)indole).

(XL) EG-018 (9-Pentyl-3-(1-naphthoyl)carbazole).

(XLI) EG-2201 (9-(5-Fluoropentyl)-3-(1-
naphthoyl)carbazole).

c. Naphthoylpyrroles.—Any compound containing a
naphthoylpyrrole structure, with or without substitution on the
pyrrole ring to any extent, whether or not substituted on the
naphthyl ring to any extent, including, but not limited to:

(I) JWH-030 (1-Pentyl-3-(1-naphthoyl)pyrrole).

(II) JWH-031 (1-Hexyl-3-(1-naphthoyl)pyrrole).

(III) JWH-145 (1-Pentyl-5-phenyl-3-(1-naphthoyl)pyrrole).

(IV) JWH-146 (1-Heptyl-5-phenyl-3-(1-naphthoyl)pyrrole).

(V) JWH-147 (1-Hexyl-5-phenyl-3-(1-naphthoyl)pyrrole).

(VI) JWH-307 (1-Pentyl-5-(2-fluorophenyl)-3-(1-
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CODING: Words stricken are deletions; words underlined are additions.
naphthoyl)pyrrole).

(VII)  JWH-309 (1-Pentyl-5-(1-naphthalenyl)-3-(1-
  naphthoyl)pyrrole).

(VIII) JWH-368 (1-Pentyl-5-(3-fluorophenyl)-3-(1-
  naphthoyl)pyrrole).

(IX)  JWH-369 (1-Pentyl-5-(2-chlorophenyl)-3-(1-
  naphthoyl)pyrrole).

(X)  JWH-370 (1-Pentyl-5-(2-methylphenyl)-3-(1-
  naphthoyl)pyrrole).

d.  Naphthylmethylenindenes.—Any compound containing a
  naphthylmethylenindene structure, with or without substitution
  at the 3-position of the indene ring to any extent, whether or
  not substituted on the naphthyl ring to any extent, including,
  but not limited to, JWH-176 (3-Pentyl-1-
  (naphthylmethylene)indene).

e.  Phenylacetylindoles and Phenylacetylindazoles.—Any
  compound containing a phenylacetylindole or phenylacetylindazole
  structure, with or without substitution on the indole or
  indazole ring to any extent, whether or not substituted on the
  phenyl ring to any extent, including, but not limited to:

  (I)  JWH-167 (1-Pentyl-3-(phenylacetyl)indole).

  (II) JWH-201 (1-Pentyl-3-(4-methoxyphenylacetyl)indole).

  (III) JWH-203 (1-Pentyl-3-(2-chlorophenylacetyl)indole).

  (IV) JWH-250 (1-Pentyl-3-(2-methoxyphenylacetyl)indole).

  (V)  JWH-251 (1-Pentyl-3-(2-methylphenylacetyl)indole).
(VI) JWH-302 (1-Pentyl-3-(3-methoxyphenylacetyl)indole).

(VII) Cannabipiperidiethanone.

(VIII) RCS-8 (1-(2-Cyclohexylethyl)-3-(2-methoxyphenylacetyl)indole).

f. Cyclohexylphenols.—Any compound containing a cyclohexylphenol structure, with or without substitution at the 5-position of the phenolic ring to any extent, whether or not substituted on the cyclohexyl ring to any extent, including, but not limited to:

(I) CP 47,497 (2-(3-Hydroxycyclohexyl)-5-(2-methyloctan-2-yl)phenol).

(II) Cannabicyclohexanol (CP 47,497 dimethyloctyl (C8) homologue).

(III) CP-55,940 (2-(3-Hydroxy-6-propanol-cyclohexyl)-5-(2-methyloctan-2-yl)phenol).

g. Benzoylindoles and Benzoylindazoles.—Any compound containing a benzoylindole or benzoylindazole structure, with or without substitution on the indole or indazole ring to any extent, whether or not substituted on the phenyl ring to any extent, including, but not limited to:

(I) AM-679 (1-Pentyl-3-(2-iodobenzoyl)indole).

(II) AM-694 (1-(5-Fluoropentyl)-3-(2-iodobenzoyl)indole).

(III) AM-1241 (1-[(N-Methyl-2-piperidinyl)methyl]-3-(2-iodo-5-nitrobenzoyl)indole).

(IV) Pravadoline (1-[2-(4-Morpholinyl)ethyl]-2-methyl-3-
(4-methoxybenzoyl)indole).

(V) AM-2233 (1-[(N-Methyl-2-piperidinyl)methyl]-3-(2-
iodobenzoyl)indole).

(VI) RCS-4 (1-Pentyl-3-(4-methoxybenzoyl)indole).

(VII) RCS-4 C4 homologue (1-Butyl-3-(4-
methoxybenzoyl)indole).

(VIII) AM-630 (1-[2-(4-Morpholinyl)ethyl]-2-methyl-6-iodo-
3-(4-methoxybenzoyl)indole).

h. Tetramethylcyclopropanoylindoles and
Tetramethylcyclopropanoylindazoles.—Any compound containing a
tetramethylcyclopropanoylindole or
tetramethylcyclopropanoylindazole structure, with or without
substitution on the indole or indazole ring to any extent,
whether or not substituted on the tetramethylcyclopropyl group
to any extent, including, but not limited to:

(I) UR-144 (1-Pentyl-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

(II) XLR11 (1-(5-Fluoropentyl)-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

(III) Chloro UR-144 (1-(Chloropentyl)-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

(IV) A-796,260 (1-[2-(4-Morpholinyl)ethyl]-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

(V) A-834,735 (1-[4-(Tetrahydropyranyl)methyl]-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).
(VI) M-144 (1-(5-Fluoropentyl)-2-methyl-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

(VII) FUB-144 (1-(4-Fluorobenzyl)-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

(VIII) FAB-144 (1-(5-Fluoropentyl)-3-(2,2,3,3-
tetramethylcyclopropanoyl)indazole).

(IX) XLR12 (1-(4,4,4-Trifluorobutyl)-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

(X) AB-005 (1-[(1-Methyl-2-piperidinyl)methyl]-3-(2,2,3,3-
tetramethylcyclopropanoyl)indole).

i. Adamantoylindoles, Adamantoylindazoles, Adamantylindole
carboxamides, and Adamantylindazole carboxamides.—Any compound
containing an adamantoyl indole, adamantoyl indazole, adamantyl
indole carboxamide, or adamantyl indazole carboxamide structure,
with or without substitution on the indole or indazole ring to
any extent, whether or not substituted on the adamantyl ring to
any extent, including, but not limited to:

(I) AKB48 (N-Adamant-1-yl 1-pentylyndazole-3-carboxamide).

(II) Fluoro AKB48 (N-Adamant-1-yl 1-
(fluoropentyl)indazole-3-carboxamide).

(III) STS-135 (N-Adamant-1-yl 1-(5-fluoropentyl)indole-3-
carboxamide).

(IV) AM-1248 (1-(1-Methylpiperidine)methyl-3-(1-
adamantoyl)indole).

(V) AB-001 (1-Pentyl-3-(1-adamantoyl)indole).
(VI) APICA (N-Adamant-1-yl 1-pentylindole-3-carboxamide).

(VII) Fluoro AB-001 (1-(Fluoropentyl)-3-(1 adamantoyl)indole).

j. Quinolinylindolecarboxylates, Quinolinylindazolecarboxylates, Quinolinylindolecarboxamides, and Quinolinylindazolecarboxamides.—Any compound containing a quinolinylindole carboxylate, quinolinylindazole carboxylate, isoquinolinylindole carboxylate, isoquinolinylindazole carboxylate, quinolinylindole carboxamide, quinolinylindazole carboxamide, isoquinolinylindole carboxamide, or isoquinolinylindazole carboxamide structure, with or without substitution on the indole or indazole ring to any extent, whether or not substituted on the quinoline or isoquinoline ring to any extent, including, but not limited to:

(I) PB-22 (8-Quinolinyl 1-pentylindole-3-carboxylate).

(II) Fluoro PB-22 (8-Quinolinyl 1-(fluoropentyl)indole-3-carboxylate).

(III) BB-22 (8-Quinolinyl 1-(cyclohexylmethyl)indole-3-carboxylate).

(IV) FUB-PB-22 (8-Quinolinyl 1-(4-fluorobenzyl)indole-3-carboxylate).

(V) NPB-22 (8-Quinolinyl 1-pentylindazole-3-carboxylate).

(VI) Fluoro NPB-22 (8-Quinolinyl 1-(fluoropentyl)indazole-3-carboxylate).

(VII) FUB-NPB-22 (8-Quinolinyl 1-(4-fluorobenzyl)indazole-3-carboxylate).
k. Naphthylindolecarboxylates and Naphthylindazolecarboxylates.—Any compound containing a naphthylindole carboxylate or naphthylindazole carboxylate structure, with or without substitution on the indole or indazole ring to any extent, whether or not substituted on the naphthyl ring to any extent, including, but not limited to:

(I) NM-2201 (1-Naphthalenyl 1-(5-fluoropentyl)indole-3-carboxylate).

(II) SDB-005 (1-Naphthalenyl 1-pentylinazole-3-carboxylate).

(III) Fluoro SDB-005 (1-Naphthalenyl 1-(fluoropentyl)indazole-3-carboxylate).

(IV) FDU-PB-22 (1-Naphthalenyl 1-(4-fluorobenzyl)indole-3-carboxylate).

(V) 3-CAF (2-Naphthalenyl 1-(2-fluorophenyl)indazole-3-carboxylate).

l. Naphthylindole carboxamides and Naphthylindazole carboxamides.—Any compound containing a naphthylindole carboxamide or naphthylindazole carboxamide structure, with or without substitution on the indole or indazole ring to any extent, whether or not substituted on the naphthyl ring to any
extent, including, but not limited to:

(I) NNEI (N-Naphthalen-1-yl 1-pentylindole-3-carboxamide).

(II) Fluoro-NNEI (N-Naphthalen-1-yl 1-fluoropentyl)indole-3-carboxamide).

(III) Chloro-NNEI (N-Naphthalen-1-yl 1-chloropentyl)indole-3-carboxamide).

(IV) MN-18 (N-Naphthalen-1-yl 1-pentylindazole-3-carboxamide).

(V) Fluoro MN-18 (N-Naphthalen-1-yl 1-fluoropentyl)indazole-3-carboxamide).

m. Alkylcarbonyl indole carboxamides, Alkylcarbonyl indazole carboxamides, Alkylcarbonyl indole carboxylates, and Alkylcarbonyl indazole carboxylates.-Any compound containing an alkylcarbonyl group, including 1-amino-3-methyl-1-oxobutan-2-yl, 1-methoxy-3-methyl-1-oxobutan-2-yl, 1-amino-1-oxo-3-phenylpropan-2-yl, 1-methoxy-1-oxo-3-phenylpropan-2-yl, with an indole carboxamide, indazole carboxamide, indole carboxylate, or indazole carboxylate, with or without substitution on the indole or indazole ring to any extent, whether or not substituted on the alkylcarbonyl group to any extent, including, but not limited to:

(I) ADBICA, (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentylindole-3-carboxamide).

(II) Fluoro ADBICA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(fluoropentyl)indole-3-carboxamide).
(III) Fluoro ABICA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-(fluoropentyl)indole-3-carboxamide).

(IV) AB-PINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-pentylindazole-3-carboxamide).

(V) Fluoro AB-PINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-(fluoropentyl)indazole-3-carboxamide).

(VI) ADB-PINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-pentylindazole-3-carboxamide).

(VII) Fluoro ADB-PINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).

(VIII) AB-FUBINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).

(IX) ADB-FUBINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).

(X) AB-CHMINACA (N-(1-Amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).

(XI) MA-CHMINACA (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).

(XII) MAB-CHMINACA (N-(1-Amino-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).

(XIII) AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-pentylindazole-3-carboxamide).

(XIV) Fluoro-AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-(fluoropentyl)indazole-3-carboxamide).

(XV) FUB-AMB (N-(1-Methoxy-3-methyl-1-oxobutan-2-yl)-1-(4-
fluorobenzyl)indazole-3-carboxamide).

(XVI) MDMB-CHMINACA (N-(1-Methoxy-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).

(XVII) MDMB-FUBINACA (N-(1-Methoxy-3,3-dimethyl-1-oxobutan-2-yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).

(XVIII) MDMB-CHMICA (N-(1-Methoxy-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indole-3-carboxamide).

(XIX) PX-1 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-(5-fluoropentyl)indole-3-carboxamide).

(XX) PX-2 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-(5-fluoropentyl)indazole-3-carboxamide).

(XXI) PX-3 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-(cyclohexylmethyl)indazole-3-carboxamide).

(XXII) PX-4 (N-(1-Amino-1-oxo-3-phenylpropan-2-yl)-1-(4-fluorobenzyl)indazole-3-carboxamide).

(XXIII) MO-CHMINACA (N-(1-Methoxy-3,3-dimethyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)indazole-3-carboxylate).

n. Cumylindolecarboxamides and Cumylindazolecarboxamides.—Any compound containing a N-(2-phenylpropan-2-yl) indole carboxamide or N-(2-phenylpropan-2-yl) indazole carboxamide structure, with or without substitution on the indole or indazole ring to any extent, whether or not substituted on the phenyl ring of the cumyl group to any extent, including, but not limited to:

(I) CUMYL-PICA (N-(2-Phenylpropan-2-yl)-1-pentyllindole-3-
carboxamide).

(II) Fluoro CUMYL-PICA (N-(2-Phenylpropan-2-yl)-1-(fluoropentyl)indole-3-carboxamide).

o. Other Synthetic Cannabinoids.—Any material, compound, mixture, or preparation that contains any quantity of a Synthetic Cannabinoid, as described in sub-subparagraphs a.-n.:

(I) With or without modification or replacement of a carbonyl, carboxamide, alkylene, alkyl, or carboxylate linkage between either two core rings, or linkage between a core ring and group structure, with or without the addition of a carbon or replacement of a carbon;

(II) With or without replacement of a core ring or group structure, whether or not substituted on the ring or group structures to any extent; and

(III) Is a cannabinoid receptor agonist, unless specifically excepted or unless listed in another schedule or contained within a pharmaceutical product approved by the United States Food and Drug Administration.

191. Substituted Cathinones.—Unless specifically excepted, listed in another schedule, or contained within a pharmaceutical product approved by the United States Food and Drug Administration, any material, compound, mixture, or preparation, including its salts, isomers, esters, or ethers, and salts of isomers, esters, or ethers, whenever the existence of such salts is possible within any of the following specific chemical
designations:
   a. Any compound containing a 2-amino-1-phenyl-1-propanone structure;
   b. Any compound containing a 2-amino-1-naphthyl-1-propanone structure; or
   c. Any compound containing a 2-amino-1-thiophenyl-1-propanone structure,

whether or not the compound is further modified:
   (I) With or without substitution on the ring system to any extent with alkyl, alkylthio, thio, fused alkylenedioxy, alkoxy, haloalkyl, hydroxyl, nitro, fused furan, fused benzofuran, fused dihydrofuran, fused tetrahydropyran, fused alkyl ring, or halide substituents;
   (II) With or without substitution at the 3-propanone position with an alkyl substituent or removal of the methyl group at the 3-propanone position;
   (III) With or without substitution at the 2-amino nitrogen atom with alkyl, dialkyl, acetyl, or benzyl groups, whether or not further substituted in the ring system; or
   (IV) With or without inclusion of the 2-amino nitrogen atom in a cyclic structure, including, but not limited to:
      (A) Methcathinone.
      (B) Ethcathinone.
      (C) Methylone (3,4-Methylenedioxymethcathinone).
(D) 2,3-Methylenedioxymethcathinone.
(E) MDPV (3,4-Methylenedioxypyrovalerone).
(F) Methylmethcathinone.
(G) Methoxymethcathinone.
(H) Fluoromethcathinone.
(I) Methylethcathinone.
(J) Butylone (3,4-Methylenedioxy-alpha-methylaminobutyrophenone).
(K) Ethylone (3,4-Methylenedioxy-N-ethylcathinone).
(L) BMDP (3,4-Methylenedioxy-N-benzylcathinone).
(M) Naphyrone (Naphthylpyrovalerone).
(N) Bromomethcathinone.
(O) Buphedrone (alpha-Methylaminobutyrophenone).
(P) Eutylone (3,4-Methylenedioxy-alpha-ethylaminobutyrophenone).
(Q) Dimethylcathinone.
(R) Dimethylethcathinone.
(S) Pentedrone (3,4-Methylenedioxy-alpha-methylnovalerophenone).
(T) Pentedrone (alpha-Methylaminovalerophenone).
(U) MDPPP (3,4-Methylenedioxy-alpha-pyrrolidinopropiophenone).
(V) MDPBP (3,4-Methylenedioxy-alpha-pyrrolidinobutyrophenone).
(W) MPPP (Methyl-alpha-pyrrolidinopropiophenone).
(X) PPP (Pyrrolidinopropiophenone).
(Y) PVP (Pyrrolidinovalerophenone) or (Pyrrolidinopentiophenone).
(Z) MOPPP (Methoxy-alpha-pyrrolidinopropiophenone).
(AA) MPH (Methyl-alpha-pyrrolidinoheptanophenone).
(BB) F-MABP (Fluoromethylaminobutyrophenone).
(CC) Me-EABP (Methylethylaminobutyrophenone).
(DD) PBP (Pyrrolidinobutyrophenone).
(EE) MeO-PBP (Methoxypyrrolidinobutyrophenone).
(FF) Et-PBP (Ethylpyrrolidinobutyrophenone).
(GG) 3-Me-4-MeO-MCAT (3-Methyl-4-Methoxymethcathinone).
(HH) Dimethylone (3,4-Methylenedioxy-N,N-dimethylcathinone).
(II) 3,4-Methylenedioxy-N,N-diethylcathinone.
(JJ) 3,4-Methylenedioxy-N-acetylcathinone.
(KK) 3,4-Methylenedioxy-N-acetylmethcathinone.
(LL) 3,4-Methylenedioxy-N-acetylmethcathinone.
(MM) Methylbuphedrone (Methyl-alpha-methylaminobutyrophenone).
(NN) Methyl-alpha-methylaminohexanophenone.
(OO) N-Ethyl-N-methylcathinone.
(PP) PHP (Pyrrolidinohexanophenone).
(QQ) PV8 (Pyrrolidinoheptanophenone).
(RR) Chloromethcathinone.
(SS) 4-Bromo-2,5-dimethoxy-alpha-aminoacetophenone.
192. Substituted Phenethylamines.—Unless specifically excepted or unless listed in another schedule, or contained within a pharmaceutical product approved by the United States Food and Drug Administration, any material, compound, mixture, or preparation, including its salts, isomers, esters, or ethers, and salts of isomers, esters, or ethers, whenever the existence of such salts is possible within any of the following specific chemical designations, any compound containing a phenethylamine structure, without a beta-keto group, and without a benzyl group attached to the amine group, whether or not the compound is further modified with or without substitution on the phenyl ring to any extent with alkyl, alkylthio, nitro, alkoxy, thio, halide, fused alkylenedioxy, fused furan, fused benzofuran, fused dihydrofuran, or fused tetrahydropyran substituents, whether or not further substituted on a ring to any extent, with or without substitution at the alpha or beta position by any alkyl substituent, with or without substitution at the nitrogen atom, and with or without inclusion of the 2-amino nitrogen atom in a cyclic structure, including, but not limited to:

a. 2C-B (4-Bromo-2,5-dimethoxyphenethylamine).
b. 2C-E (4-Ethyl-2,5-dimethoxyphenethylamine).
c. 2C-T-4 (4-Isopropylthio-2,5-dimethoxyphenethylamine).
d. 2C-C (4-Chloro-2,5-dimethoxyphenethylamine).
e. 2C-T (4-Methylthio-2,5-dimethoxyphenethylamine).
f. 2C-T-2 (4-Ethylthio-2,5-dimethoxyphenethylamine).
q. 2C-T-7 (4-(n)-Propylthio-2,5-dimethoxyphenethylamine).

h. 2C-I (4-Iodo-2,5-dimethoxyphenethylamine).

i. 2C-D (4-Methyl-2,5-dimethoxyphenethylamine).

j. 2C-H (2,5-Dimethoxyphenethylamine).

k. 2C-N (4-Nitro-2,5-dimethoxyphenethylamine).

l. 2C-P (4-(n)-Propyl-2,5-dimethoxyphenethylamine).

m. MDMA (3,4-Methylenedioxymethamphetamine).

n. MBDB (Methylbenzodioxolylbutanamine) or (3,4-Methylenedioxy-N-methylbutanamine).

o. MDA (3,4-Methylenedioxyamphetamine).

p. 2,5-Dimethoxyamphetamine.

q. Fluoroamphetamine.

r. Fluoromethamphetamine.

s. MDEA (3,4-Methylenedioxoy-N-ethylanphetamine).

t. DOB (4-Bromo-2,5-dimethoxyamphetamine).

u. DOC (4-Chloro-2,5-dimethoxyamphetamine).

v. DOET (4-Ethyl-2,5-dimethoxyamphetamine).

w. DOI (4-Iodo-2,5-dimethoxyamphetamine).

x. DOM (4-Methyl-2,5-dimethoxyamphetamine).

y. PMA (4-Methoxyamphetamine).

z. N-Ethylamphetamine.

aa. 3,4-Methylenedioxoy-N-hydroxyamphetamine.

bb. 5-Methoxy-3,4-methylenedioxoyamphetamine.

cc. PMMA (4-Methoxymethamphetamine).

dd. N,N-Dimethylamphetamine.
ee.  3,4,5-Trimethoxyamphetamine.
ff.  4-APB (4-(2-Aminopropyl)benzofuran).
gg.  5-APB (5-(2-Aminopropyl)benzofuran).
hh.  6-APB (6-(2-Aminopropyl)benzofuran).
ii.  7-APB (7-(2-Aminopropyl)benzofuran).
jj.  4-APDB (4-(2-Aminopropyl)-2,3-dihydrobenzofuran).
kk.  5-APDB (5-(2-Aminopropyl)-2,3-dihydrobenzofuran).
ll.  6-APDB (6-(2-Aminopropyl)-2,3-dihydrobenzofuran).
mm.  7-APDB (7-(2-Aminopropyl)-2,3-dihydrobenzofuran).
nn.  4-MAPB (4-(2-Methylaminopropyl)benzofuran).
oo.  5-MAPB (5-(2-Methylaminopropyl)benzofuran).
pp.  6-MAPB (6-(2-Methylaminopropyl)benzofuran).
qq.  7-MAPB (7-(2-Methylaminopropyl)benzofuran).
rr.  5-EAPB (5-(2-Ethylaminopropyl)benzofuran).
ss.  5-MAPDB (5-(2-Methylaminopropyl)-2,3-dihydrobenzofuran).

which does not include phenethylamine, mescaline as described in subparagraph 20., substituted cathinones as described in subparagraph 191., N-Benzyl phenethylamine compounds as described in subparagraph 193., or methamphetamine as described in subparagraph (2)(c)5. (2)(c)4.

193. N-Benzyl Phenethylamine Compounds.—Unless specifically excepted or unless listed in another schedule, or contained within a pharmaceutical product approved by the United
States Food and Drug Administration, any material, compound, mixture, or preparation, including its salts, isomers, esters, or ethers, and salts of isomers, esters, or ethers, whenever the existence of such salts is possible within any of the following specific chemical designations, any compound containing a phenethylamine structure without a beta-keto group, with substitution on the nitrogen atom of the amino group with a benzyl substituent, with or without substitution on the phenyl or benzyl ring to any extent with alkyl, alkoxy, thio, alkylthio, halide, fused alkylenedioxy, fused furan, fused benzofuran, or fused tetrahydropyran substituents, whether or not further substituted on a ring to any extent, with or without substitution at the alpha position by any alkyl substituent, including, but not limited to:

a. 25B-NBOMe (4-Bromo-2,5-dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine).

b. 25B-NBOH (4-Bromo-2,5-dimethoxy-[N-(2-
hydroxybenzyl)]phenethylamine).

c. 25B-NBF (4-Bromo-2,5-dimethoxy-[N-(2-
fluorobenzyl)]phenethylamine).

d. 25B-NBMD (4-Bromo-2,5-dimethoxy-[N-(2,3-
methylenedioxybenzyl)]phenethylamine).

e. 25I-NBOMe (4-Iodo-2,5-dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine).

f. 25I-NBOH (4-Iodo-2,5-dimethoxy-[N-(2-
hydroxybenzyl))phenethylamine).

   g. 25I-NBF (4-Iodo-2,5-dimethoxy-[N-(2-
fluorobenzyl)]phenethylamine).

   h. 25I-NBMD (4-Iodo-2,5-dimethoxy-[N-(2,3-
methylenedioxybenzyl)]phenethylamine).

   i. 25T2-NBOMe (4-Methylthio-2,5-dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine).

   j. 25T4-NBOMe (4-Isopropylthio-2,5-dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine).

   k. 25T7-NBOMe (4-(n)-Propylthio-2,5-dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine).

   l. 25C-NBOMe (4-Chloro-2,5-dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine).

   m. 25C-NBOH (4-Chloro-2,5-dimethoxy-[N-(2-
hydroxybenzyl)]phenethylamine).

   n. 25C-NBF (4-Chloro-2,5-dimethoxy-[N-(2-
fluorobenzyl)]phenethylamine).

   o. 25C-NBMD (4-Chloro-2,5-dimethoxy-[N-(2,3-
methylenedioxybenzyl)]phenethylamine).

   p. 25H-NBOMe (2,5-Dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine).

   q. 25H-NBOH (2,5-Dimethoxy-[N-(2-
hydroxybenzyl)]phenethylamine).

   r. 25H-NBF (2,5-Dimethoxy-[N-(2-
fluorobenzyl)]phenethylamine).

CODING: Words stricken are deletions; words underlined are additions.
s. 25D-NBOMe (4-Methyl-2,5-dimethoxy-[N-(2-
methoxybenzyl)]phenethylamine),

which does not include substituted cathinones as described in

subparagraph 191.

194. Substituted Tryptamines.—Unless specifically excepted
or unless listed in another schedule, or contained within a
pharmaceutical product approved by the United States Food and
Drug Administration, any material, compound, mixture, or
preparation containing a 2-[(1H-indol-3-yl)ethanamine, for
example tryptamine, structure with or without mono- or di-
substitution of the amine nitrogen with alkyl or alkenyl groups,
or by inclusion of the amino nitrogen atom in a cyclic
structure, whether or not substituted at the alpha position with
an alkyl group, whether or not substituted on the indole ring to
any extent with any alkyl, alkoxy, halo, hydroxyl, or acetoxy
groups, including, but not limited to:

   a. Alpha-Ethyltryptamine.
   b. Bufotenine.
   c. DET (Diethyltryptamine).
   d. DMT (Dimethyltryptamine).
   e. MET (N-Methyl-N-ethyltryptamine).
   f. DALT (N,N-Diallyltryptamine).
   g. EiPT (N-Ethyl-N-isopropyltryptamine).
   h. MiPT (N-Methyl-N-isopropyltryptamine).
i. 5-Hydroxy-AMT (5-Hydroxy-alpha-methyltryptamine).

j. 5-Hydroxy-N-methyltryptamine.

k. 5-MeO-MiPT (5-Methoxy-N-methyl-N-isopropyltryptamine).

l. 5-MeO-AMT (5-Methoxy-alpha-methyltryptamine).

m. Methyltryptamine.

n. 5-MeO-DMT (5-Methoxy-N,N-dimethyltryptamine).

o. 5-Me-DMT (5-Methyl-N,N-dimethyltryptamine).

p. 5-MeO-DiPT (5-Methoxy-N,N-Diisopropyltryptamine).

q. DiPT (N,N-Diisopropyltryptamine).

r. DPT (N,N-Dipropyltryptamine).

s. 4-Hydroxy-DiPT (4-Hydroxy-N,N-diisopropyltryptamine).

t. 5-MeO-DALT (5-Methoxy-N,N-Diallyltryptamine).

u. 4-AcO-DMT (4-Acetoxy-N,N-dimethyltryptamine).

v. 4-AcO-DiPT (4-Acetoxy-N,N-diisopropyltryptamine).

w. 4-Hydroxy-DET (4-Hydroxy-N,N-diethyltryptamine).

x. 4-Hydroxy-MET (4-Hydroxy-N-methyl-N-ethyltryptamine).

y. 4-Hydroxy-MiPT (4-Hydroxy-N-methyl-N-isopropyltryptamine).

z. Methyl-alpha-ethyltryptamine.

aa. Bromo-DALT (Bromo-N,N-diallyltryptamine),

which does not include tryptamine, psilocyn as described in subparagraph 34., or psilocybin as described in subparagraph 33.

195. Substituted Phenylcyclohexylamines.—Unless specifically excepted or unless listed in another schedule, or
contained within a pharmaceutical product approved by the United States Food and Drug Administration, any material, compound, mixture, or preparation containing a phenylcyclohexylamine structure, with or without any substitution on the phenyl ring, any substitution on the cyclohexyl ring, any replacement of the phenyl ring with a thiophenyl or benzothiophenyl ring, with or without substitution on the amine with alkyl, dialkyl, or alkoxy substituents, inclusion of the nitrogen in a cyclic structure, or any combination of the above, including, but not limited to:

a. BTCP (Benzothiophenylcyclohexylpiperidine) or BCP (Benocyclidine).

b. PCE (N-Ethyl-1-phenylcyclohexylamine) (Ethylamine analog of phencyclidine).

c. PCPY (N-(1-Phenylcyclohexyl)-pyrrolidine) (Pyrroline analog of phencyclidine).

d. PCPr (Phenylcyclohexylpropylamine).

e. TCP (1-[1-(2-Thienyl)-cyclohexyl]-piperidine) (Thiophene analog of phencyclidine).

f. PCEEA (Phenylcyclohexyl(ethoxyethylamine)).

g. PCMPA (Phenylcyclohexyl(methoxypropylamine)).

h. Methoxetamine.

i. 3-Methoxy-PCE ((3-Methoxyphenyl)cyclohexylethylamine).

j. Bromo-PCP ((Bromophenyl)cyclohexylpiperidine).

k. Chloro-PCP ((Chlorophenyl)cyclohexylpiperidine).

l. Fluoro-PCP ((Fluorophenyl)cyclohexylpiperidine).
m. Hydroxy-PCP ((Hydroxyphenyl)cyclohexylpiperidine).

n. Methoxy-PCP ((Methoxyphenyl)cyclohexylpiperidine).

o. Methyl-PCP ((Methylphenyl)cyclohexylpiperidine).


q. Oxo-PCP ((Oxophenyl)cyclohexylpiperidine).

r. Amino-PCP ((Aminophenyl)cyclohexylpiperidine).

196. W-15, 4-chloro-N-[1-(2-phenylethyl)-2-piperidinyllidene]-benzenesulfonamide.

197. W-18, 4-chloro-N-[1-[2-(4-nitrophenyl)ethyl]-2-piperidinyllidene]-benzenesulfonamide.

198. AH-7921, 3,4-dichloro-N-[1-(dimethylamino)cyclohexyl]methyl]-benzamide.

199. U47700, trans-3,4-dichloro-N-[2-(dimethylamino)cyclohexyl]-N-methyl-benzamide.

200. MT-45, 1-cyclohexyl-4-(1,2-diphenylethyl)-piperazine, dihydrochloride.

(2) SCHEDULE II.—A substance in Schedule II has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. The following substances are controlled in Schedule II:

(a) Unless specifically excepted or unless listed in another schedule, any of the following substances, whether produced directly or indirectly by extraction from substances of
vegetable origin or independently by means of chemical synthesis:

1. Opium and any salt, compound, derivative, or preparation of opium, except nalmefene or isoquinoline alkaloids of opium, including, but not limited to the following:
   a. Raw opium.
   b. Opium extracts.
   c. Opium fluid extracts.
   d. Powdered opium.
   e. Granulated opium.
   f. Tincture of opium.
   g. Codeine.
   h. Dihydroetorphine.
   i. Ethylmorphine.
   j. Etorphine hydrochloride.
   k. Hydrocodone and hydrocodone combination products.
   l. Hydromorphone.
   m. Levo-alphacetylmethadol (also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM).
   n. Metopon (methyldihydromorphinone).
   o. Morphine.
   p. Oripavine.
   q. Oxycodone.
   r. Oxymorphone.
   s. Thebaine.
2. Any salt, compound, derivative, or preparation of a substance which is chemically equivalent to or identical with any of the substances referred to in subparagraph 1., except that these substances shall not include the isoquinoline alkaloids of opium.

3. Any part of the plant of the species *Papaver somniferum*, L.

4. Cocaine or ecgonine, including any of their stereoisomers, and any salt, compound, derivative, or preparation of cocaine or ecgonine, except that these substances shall not include ioflupane I 123.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

1. Alfentanil.
2. Alphaprodine.
3. Anileridine.
5. Bulk propoxyphene (nondosage forms).
6. Carfentanil.
7. Dihydrocodeine.
8. Diphenoxylate.
10. Isomethadone.
11. Levomethorphan.
12. Levorphanol.
15. Methadone-Intermediate, 4-cyano-2-
    dimethylamino-4,4-diphenylbutane.
16. Moramide-Intermediate, 2-methyl-
    3-morpholino-1,1-diphenylpropane-carboxylic acid.
17. Nabilone.
18. Pethidine (meperidine).
19. Pethidine-Intermediate-A, 4-cyano-1-
    methyl-4-phenylpiperidine.
20. Pethidine-Intermediate-B, ethyl-4-
    phenylpiperidine-4-carboxylate.
21. Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-
    4-carboxylic acid.
22. Phenazocine.
23. Phencyclidine.
24. 1-Phenylcyclohexylamine.
25. Piminodine.
26. 1-Piperidinocyclohexanecarbonitrile.
27. Racemethorphan.
28. Racemorphan.
29. Remifentanil.
30. Sufentanil.
31. Tapentadol.
32. Thiafentanil.
(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including their salts, isomers, optical isomers, salts of their isomers, and salts of their optical isomers:

1. Amobarbital.
2. Amphetamine.
4. Lisdexamfetamine.
5. Methamphetamine.
7. Pentobarbital.
8. Phenmetrazine.
10. Secobarbital.
(d) Dronabinol (synthetic THC) in oral solution in a drug product approved by the United States Food and Drug Administration.
(3) SCHEDULE III.—A substance in Schedule III has a potential for abuse less than the substances contained in Schedules I and II and has a currently accepted medical use in...
treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. The following substances are controlled in Schedule III:

(a) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant or stimulant effect on the nervous system:

1. Any substance which contains any quantity of a derivative of barbituric acid, including thiobarbituric acid, or any salt of a derivative of barbituric acid or thiobarbituric acid, including, but not limited to, butabarbital and butalbital.
   2. Benzphetamine.
   5. Chlorphentermine.
   6. Clortermine.
   7. Embutramide.
   8. Lysergic acid.
   9. Lysergic acid amide.
10. Methyprylon.
11. Perampanel.
13. Sulfondiethylmethane.
15. Sulfonmethane.
16. Tiletamine and zolazepam or any salt thereof.

(b) Nalorphine.

c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following controlled substances or any salts thereof:

1. Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.

2. Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

3. Not more than 300 milligrams of hydrocodone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.

4. Not more than 300 milligrams of hydrocodone per 100 milliliters or not more than 15 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients that are not controlled substances.
5. Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

6. Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

7. Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

For purposes of charging a person with a violation of s. 893.135 involving any controlled substance described in subparagraph 3. or subparagraph 4., the controlled substance is a Schedule III controlled substance pursuant to this paragraph but the weight of the controlled substance per milliliters or per dosage unit is not relevant to the charging of a violation of s. 893.135. The weight of the controlled substance shall be determined pursuant to s. 893.135(6).

(d) Anabolic steroids.

1. The term "anabolic steroid" means any drug or hormonal substance, chemically and pharmacologically related to testosterone, other than estrogens, progestins, and
corticosteroids, that promotes muscle growth and includes:

a. Androsterone.
b. Androsterone acetate.
c. Boldenone.
d. Boldenone acetate.
e. Boldenone benzoate.
f. Boldenone undecylenate.
g. Chlorotestosterone (Clostebol).
h. Dehydrochloromethyltestosterone.
i. Dihydrotestosterone (Stanolone).
j. Drostanolone.
k. Ethylestrenol.
l. Fluoxymesterone.
m. Formebulone (Formebolone).
n. Mesterolone.
o. Methandrostenolone (Methandienone).
p. Methandranone.
q. Methandriol.
r. Methenolone.
s. Methyltestosterone.
t. Mibolerone.
u. Nortestosterone (Nandrolone).
v. Norethandrolone.
w. Nortestosterone decanoate.
x. Nortestosterone phenylpropionate.
y.  Nortestosterone propionate.

z.  Oxandroline.

aa.  Oxymesterone.

bb.  Oxymetholone.

c.  Stanozolol.

d.  Testolactone.

e.  Testosterone.

ff.  Testosterone acetate.

g.  Testosterone benzoate.

hh.  Testosterone cypionate.

ii.  Testosterone decanoate.

jj.  Testosterone enanthate.

kk.  Testosterone isocaproate.

ll.  Testosterone oleate.

mm.  Testosterone phenylpropionate.

nn.  Testosterone propionate.

oo.  Testosterone undecanoate.

pp.  Trenbolone.

qq.  Trenbolone acetate.

rr.  Any salt, ester, or isomer of a drug or substance described or listed in this subparagraph if that salt, ester, or isomer promotes muscle growth.

2. The term does not include an anabolic steroid that is expressly intended for administration through implants to cattle or other nonhuman species and that has been approved by the
United States Secretary of Health and Human Services for such administration. However, any person who prescribes, dispenses, or distributes such a steroid for human use is considered to have prescribed, dispensed, or distributed an anabolic steroid within the meaning of this paragraph.

(e) Ketamine, including any isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation.

(f) Dronabinol (synthetic THC) in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the United States Food and Drug Administration.

(g) Any drug product containing gamma-hydroxybutyric acid, including its salts, isomers, and salts of isomers, for which an application is approved under s. 505 of the Federal Food, Drug, and Cosmetic Act.

(4)(a) SCHEDULE IV.—A substance in Schedule IV has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following
substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation, are controlled in Schedule IV:

1. Alfaxalone.
2. (a) Alprazolam.
3. (b) Barbital.
4. (c) Bromazepam.
5. (iii) Butorphanol tartrate.
6. (d) Camazepam.
7. (jjj) Carisoprodol.
8. (e) Cathine.
9. (f) Chlorthal betaine.
10. (g) Chlordiazepoxide.
11. (h) Clonazepam.
12. (i) Clobazam.
13. (j) Clonazepam.
15. (l) Clotiazepam.
16. (m) Cloxazolam.
17. Dextroamphetamine.
18. (n) Delorazepam.
19. Dichloralphenazone.
20. (p) Diazepam.
21. (q) Diethylpropion.
22. Eluxadoline.
23. Estazolam.
24. Eszopiclone.
25. Ethchlorvynol.
27. Ethyl loflazepate.
28. Fencamfamin.
29. Fenfluramine.
30. Fenproporex.
31. Fludiazepam.
32. Flurazepam.
33. Fospropofol.
34. Halazepam.
35. Haloxazolam.
36. Ketazolam.
37. Loprazolam.
38. Lorazepam.
39. Lorcaserin.
40. Lormetazepam.
41. Mazindol.
42. Mebutamate.
43. Medazepam.
44. Mefenorex.
45. Meprobamate.
46. Methohexital.
47. (mm) Methylphenobarbital.
48. (nn) Midazolam.
49. Modafinil.
50. (oo) Nimetazepam.
51. (pp) Nitrazepam.
52. (qq) Nordiazepam.
53. (rr) Oxazepam.
54. (ss) Oxazolam.
55. (tt) Paraldehyde.
56. (uu) Pemoline.
57. (vv) Pentazocine.
58. Petrichloral.
59. (ww) Phenobarbital.
60. (xx) Phentermine.
61. (yy) Pinazepam.
62. (zz) Pipradrol.
63. (aaa) Prazepam.
64. (cc) Propoxyphene (dosage forms).
65. (dd) Propylhexedrine, excluding any patent or proprietary preparation containing propylhexedrine, unless otherwise provided by federal law.
66. (ee) Quazepam.
67. Sibutramine.
68. (ee) SPA[(-)-1 dimethylamino-1, 2 diphenylethane].
69. Suvorexant.

70. (fff) Temazepam.

71. (ddd) Tetrazepam.

72. Tramadol.

73. (ggg) Triazolam.

74. Zaleplon.

75. Zolpidem.

76. Zopiclone.

77. (hhh) Not more than 1 milligram of difenoaxin and not less than 25 micrograms of atropine sulfate per dosage unit.

(5) SCHEDULE V.—A substance, compound, mixture, or preparation of a substance in Schedule V has a low potential for abuse relative to the substances in Schedule IV and has a currently accepted medical use in treatment in the United States, and abuse of such compound, mixture, or preparation may lead to limited physical or psychological dependence relative to the substances in Schedule IV.

(a) Substances controlled in Schedule V include any compound, mixture, or preparation containing any of the following limited quantities of controlled substances, which must shall include one or more active medicinal ingredients that are not controlled substances in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the controlled substance alone:
1. Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams.
2. Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams.
3. Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.
4. Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.
5. Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.
6. Not more than 0.5 milligrams of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.
(b) Unless a specific exception exists or unless listed in another schedule, any material, compound, mixture, or preparation that contains any quantity of the following substances is controlled in Schedule V:
   1. Brivaracetam.
   2. Ezogabine.
   3. Lacosamide.
   4. Pregabalin

(c) Narcotic drugs. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following narcotic drugs and their salts: Buprenorphine.

(c) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following stimulants and their salts: Buprenorphine.
preparation which contains any quantity of the following
substances having a stimulant effect on the central nervous
system, including its salts, isomers, and salts of isomers:
Pyrovalerone.

Section 9. Subsection (1) of section 893.04, Florida
Statutes, is amended to read:

893.04  Pharmacist and practitioner.—
(1)  A pharmacist, in good faith and in the course of
professional practice only, may dispense controlled substances
upon a written, oral, or electronic prescription of a
practitioner, under the following conditions:
(a)  Oral prescriptions must be promptly reduced to writing
by the pharmacist or recorded electronically if permitted by
federal law.
(b)  The written prescription must be dated and signed by
the prescribing practitioner on the day when issued.
(c)  There shall appear on the face of the prescription or
written record thereof for the controlled substance the
following information:
   1.  The full name and address of the person for whom, or
the owner of the animal for which, the controlled substance is
dispensed.
   2.  The full name and address of the prescribing
practitioner and the practitioner's federal controlled substance
registry number shall be printed thereon.
3. If the prescription is for an animal, the species of animal for which the controlled substance is prescribed.

4. The name of the controlled substance prescribed and the strength, quantity, and directions for use thereof.

5. The number of the prescription, as recorded in the prescription files of the pharmacy in which it is filled.

6. The initials of the pharmacist filling the prescription and the date filled.

(d) The prescription shall be retained on file by the proprietor of the pharmacy in which it is filled for a period of 2 years.

(e) Affixed to the original container in which a controlled substance is delivered upon a prescription or authorized refill thereof, as hereinafter provided, there shall be a label bearing the following information:

1. The name and address of the pharmacy from which such controlled substance was dispensed.

2. The date on which the prescription for such controlled substance was filled.

3. The number of such prescription, as recorded in the prescription files of the pharmacy in which it is filled.

4. The name of the prescribing practitioner.

5. The name of the patient for whom, or of the owner and species of the animal for which, the controlled substance is prescribed.
6. The directions for the use of the controlled substance prescribed in the prescription.

7. A clear, concise warning that it is a crime to transfer the controlled substance to any person other than the patient for whom prescribed.

(f) A prescription for a controlled substance listed in Schedule II may be dispensed only upon a written or electronic prescription of a practitioner, except that in an emergency situation, as defined by regulation of the Department of Health, such controlled substance may be dispensed upon oral prescription but is limited to a 72-hour supply. A prescription for a controlled substance listed in Schedule II may not be refilled.

(g) A prescription for a controlled substance listed in Schedule III, Schedule IV, or Schedule V may not be filled or refilled more than five times within a period of 6 months after the date on which the prescription was written unless the prescription is renewed by a practitioner.

Section 10. Section 893.055, Florida Statutes, is amended to read:

(1) As used in this section, the term:

(a) "Active investigation" means an investigation that is

893.055 Prescription drug monitoring program. —

(Substantial rewording of section. See s. 893.055, F.S., for present text.)
being conducted with a reasonable, good faith belief that it
could lead to the filing of administrative, civil, or criminal
proceedings, or that is ongoing and continuing and for which
there is a reasonable, good faith anticipation of securing an
arrest or prosecution in the foreseeable future.

(b) "Administration" means the obtaining and giving of a
single dose of a controlled substance by a legally authorized
person to a patient for her or his consumption.

(c) "Controlled substance" means a controlled substance
listed in Schedule II, Schedule III, Schedule IV, or Schedule V
of s. 893.03 or 21 U.S.C. s. 812.

(d) "Dispense" means the transfer of possession of one or
more doses of a controlled substance by a dispenser to the
ultimate consumer or to his or her agent.

(e) "Dispenser" means a dispensing health care
practitioner, pharmacy, or pharmacist licensed to dispense
controlled substances in or into this state.

(f) "Health care practitioner" or "practitioner" means any
practitioner licensed under chapter 458, chapter 459, chapter
461, chapter 463, chapter 464, chapter 465, or chapter 466.

(g) "Health care regulatory board" has the same meaning as
in s. 456.001(1).

(h) "Law enforcement agency" means the Department of Law
Enforcement, a sheriff's office in this state, a police
department in this state, or a law enforcement agency of the
Federal Government which enforces the laws of this state or the United States relating to controlled substances and whose agents and officers are empowered by law to conduct criminal investigations and make arrests.

   (i) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, or an Internet pharmacy that is licensed by the department under chapter 465 and that dispenses or delivers controlled substances to an individual or address in this state.

   (j) "Prescriber" means a prescribing physician, prescribing practitioner, or other prescribing health care practitioner authorized by the laws of this state to order controlled substances.

   (k) "Program manager" means an employee of or a person contracted by the department who is designated to ensure the integrity of the prescription drug monitoring program in accordance with the requirements established in this section.

   (2)(a) The department shall maintain an electronic system to collect and store controlled substance dispensing information and shall release the information as authorized in this section and s. 893.0551. The electronic system must:

       1. Not infringe upon the legitimate prescribing or dispensing of a controlled substance by a prescriber or dispenser acting in good faith and in the course of professional practice.
2. Be consistent with standards of the American Society for Automation in Pharmacy.

3. Comply with the Health Insurance Portability and Accountability Act as it pertains to protected health information, electronic protected health information, and all other relevant state and federal privacy and security laws and regulations.

4. Purge or cause to be purged information in the database that is more than 4 years old.

(b) The department may collaborate with professional health care regulatory boards, appropriate organizations, and other state agencies to identify indicators of controlled substance abuse.

(3)(a) For each controlled substance dispensed to a patient in this state, the following information must be reported by the dispenser to the system as soon thereafter as possible but no later than the close of the next business day after the day the controlled substance is dispensed unless an extension or exemption is approved by the department:

1. The name of the prescribing practitioner, the practitioner's federal Drug Enforcement Administration registration number, the practitioner's National Provider Identification or other appropriate identifier, and the date of the prescription.

2. The date the prescription was filled and the method of
payment, such as cash by an individual, insurance coverage through a third party, or Medicaid payment. This paragraph does not authorize the department to include individual credit card numbers or other account numbers in the system.

3. The full name, address, telephone number, and date of birth of the person for whom the prescription was written.

4. The name, national drug code, quantity, and strength of the controlled substance dispensed.

5. The full name, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued pharmacy permit number, and address of the pharmacy or other location from which the controlled substance was dispensed. If the controlled substance was dispensed by a practitioner other than a pharmacist, the practitioner's full name, address, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued license number, and National Provider Identification.

6. Whether the drug was dispensed as an initial prescription or a refill, and the number of refills ordered.

7. The name of the individual picking up the controlled substance prescription and type and issuer of the identification provided.

8. Other appropriate identifying information as determined by department rule.

(b) The following acts of administration or dispensing are
exempt from the reporting requirements of this subsection:

1. All acts of administration of a controlled substance.
2. The dispensing of a controlled substance in the health care system of the Department of Corrections.
3. The dispensing of a controlled substance to a person under the age of 16.

(4) The following persons must be provided direct access to information in the system:

(a) A prescriber or dispenser or his or her designee.

(b) An employee of the United States Department of Veterans Affairs, the United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe or dispense controlled substances shall have access to the information in the program's system upon verification of employment.

(c) The program manager or designated program and support staff to administer the system.

1. In order to calculate performance measures pursuant to subsection (14), the program manager or program and support staff members who have been directed by the program manager to calculate performance measures may have direct access to information that contains no identifying information of any patient, physician, health care practitioner, prescriber, or dispenser.
2. The program manager or designated program and support staff must provide the department, upon request, data that does not contain patient, physician, health care practitioner, prescriber, or dispenser identifying information for public health care and safety initiatives purposes.

3. The program manager, upon determining a pattern consistent with the department's rules established under subsection (16), may provide relevant information to the prescriber and dispenser.

4. The program manager, upon determining a pattern consistent with the rules established under subsection (16) and having cause to believe a violation of s. 893.13(7)(a)8., (8)(a), or (8)(b) has occurred, may provide relevant information to the applicable law enforcement agency.

The program manager and designated program and support staff must complete a level II background screening.

5. The following entities may not directly access information in the system, but may request information from the program manager or designated program and support staff:

   (a) The department and its health care regulatory boards, as appropriate, for investigations involving licensees authorized to prescribe or dispense controlled substances.

   (b) The Attorney General for Medicaid fraud cases involving prescribed controlled substances.
(c) A law enforcement agency during active investigations of potential criminal activity, fraud, or theft regarding prescribed controlled substances.

(d) A medical examiner when conducting an authorized investigation under s. 406.11, to determine the cause of death of an individual.

(e) An impaired practitioner consultant who is retained by the department under s. 456.076 to review the system information of an impaired practitioner program participant or a referral who has agreed to be evaluated or monitored through the program and who has separately agreed in writing to the consultant's access to and review of such information.

(f) A patient or the legal guardian or designated health care surrogate of an incapacitated patient who submits a written and notarized request that includes the patient's full name, address, phone number, date of birth, and a copy of a government-issued photo identification.

(6) The department may enter into one or more reciprocal agreements or contracts to share prescription drug monitoring information with other states, districts, or territories if the prescription drug monitoring programs of such other states, districts, or territories are compatible with the Florida program.

   (a) In determining compatibility, the department shall consider:
1. The safeguards for privacy of patient records and the success of the program in protecting patient privacy.

2. The persons authorized to view the data collected by the program. Comparable entities and licensed health care practitioners in other states, districts, or territories of the United States, law enforcement agencies, the Attorney General's Medicaid Fraud Control Unit, medical regulatory boards, and, as needed, management staff that have similar duties as management staff who work with the prescription drug monitoring program as authorized in s. 893.0551 are authorized access upon approval by the department.

3. The schedules of the controlled substances that are monitored by the program.

4. The data reported to or included in the program's system.

5. Any implementing criteria deemed essential for a thorough comparison.

6. The costs and benefits to the state of sharing prescription information.

(b) The department shall assess the prescription drug monitoring program's continued compatibility with other states', districts', or territories' programs every 4 years.

(c) Any agreements or contracts for sharing of prescription drug monitoring information between the department and other states, districts, or territories shall contain the
same restrictions and requirements as this section or s. 893.0551, and the information must be provided according to the department's determination of compatibility.

(7) The department may enter into agreements or contracts to establish secure connections between the system and a prescribing or dispensing health care practitioner's electronic health recordkeeping system. The electronic health recordkeeping system owner or license holder will be responsible for ensuring that only authorized individuals have access to prescription drug monitoring program information.

(8) A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance for a patient age 16 or older. This requirement does not apply when prescribing or dispensing a nonopioid controlled substance listed in Schedule V of s. 893.03 or 21 U.S.C. 812. For purposes of this subsection, a "nonopioid controlled substance" is a controlled substance that does not contain any amount of a substance listed as an opioid in s. 893.03 or 21 U.S.C. 812.

(a) The duty to consult the system does not apply when the system:

1. Is determined by the department to be nonoperational;

or

2. Cannot be accessed by the prescriber or dispenser or a
designee of the prescriber or dispenser because of a temporary technological or electrical failure.

(b) A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system under this subsection shall document the reason he or she did not consult the system in the patient's medical record or prescription record and shall not prescribe or dispense greater than a 3-day supply of a controlled substance to the patient.

(c) The department shall issue a nondisciplinary citation to any prescriber or dispenser who fails to consult the system as required by this subsection for an initial offense. Each subsequent offense is subject to disciplinary action pursuant to s. 456.073.

(9) A person who willfully and knowingly fails to report the dispensing of a controlled substance as required by this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(10) Information in the prescription drug monitoring program's system may be released only as provided in this section and s. 893.0551. The content of the system is intended to be informational only. Information in the system is not subject to discovery or introduction into evidence in any civil or administrative action against a prescriber, dispenser, pharmacy, or patient arising out of matters that are the subject of information in the system. The program manager and authorized
persons who participate in preparing, reviewing, issuing, or any other activity related to management of the system may not be permitted or required to testify in any such civil or administrative action as to any findings, recommendations, evaluations, opinions, or other actions taken in connection with management of the system.

(11) A prescriber or dispenser, or his or her designee, may have access to the information under this section which relates to a patient of that prescriber or dispenser as needed for the purpose of reviewing the patient's controlled drug prescription history. A prescriber or dispenser acting in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for receiving or using information from the prescription drug monitoring program. This subsection does not create a private cause of action, and a person may not recover damages against a prescriber or dispenser authorized to access information under this subsection for accessing or failing to access such information.

(12)(a) All costs incurred by the department in administering the prescription drug monitoring program shall be funded through federal grants, private funding applied for or received by the state, or state funds appropriated in the General Appropriations Act. The department may not:

1. Commit funds for the monitoring program without
ensuring funding is available; or

2. Use funds provided, directly or indirectly, by prescription drug manufacturers to implement the program.

(b) The department shall cooperate with the direct-support organization established under subsection (15) in seeking federal grant funds, other nonstate grant funds, gifts, donations, or other private moneys for the department if the costs of doing so are immaterial. Immaterial costs include, but are not limited to, the costs of mailing and personnel assigned to research or apply for a grant. The department may competitively procure and contract pursuant to s. 287.057 for any goods and services required by this section.

(13) The department shall conduct or participate in studies to examine the feasibility of enhancing the prescription drug monitoring program for the purposes of public health initiatives and statistical reporting. Such studies shall respect the privacy of the patient, the prescriber, and the dispenser. Such studies may be conducted by the department or a contracted vendor in order to:

(a) Improve the quality of health care services and safety by improving prescribing and dispensing practices for controlled substances;

(b) Take advantage of advances in technology;

(c) Reduce duplicative prescriptions and the overprescribing of controlled substances; and
(d) Reduce drug abuse.

(14) The department shall annually report on performance measures to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1. Performance measures may include, but are not limited to, the following outcomes:

(a) Reduction of the rate of inappropriate use of controlled substances through department education and safety efforts.

(b) Reduction of the quantity of controlled substances obtained by individuals attempting to engage in fraud and deceit.

(c) Increased coordination among partners participating in the prescription drug monitoring program.

(d) Involvement of stakeholders in achieving improved patient health care and safety and reduction of controlled substance abuse and controlled substance diversion.

(15) The department may establish a direct-support organization to provide assistance, funding, and promotional support for the activities authorized for the prescription drug monitoring program.

(a) As used in this subsection, the term "direct-support organization" means an organization that is:

1. A Florida corporation not for profit incorporated under chapter 617, exempted from filing fees, and approved by the
Department of State.

2. Organized and operated to conduct programs and activities; raise funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, and invest, in its own name, securities, funds, objects of value, or other property, either real or personal; and make expenditures or provide funding to or for the direct or indirect benefit of the department in the furtherance of the prescription drug monitoring program.

(b) The State Surgeon General shall appoint a board of directors for the direct-support organization.

1. The board of directors shall consist of no fewer than five members who shall serve at the pleasure of the State Surgeon General.

2. The State Surgeon General shall provide guidance to members of the board to ensure that moneys received by the direct-support organization are not received from inappropriate sources. Inappropriate sources include, but are not limited to, donors, grantors, persons, prescription drug manufacturers, or organizations that may monetarily or substantively benefit from the purchase of goods or services by the department in furtherance of the prescription drug monitoring program.

(c) The direct-support organization shall operate under written contract with the department. The contract must, at a minimum, provide for:
1. Approval of the articles of incorporation and bylaws of the direct-support organization by the department.

2. Submission of an annual budget for the approval of the department.

3. The reversion, without penalty, to the department's grants and donations trust fund for the administration of the prescription drug monitoring program of all moneys and property held in trust by the direct-support organization for the benefit of the prescription drug monitoring program if the direct-support organization ceases to exist or if the contract is terminated.

4. The fiscal year of the direct-support organization, which must begin July 1 of each year and end June 30 of the following year.

5. The disclosure of the material provisions of the contract to donors of gifts, contributions, or bequests, including such disclosure on all promotional and fundraising publications, and an explanation to such donors of the distinction between the department and the direct-support organization.

6. The direct-support organization's collecting, expending, and providing of funds to the department for the development, implementation, and operation of the prescription drug monitoring program as described in this section. The direct-support organization may collect and expend funds to be
used for the functions of the direct-support organization's
board of directors, as necessary and approved by the department.
In addition, the direct-support organization may collect and
provide funding to the department in furtherance of the
prescription drug monitoring program by:

a. Establishing and administering the prescription drug
monitoring program's electronic system, including hardware and
software.

b. Conducting studies on the efficiency and effectiveness
of the program to include feasibility studies as described in
subsection (13).

c. Providing funds for future enhancements of the program
within the intent of this section.

d. Providing user training of the prescription drug
monitoring program, including distribution of materials to
promote public awareness and education and conducting workshops
or other meetings for health care practitioners, pharmacists,
and others as appropriate.

e. Providing funds for travel expenses.

f. Providing funds for administrative costs, including
personnel, audits, facilities, and equipment.

g. Fulfilling all other requirements necessary to
implement and operate the program as outlined in this section.

7. Certification by the department that the direct-support
organization is complying with the terms of the contract in a
manner consistent with and in furtherance of the goals and
purposes of the prescription drug monitoring program and in the
best interests of the state. Such certification must be made
annually and reported in the official minutes of a meeting of
the direct-support organization.

(d) The activities of the direct-support organization must
be consistent with the goals and mission of the department, as
determined by the department, and in the best interests of the
state. The direct-support organization must obtain written
approval from the department for any activities in support of
the prescription drug monitoring program before undertaking
those activities.

(e) The direct-support organization shall provide for an
independent annual financial audit in accordance with s.
215.981. Copies of the audit shall be provided to the department
and the Office of Policy and Budget in the Executive Office of
the Governor.

(f) The direct-support organization may not exercise any
power under s. 617.0302(12) or (16).

(g) The direct-support organization is not considered a
lobbying firm within the meaning of s. 11.045.

(h) The department may permit, without charge, appropriate
use of administrative services, property, and facilities of the
department by the direct-support organization, subject to this
section. The use must be directly in keeping with the approved
purposes of the direct-support organization and may not be made at times or places that would unreasonably interfere with opportunities for the public to use such facilities for established purposes. Any moneys received from rentals of facilities and properties managed by the department may be held in a separate depository account in the name of the direct-support organization and subject to the provisions of the letter of agreement with the department. The letter of agreement must provide that any funds held in the separate depository account in the name of the direct-support organization must revert to the department if the direct-support organization is no longer approved by the department to operate in the best interests of the state.

(i) The department may adopt rules under s. 120.54 to govern the use of administrative services, property, or facilities of the department or office by the direct-support organization.

(j) The department may not permit the use of any administrative services, property, or facilities of the state by a direct-support organization if that organization does not provide equal membership and employment opportunities to all persons regardless of race, color, religion, gender, age, or national origin.

(k) This subsection is repealed October 1, 2027, unless reviewed and saved from repeal by the Legislature.
(16) The department shall adopt rules necessary to implement this section.

Section 11. Section 893.0551, Florida Statutes, is amended to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

(1) For purposes of this section, the terms used in this section have the same meanings as provided in s. 893.055.

(2) The following information of a patient or patient's agent, a health care practitioner, a dispenser, an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy that is contained in records held by the department under s. 893.055 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Name.

(b) Address.

(c) Telephone number.

(d) Insurance plan number.

(e) Government-issued identification number.

(f) Provider number.

(g) Drug Enforcement Administration number.

(h) Any other unique identifying information or number.

(3) The department shall disclose such confidential and exempt information to the following persons or entities upon confidential and exempt information to the following persons or entities upon
request and after using a verification process to ensure the legitimacy of the request as provided in s. 893.055:

(a) A health care practitioner, or his or her designee, who certifies that the information is necessary to provide medical treatment to a current patient in accordance with ss. 893.04, 893.05, and 893.055.

(b) An employee of the United States Department of Veterans Affairs, the United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe or dispense controlled substances shall have access to the information in the program’s system upon verification of such employment.

(c) The program manager and designated support staff for administration of the program, and to provide relevant information to the prescriber, dispenser, and appropriate law enforcement agencies, in accordance with s. 893.055.

(d) The department and its relevant health care regulatory boards for investigations involving licensees authorized to prescribe or dispense controlled substances. The department or health care regulatory board may request information from the program but may not have direct access to its system. The department may provide to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation that prompted the
request for the information.

(e)(a) The Attorney General or his or her designee when working on Medicaid fraud cases involving prescribed controlled substances prescription drugs or when the Attorney General has initiated a review of specific identifiers of Medicaid fraud or specific identifiers that warrant a Medicaid investigation regarding prescribed controlled substances prescription drugs. The Attorney General's Medicaid fraud investigators may not have direct access to the department's system database. The Attorney General or his or her designee may disclose to a criminal justice agency, as defined in s. 119.011, only the confidential and exempt information received from the department that is relevant to an identified active investigation that prompted the request for the information.

(b) The department's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a practitioner, pharmacist, or other person who is authorized to prescribe, administer, or dispense controlled substances and who is involved in a specific controlled substances investigation for prescription drugs involving a designated person. The health care regulatory boards may request information from the department but may not have direct access to its database. The health care regulatory boards may provide to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation.
substances investigation that prompted the request for the
information.

(f) A law enforcement agency that has initiated an
active investigation involving a specific violation of law
regarding prescription drug abuse or diversion of prescribed
controlled substances and that has entered into a user agreement
with the department. A law enforcement agency may request
information from the department but may not have direct access
to its system database. The law enforcement agency may disclose
to a criminal justice agency, as defined in s. 119.011, only
confidential and exempt information received from the department
that is relevant to an identified active investigation that
prompted the request for such information.

(g) A district medical examiner or associate medical
examiner, as described in s. 406.06, pursuant to his or her
official duties, as required by s. 406.11, to determine the
cause of death of an individual. Such medical examiners may
request information from the department but may not have direct
access to the system

(d) A health care practitioner, or his or her designee,
who certifies that the information is necessary to provide
medical treatment to a current patient in accordance with ss.
893.05 and 893.055.

(e) A pharmacist, or his or her designee, who certifies
that the requested information will be used to dispense
controlled substances to a current patient in accordance with ss. 893.04 and 893.055.

(f) A patient or the legal guardian or designated health care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(7)(c)4.

(g) The patient's pharmacy, prescriber, or dispenser, or the designee of the pharmacy, prescriber, or dispenser, who certifies that the information is necessary to provide medical treatment to his or her current patient in accordance with s. 893.055.

(h) An impaired practitioner consultant who has been authorized in writing by a participant in, or by a referral to, the impaired practitioner program to access and review information as provided in s. 893.055(5)(e) 893.055(7)(e)5.

(i) A patient or the legal guardian or designated health care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(5)(f).

(4) If the department determines consistent with its rules that a pattern of controlled substance abuse exists, the department may disclose such confidential and exempt information to the applicable law enforcement agency in accordance with s. 893.055. The law enforcement agency may disclose to a criminal justice agency, as defined in s. 119.011, only confidential and exempt information received from the department that is relevant to an identified active investigation that is specific to a
violation of s. 893.13(7)(a)8., s. 893.13(8)(a), or s. 893.13(8)(b).

(5) Before disclosing confidential and exempt information to a criminal justice agency or a law enforcement agency pursuant to this section, the disclosing person or entity must take steps to ensure the continued confidentiality of all confidential and exempt information. At a minimum, these steps must include redacting any nonrelevant information.

(6) An agency or person who obtains any confidential and exempt information pursuant to this section must maintain the confidential and exempt status of that information and may not disclose such information unless authorized by law. Information shared with a state attorney pursuant to paragraph (3)(f) or paragraph (3)(h) may be released only in response to a discovery demand if such information is directly related to the criminal case for which the information was requested. Unrelated information may be released only upon an order of a court of competent jurisdiction.

(7) A person who willfully and knowingly violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 12. Paragraphs (a), (c), (d), (e), (f), and (h) of subsection (1), subsection (2), paragraphs (a) and (b) of subsection (4), and subsections (5) and (7) of section 893.13, Florida Statutes, are amended to read:
893.13  Prohibited acts; penalties.—

(1)(a) Except as authorized by this chapter and chapter 499, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302 or a public or private elementary, middle, or secondary school between the hours of 6 a.m. and 12 midnight, or at any time in, on, or within 1,000 feet of real property comprising a state, county, or municipal
park, a community center, or a publicly owned recreational facility. As used in this paragraph, the term "community center" means a facility operated by a nonprofit community-based organization for the provision of recreational, social, or educational services to the public. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.
2. (c)4. commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The defendant must be sentenced to a minimum term of imprisonment of 3 calendar years unless the offense was committed within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

This paragraph does not apply to a child care facility unless
the owner or operator of the facility posts a sign that is not
less than 2 square feet in size with a word legend identifying
the facility as a licensed child care facility and that is
posted on the property of the child care facility in a
conspicuous place where the sign is reasonably visible to the
public.

(d) Except as authorized by this chapter, a person may not
sell, manufacture, or deliver, or possess with intent to sell,
multiply, or deliver, a controlled substance in, on, or
within 1,000 feet of the real property comprising a public or
private college, university, or other postsecondary educational
institutions. A person who violates this paragraph with respect
to:

1. A controlled substance named or described in s.
2876 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.
2877 . (2)(c)4. commits a felony of the first degree, punishable as
2878 provided in s. 775.082, s. 775.083, or s. 775.084.
2879
2. A controlled substance named or described in s.
2879 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6.,
2880 (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
2881 felony of the second degree, punishable as provided in s.
2882 775.082, s. 775.083, or s. 775.084.
2883
3. Any other controlled substance, except as lawfully
2884 sold, manufactured, or delivered, must be sentenced to pay a
2885 $500 fine and to serve 100 hours of public service in addition
to any other penalty prescribed by law.

(e) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance not authorized by law in, on, or within 1,000 feet of a physical place for worship at which a church or religious organization regularly conducts religious services or within 1,000 feet of a convenience business as defined in s. 812.171. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., or (2)(c)10., commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(f) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or
within 1,000 feet of the real property comprising a public
ehousing facility at any time. As used in this section, the term
"real property comprising a public housing facility" means real
property, as defined in s. 421.03(12), of a public corporation
created as a housing authority pursuant to part I of chapter
421. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s.

893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

2. A controlled substance named or described in s.

893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6.,
(2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a
felony of the second degree, punishable as provided in s.
775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully
sold, manufactured, or delivered, must be sentenced to pay a

$500 fine and to serve 100 hours of public service in addition
to any other penalty prescribed by law.

(h) Except as authorized by this chapter, a person may not
sell, manufacture, or deliver, or possess with intent to sell,
manufacture, or deliver, a controlled substance in, on, or
within 1,000 feet of the real property comprising an assisted
living facility, as that term is used in chapter 429. A person
who violates this paragraph with respect to:
1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

2. (c)4. commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(2)(a) Except as authorized by this chapter and chapter 499, a person may not purchase, or possess with intent to purchase, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

2. (c)4. commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s.
3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Except as provided in this chapter, a person may not purchase more than 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any mixture containing any such substance. A person who violates this paragraph commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Except as authorized by this chapter, a person 18 years of age or older may not deliver any controlled substance to a person younger than 18 years of age, use or hire a person younger than 18 years of age as an agent or employee in the sale or delivery of such a substance, or use such person to assist in avoiding detection or apprehension for a violation of this chapter. A person who violates this subsection with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s.
775.082, s. 775.083, or s. 775.084.

Imposition of sentence may not be suspended or deferred, and the person so convicted may not be placed on probation.

(5) A person may not bring into this state any controlled substance unless the possession of such controlled substance is authorized by this chapter or unless such person is licensed to do so by the appropriate federal agency. A person who violates this provision with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(e) A person or health care practitioner who violates the provisions of subparagraph (a)13. or paragraph (b) commits a felony of the second degree, punishable as provided in s.
Section 13. Section 893.147, Florida Statutes, is amended, to read:

893.147  Use, possession, manufacture, delivery, transportation, advertisement, or retail sale of drug paraphernalia, specified machines, and materials.—

(1) USE OR POSSESSION OF DRUG PARAPHERNALIA.—It is unlawful for any person to use, or to possess with intent to use, drug paraphernalia:

(a) To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of this chapter; or

(b) To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this chapter.

Any person who violates this subsection is guilty of a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(2) MANUFACTURE OR DELIVERY OF DRUG PARAPHERNALIA.—It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver drug
paraphernalia, knowing, or under circumstances where one
reasonably should know, that it will be used:

(a) To plant, propagate, cultivate, grow, harvest,
manufacture, compound, convert, produce, process, prepare, test,
analyze, pack, repack, store, contain, or conceal a controlled
substance in violation of this act; or

(b) To inject, ingest, inhale, or otherwise introduce into
the human body a controlled substance in violation of this act.

Any person who violates this subsection is guilty of a felony of
the third degree, punishable as provided in s. 775.082, s.
775.083, or s. 775.084.

(3) DELIVERY OF DRUG PARAPHERNALIA TO A MINOR.—

(a) Any person 18 years of age or over who violates
subsection (2) by delivering drug paraphernalia to a person
under 18 years of age is guilty of a felony of the second
degree, punishable as provided in s. 775.082, s. 775.083, or s.
775.084.

(b) It is unlawful for any person to sell or otherwise
deliver hypodermic syringes, needles, or other objects which may
be used, are intended for use, or are designed for use in
parenterally injecting substances into the human body to any
person under 18 years of age, except that hypodermic syringes,
needles, or other such objects may be lawfully dispensed to a
person under 18 years of age by a licensed practitioner, parent,
or legal guardian or by a pharmacist pursuant to a valid
prescription for same. Any person who violates the provisions of
this paragraph is guilty of a misdemeanor of the first degree,
punishable as provided in s. 775.082 or s. 775.083.

(4) TRANSPORTATION OF DRUG PARAPHERNALIA.—It is unlawful
to use, possess with the intent to use, or manufacture with the
intent to use drug paraphernalia, knowing or under circumstances
in which one reasonably should know that it will be used to
transport:

(a) A controlled substance in violation of this chapter;

or

(b) Contraband as defined in s. 932.701(2)(a)1.

Any person who violates this subsection commits a felony of the
third degree, punishable as provided in s. 775.082, s. 775.083,
or s. 775.084.

(5) ADVERTISEMENT OF DRUG PARAPHERNALIA.—It is unlawful
for any person to place in any newspaper, magazine, handbill, or
other publication any advertisement, knowing, or under
circumstances where one reasonably should know, that the purpose
of the advertisement, in whole or in part, is to promote the
sale of objects designed or intended for use as drug
paraphernalia. Any person who violates this subsection is guilty
of a misdemeanor of the first degree, punishable as provided in
s. 775.082 or s. 775.083.
(6) RETAIL SALE OF DRUG PARAPHERNALIA.—
(a) It is unlawful for a person to knowingly and willfully sell or offer for sale at retail any drug paraphernalia described in s. 893.145(12)(a)-(c) or (g)-(m), other than a pipe that is primarily made of briar, meerschaum, clay, or corn cob.
(b) A person who violates paragraph (a) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, and, upon a second or subsequent violation, commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(7) TABLETING MACHINES, ENCAPSULATING MACHINES, AND CONTROLLED SUBSTANCE COUNTERFEITING MATERIALS.—
(a) Except as provided in paragraph (b), it is unlawful for any person to possess, purchase, deliver, sell, or possess with intent to sell or deliver a tableting machine, an encapsulating machine, or controlled substance counterfeiting materials knowing, intending, or having reasonable cause to believe that it will be used to manufacture a controlled substance or counterfeit controlled substance.
(b) 1. A regulated person may possess, purchase, deliver, sell, or possess with intent to deliver or sell a tableting machine or encapsulating machine as part of a regulated transaction with a regular customer or regular importer if he or she is in compliance with 21 U.S.C. s. 830. For purposes of this paragraph, the terms "regulated person," "regulated...
transaction," "regular customer," and "regular importer" have the same meanings as provided in 21 U.S.C. s. 802.

2. A person registered under 21 U.S.C. s. 822 may possess, purchase, deliver, sell, or possess with intent to deliver or sell a tableting machine or encapsulating machine to manufacture a controlled substance pursuant to such registration.

3. A person who holds an active, unencumbered license or a permit under s. 381.986 or chapter 465 may possess, purchase, deliver, sell, or possess with intent to sell or deliver a tableting machine or encapsulating machine to manufacture a controlled substance, if such person is performing functions in compliance with or under the authority of that license or permit.

(c) For purposes of this subsection, the term:

1. "Controlled substance" has the same meaning as provided in s. 893.02(4).

2. "Controlled substance counterfeiting material" means a punch, die, plate, stone, or other item designed to print, imprint, or reproduce the trademark, trade name, or other identifying mark, imprint, or device of another or any likeness of any of the foregoing upon a drug or container or labeling thereof so as to render such drug a counterfeit controlled substance.

3. "Counterfeit controlled substance" has the same meaning as provided in s. 831.31(2).
4. "Encapsulating machine" means manual, semiautomatic, or fully automatic equipment that can be used to fill shells or capsules with powdered or granular solids or semisolid material to produce coherent solid tablets.

5. "Tableting machine" means manual, semiautomatic, or fully automatic equipment that can be used to compact or mold powdered or granular solids or semisolid material to produce coherent solid tablets.

(d) 1. Except as provided in subparagraph 2., a person who violates this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. Any person who violates this subsection knowing, intending, or having reasonable cause to believe that such action will result in the unlawful manufacture of a controlled substance or counterfeit controlled substance that contains:
   a. A substance controlled under s. 893.03(1);
   b. Cocaine, as described in s. 893.03(2)(a)4.;
   c. Opium or any synthetic or natural salt, compound, derivative, or preparation of opium;
   d. Methadone;
   e. Alfentanil, as described in s. 893.03(2)(b)1.;
   f. Carfentanil, as described in s. 893.03(2)(b)6.;
   g. Fentanyl, as described in s. 893.03(2)(b)9.;
   h. Sufentanil, as described in s. 893.03(2)(b)30.; or
   i. A controlled substance analog, as described in s.
3176 893.0356, of any substance specified in sub-subparagraphs a.–h.,
3177 commits a felony of the second degree, punishable as provided in
3178 s. 775.082, s. 775.083, or s. 775.084.
3179
3180 Section 14. Effective January 1, 2019, paragraphs (pp) and
3181 (qq) of subsection (1) of section 458.331, Florida Statutes, are
3182 amended to read:
3183 458.331 Grounds for disciplinary action; action by the
3184 board and department.—
3185 (1) The following acts constitute grounds for denial of a
3186 license or disciplinary action, as specified in s. 456.072(2):
3187 (pp) Applicable to a licensee who serves as the designated
3188 physician of a pain-management clinic as defined in s. 458.3265
3189 or s. 459.0137:
3190 1. Registering a pain-management clinic through
3191 misrepresentation or fraud;
3192 2. Procuring, or attempting to procure, the registration
3193 of a pain-management clinic for any other person by making or
3194 causing to be made, any false representation;
3195 3. Failing to comply with any requirement of chapter 499, the
3196 Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301–392, the
3198 the Drug Abuse Prevention and Control Act; or chapter 893, the
3199 Florida Comprehensive Drug Abuse Prevention and Control Act;
3200 4. Being convicted or found guilty of, regardless of
adjudication to, a felony or any other crime involving moral
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turpitude, fraud, dishonesty, or deceit in any jurisdiction of
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the courts of this state, of any other state, or of the United
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States;
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5. Being convicted of, or disciplined by a regulatory
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agency of the Federal Government or a regulatory agency of
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another state for, any offense that would constitute a violation
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of this chapter;
3208
6. Being convicted of, or entering a plea of guilty or
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nolo contendere to, regardless of adjudication, a crime in any
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jurisdiction of the courts of this state, of any other state, or
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of the United States which relates to the practice of, or the
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ability to practice, a licensed health care profession;
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7. Being convicted of, or entering a plea of guilty or
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nolo contendere to, regardless of adjudication, a crime in any
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jurisdiction of the courts of this state, of any other state, or
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of the United States which relates to health care fraud;
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8. Dispensing any medicinal drug based upon a
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communication that purports to be a prescription as defined in
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s. 465.003(14) or s. 893.02 if the dispensing practitioner knows
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or has reason to believe that the purported prescription is not
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based upon a valid practitioner-patient relationship; or
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9. Failing to timely notify the board of the date of his
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or her termination from a pain-management clinic as required by
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s. 458.3265(3) 458.3265(2).
(qq) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of other methods for prescribing within 24 hours as required by s. 458.3265(3), 458.3265(2).

Section 15. Effective January 1, 2019, paragraphs (rr) and (ss) of subsection (1) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(rr) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;


4. Being convicted or found guilty of, regardless of
adjudication to, a felony or any other crime involving moral
turpitude, fraud, dishonesty, or deceit in any jurisdiction of
the courts of this state, of any other state, or of the United
States;

5. Being convicted of, or disciplined by a regulatory
agency of the Federal Government or a regulatory agency of
another state for, any offense that would constitute a violation
of this chapter;

6. Being convicted of, or entering a plea of guilty or
nolo contendere to, regardless of adjudication, a crime in any
jurisdiction of the courts of this state, of any other state, or
of the United States which relates to the practice of, or the
ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or
nolo contendere to, regardless of adjudication, a crime in any
jurisdiction of the courts of this state, of any other state, or
of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a
communication that purports to be a prescription as defined in
s. 465.003(14) or s. 893.02 if the dispensing practitioner knows
or has reason to believe that the purported prescription is not
based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his
or her termination from a pain-management clinic as required by
s. 459.0137(3) 459.0137(2).
(ss) Failing to timely notify the department of the theft
of prescription blanks from a pain-management clinic or a breach
of other methods for prescribing within 24 hours as required by
s. 459.0137(3) 459.0137(2).

Section 16. Paragraph (b) of subsection (4) of section
463.0055, Florida Statutes, is amended to read:
463.0055 Administration and prescription of ocular
pharmaceutical agents.—

(4) A certified optometrist shall be issued a prescriber
number by the board. Any prescription written by a certified
optometrist for an ocular pharmaceutical agent pursuant to this
section shall have the prescriber number printed thereon. A
certified optometrist may not administer or prescribe:

(b) A controlled substance for the treatment of chronic
nonmalignant pain as defined in s. 456.44(1)(f) 456.44(1)(e).

Section 17. Paragraph (a) of subsection (1) of section
782.04, Florida Statutes, is amended to read:

782.04 Murder.—

(1)(a) The unlawful killing of a human being:
1. When perpetrated from a premeditated design to effect
the death of the person killed or any human being;
2. When committed by a person engaged in the perpetration
of, or in the attempt to perpetrate, any:
   a. Trafficking offense prohibited by s. 893.135(1),
   b. Arson,
c. Sexual battery,
d. Robbery,
e. Burglary,
f. Kidnapping,
g. Escape,
h. Aggravated child abuse,
i. Aggravated abuse of an elderly person or disabled adult,
j. Aircraft piracy,
k. Unlawful throwing, placing, or discharging of a destructive device or bomb,
l. Carjacking,
m. Home-invasion robbery,
n. Aggravated stalking,
o. Murder of another human being,
p. Resisting an officer with violence to his or her person,
q. Aggravated fleeing or eluding with serious bodily injury or death,
r. Felony that is an act of terrorism or is in furtherance of an act of terrorism, including a felony under s. 775.30, s. 775.32, s. 775.33, s. 775.34, or s. 775.35, or
s. Human trafficking; or
3. Which resulted from the unlawful distribution by a person 18 years of age or older of any of the following

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substances, or mixture containing any of the following substances, when such substance or mixture is proven to be the proximate cause of the death of the user:

a. A substance controlled under s. 893.03(1);

b. Cocaine, as described in s. 893.03(2)(a)4.;

c. Opium or any synthetic or natural salt, compound, derivative, or preparation of opium;

d. Methadone;

e. Alfentanil, as described in s. 893.03(2)(b)1.;

f. Carfentanil, as described in s. 893.03(2)(b)6.;

g. Fentanyl, as described in s. 893.03(2)(b)9.;

h. Sufentanil, as described in s. 893.03(2)(b)30.

3338 i. A controlled substance analog, as described in s. 893.0356, of any substance specified in sub-subparagraphs a.–h.,

is murder in the first degree and constitutes a capital felony, punishable as provided in s. 775.082.

Section 18. Paragraphs (c) and (f) of subsection (1) of section 893.135, Florida Statutes, are amended to read:

893.135 Trafficking; mandatory sentences; suspension or reduction of sentences; conspiracy to engage in trafficking.— (1) Except as authorized in this chapter or in chapter 499 and notwithstanding the provisions of s. 893.13:

(c)1. A person who knowingly sells, purchases,
manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of any morphine, opium, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 4 grams or more of any mixture containing any such substance, but less than 30 kilograms of such substance or mixture, commits a felony of the first degree, which felony shall be known as "trafficking in illegal drugs," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

   a. Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

   b. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $100,000.

   c. Is 28 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $500,000.

2. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 14 grams or more of...
hydrocodone, as described in s. 893.03(2)(a)1.k.

or any salt thereof, or 14 grams or more of any mixture
containing any such substance, commits a felony of the first
degree, which felony shall be known as "trafficking in
hydrocodone," punishable as provided in s. 775.082, s. 775.083,
or s. 775.084. If the quantity involved:

a. Is 14 grams or more, but less than 28 grams, such
person shall be sentenced to a mandatory minimum term of
imprisonment of 3 years and shall be ordered to pay a fine of
$50,000.

b. Is 28 grams or more, but less than 50 grams, such
person shall be sentenced to a mandatory minimum term of
imprisonment of 7 years and shall be ordered to pay a fine of
$100,000.

c. Is 50 grams or more, but less than 200 grams, such
person shall be sentenced to a mandatory minimum term of
imprisonment of 15 years and shall be ordered to pay a fine of
$500,000.

d. Is 200 grams or more, but less than 30 kilograms, such
person shall be sentenced to a mandatory minimum term of
imprisonment of 25 years and shall be ordered to pay a fine of
$750,000.

3. A person who knowingly sells, purchases, manufactures,
delivers, or brings into this state, or who is knowingly in
actual or constructive possession of, 7 grams or more of oxycodone, as described in s. 893.03(2)(a)1.q., 893.03(2)(a)1.o., or any salt thereof, or 7 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in oxycodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 7 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 25 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 25 grams or more, but less than 100 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 100 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

4.a. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or
more of:

(I) Alfentanil, as described in s. 893.03(2)(b)1.;
(II) Carfentanil, as described in s. 893.03(2)(b)6.;
(III) Fentanyl, as described in s. 893.03(2)(b)9.;
(IV) Sufentanil, as described in s. 893.03(2)(b)30.
(V) A fentanyl derivative, as described in s. 893.03(1)(a)62.;
(VI) A controlled substance analog, as described in s. 893.0356, of any substance described in sub-sub-subparagraphs (I)-(V); or
(VII) A mixture containing any substance described in sub-sub-subparagraphs (I)-(VI),

commits a felony of the first degree, which felony shall be known as "trafficking in fentanyl," punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. If the quantity involved under sub-subparagraph a.:

(I) Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years, and shall be ordered to pay a fine of $50,000.

(II) Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years, and shall be ordered to pay a fine of...
5. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 30 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 30 kilograms or more of any mixture containing any such substance, commits the first degree felony of trafficking in illegal drugs. A person who has been convicted of the first degree felony of trafficking in illegal drugs under this subparagraph shall be punished by life imprisonment and is ineligible for any form of discretionary early release except pardon or executive clemency or conditional medical release under s. 947.149. However, if the court determines that, in addition to committing any act specified in this paragraph: 
   a. The person intentionally killed an individual or counseled, commanded, induced, procured, or caused the intentional killing of an individual and such killing was the result; or
   b. The person's conduct in committing that act led to a
natural, though not inevitable, lethal result,

such person commits the capital felony of trafficking in illegal
drugs, punishable as provided in ss. 775.082 and 921.142. A
person sentenced for a capital felony under this paragraph shall
also be sentenced to pay the maximum fine provided under
subparagraph 1.

6. A person who knowingly brings into this state 60
kilograms or more of any morphine, opium, oxycodone,
hydrocodone, codeine, hydromorphone, or any salt, derivative,
isomer, or salt of an isomer thereof, including heroin, as
described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or
60 kilograms or more of any mixture containing any such
substance, and who knows that the probable result of such
importation would be the death of a person, commits capital
importation of illegal drugs, a capital felony punishable as
provided in ss. 775.082 and 921.142. A person sentenced for a
capital felony under this paragraph shall also be sentenced to
pay the maximum fine provided under subparagraph 1.

(f)1. Any person who knowingly sells, purchases,
manufactures, delivers, or brings into this state, or who is
knowingly in actual or constructive possession of, 14 grams or
more of amphetamine, as described in s. 893.03(2)(c)2., or
methamphetamine, as described in s. 893.03(2)(c)5.
893.03(2)(c)4., or of any mixture containing amphetamine or
methamphetamine, or phenylacetone, phenylacetic acid,
pseudoephedrine, or ephedrine in conjunction with other
chemicals and equipment utilized in the manufacture of
amphetamine or methamphetamine, commits a felony of the first
degree, which felony shall be known as "trafficking in
amphetamine," punishable as provided in s. 775.082, s. 775.083,
or s. 775.084. If the quantity involved:

a. Is 14 grams or more, but less than 28 grams, such
person shall be sentenced to a mandatory minimum term of
imprisonment of 3 years, and the defendant shall be ordered to
pay a fine of $50,000.

b. Is 28 grams or more, but less than 200 grams, such
person shall be sentenced to a mandatory minimum term of
imprisonment of 7 years, and the defendant shall be ordered to
pay a fine of $100,000.

c. Is 200 grams or more, such person shall be sentenced to
a mandatory minimum term of imprisonment of 15 calendar years
and pay a fine of $250,000.

2. Any person who knowingly manufactures or brings into
this state 400 grams or more of amphetamine, as described in s.
893.03(2)(c)2., or methamphetamine, as described in s.
893.03(2)(c)5. 893.03(2)(c)4., or of any mixture containing
amphetamine or methamphetamine, or phenylacetone, phenylacetic
acid, pseudoephedrine, or ephedrine in conjunction with other
chemicals and equipment used in the manufacture of amphetamine

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or methamphetamine, and who knows that the probable result of
such manufacture or importation would be the death of any person
commits capital manufacture or importation of amphetamine, a
capital felony punishable as provided in ss. 775.082 and
921.142. Any person sentenced for a capital felony under this
paragraph shall also be sentenced to pay the maximum fine
provided under subparagraph 1.

Section 19. Paragraphs (b) through (e) and (g) of
subsection (3) of section 921.0022, Florida Statutes, are
amended to read:

921.0022 Criminal Punishment Code; offense severity
ranking chart.—

(3) OFFENSE SEVERITY RANKING CHART
(b) LEVEL 2

Florida Felony Description
Statute Degree

379.2431 3rd Possession of 11 or fewer marine
(1)(e)3. turtle eggs in violation of the
Marine Turtle Protection Act.

379.2431 3rd Possession of more than 11
(1)(e)4. marine turtle eggs in violation

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of the Marine Turtle Protection Act.

403.413(6)(c)  3rd  Dumps waste litter exceeding 500 lbs. in weight or 100 cubic feet in volume or any quantity for commercial purposes, or hazardous waste.

517.07(2)  3rd  Failure to furnish a prospectus meeting requirements.

590.28(1)  3rd  Intentional burning of lands.

784.05(3)  3rd  Storing or leaving a loaded firearm within reach of minor who uses it to inflict injury or death.

787.04(1)  3rd  In violation of court order, take, entice, etc., minor beyond state limits.

806.13(1)(b)  3rd  Criminal mischief; damage $1,000 or more to public communication
<table>
<thead>
<tr>
<th>Section</th>
<th>Degree</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>810.061(2)</td>
<td>3rd</td>
<td>Impairing or impeding telephone or power to a dwelling; facilitating or furthering burglary.</td>
</tr>
<tr>
<td>810.09(2)(e)</td>
<td>3rd</td>
<td>Trespassing on posted commercial horticulture property.</td>
</tr>
<tr>
<td>812.014(2)(c)1.</td>
<td>3rd</td>
<td>Grand theft, 3rd degree; $300 or more but less than $5,000.</td>
</tr>
<tr>
<td>812.014(2)(d)</td>
<td>3rd</td>
<td>Grand theft, 3rd degree; $100 or more but less than $300, taken from unenclosed curtilage of dwelling.</td>
</tr>
<tr>
<td>812.015(7)</td>
<td>3rd</td>
<td>Possession, use, or attempted use of an antishoplifting or inventory control device countermeasure.</td>
</tr>
<tr>
<td>817.234(1)(a)2.</td>
<td>3rd</td>
<td>False statement in support of insurance claim.</td>
</tr>
</tbody>
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CODING: Words *stricken* are deletions; words *underlined* are additions.
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<thead>
<tr>
<th>Section</th>
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</thead>
<tbody>
<tr>
<td>817.481(3)(a)</td>
<td>3rd</td>
<td>Obtain credit or purchase with false, expired, counterfeit, etc., credit card, value over $300.</td>
</tr>
<tr>
<td>817.52(3)</td>
<td>3rd</td>
<td>Failure to redeliver hired vehicle.</td>
</tr>
<tr>
<td>817.54</td>
<td>3rd</td>
<td>With intent to defraud, obtain mortgage note, etc., by false representation.</td>
</tr>
<tr>
<td>817.60(5)</td>
<td>3rd</td>
<td>Dealing in credit cards of another.</td>
</tr>
<tr>
<td>817.60(6)(a)</td>
<td>3rd</td>
<td>Forgery; purchase goods, services with false card.</td>
</tr>
<tr>
<td>817.61</td>
<td>3rd</td>
<td>Fraudulent use of credit cards over $100 or more within 6 months.</td>
</tr>
<tr>
<td>826.04</td>
<td>3rd</td>
<td>Knowingly marries or has sexual intercourse with person to whom</td>
</tr>
</tbody>
</table>
related.

3563
831.01  3rd Forgery.

3564
831.02  3rd Uttering forged instrument; utters or publishes alteration with intent to defraud.

3565
831.07  3rd Forging bank bills, checks, drafts, or promissory notes.

3566
831.08  3rd Possessing 10 or more forged notes, bills, checks, or drafts.

3567
831.09  3rd Uttering forged notes, bills, checks, drafts, or promissory notes.

3568
831.11  3rd Bringing into the state forged bank bills, checks, drafts, or notes.

3569
832.05(3)(a)  3rd Cashing or depositing item with intent to defraud.

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843.08  3rd  False personation.

893.13(2)(a)2.  3rd  Purchase of any s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs other than cannabis.

893.147(2)  3rd  Manufacture or delivery of drug paraphernalia.

(c)  LEVEL 3

Florida Statute  Felony  Description
Statute    Degree

119.10(2)(b)  3rd  Unlawful use of confidential information from police reports.

316.066  3rd  Unlawfully obtaining or using
<table>
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<tr>
<th>Code</th>
<th>Paragraph</th>
<th>Type</th>
<th>Explanation</th>
</tr>
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<tbody>
<tr>
<td>3582</td>
<td>(3)(b)-(d)</td>
<td></td>
<td>confidential crash reports.</td>
</tr>
<tr>
<td>3583</td>
<td>316.193(2)(b)</td>
<td>3rd</td>
<td>Felony DUI, 3rd conviction.</td>
</tr>
<tr>
<td>3584</td>
<td>316.1935(2)</td>
<td>3rd</td>
<td>Fleeing or attempting to elude law enforcement officer in patrol vehicle with siren and lights activated.</td>
</tr>
<tr>
<td>3585</td>
<td>319.30(4)</td>
<td>3rd</td>
<td>Possession by junkyard of motor vehicle with identification number plate removed.</td>
</tr>
<tr>
<td>3586</td>
<td>319.33(1)(a)</td>
<td>3rd</td>
<td>Alter or forge any certificate of title to a motor vehicle or mobile home.</td>
</tr>
<tr>
<td>3587</td>
<td>319.33(1)(c)</td>
<td>3rd</td>
<td>Procure or pass title on stolen vehicle.</td>
</tr>
<tr>
<td>3588</td>
<td>319.33(4)</td>
<td>3rd</td>
<td>With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.</td>
</tr>
</tbody>
</table>
327.35(2)(b) 3rd Felony BUI.

328.05(2) 3rd Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.

328.07(4) 3rd Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.

376.302(5) 3rd Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.

379.2431 3rd Taking, disturbing, mutilating, destroying, causing to be destroyed, transferring, selling, offering to sell, molesting, or harassing marine turtles, marine turtle eggs, or marine turtle nests in violation of the Marine Turtle Protection Act.
<table>
<thead>
<tr>
<th>379.2431</th>
<th>3rd</th>
<th>Possessing any marine turtle species or hatchling, or parts thereof, or the nest of any marine turtle species described in the Marine Turtle Protection Act.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)(e)6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>379.2431</th>
<th>3rd</th>
<th>Soliciting to commit or conspiring to commit a violation of the Marine Turtle Protection Act.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)(e)7.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>400.9935(4)(a)</th>
<th>3rd</th>
<th>Operating a clinic, or offering services requiring licensure, without a license.</th>
</tr>
</thead>
<tbody>
<tr>
<td>or (b)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>400.9935(4)(e)</th>
<th>3rd</th>
<th>Filing a false license application or other required information or failing to report information.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>440.1051(3)</th>
<th>3rd</th>
<th>False report of workers' compensation fraud or retaliation for making such a report.</th>
</tr>
</thead>
</table>

CODING: Words **stricken** are deletions; words *underlined* are additions.
501.001(2)(b)  2nd  Tampers with a consumer product or the container using materially false/misleading information.

624.401(4)(a)  3rd  Transacting insurance without a certificate of authority.

624.401(4)(b)1.  3rd  Transacting insurance without a certificate of authority; premium collected less than $20,000.

626.902(1)(a) & (b)  3rd  Representing an unauthorized insurer.

697.08  3rd  Equity skimming.

790.15(3)  3rd  Person directs another to discharge firearm from a vehicle.

806.10(1)  3rd  Maliciously injure, destroy, or interfere with vehicles or
equipment used in firefighting.

3605
806.10(2) 3rd Interferes with or assaults firefighter in performance of duty.

3606
810.09(2)(c) 3rd Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.

3607
812.014(2)(c)2. 3rd Grand theft; $5,000 or more but less than $10,000.

3608
812.0145(2)(c) 3rd Theft from person 65 years of age or older; $300 or more but less than $10,000.

3609
815.04(5)(b) 2nd Computer offense devised to defraud or obtain property.

3610
817.034(4)(a)3. 3rd Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
<table>
<thead>
<tr>
<th>Section</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3611</td>
<td>817.233</td>
<td>Burning to defraud insurer.</td>
</tr>
<tr>
<td>3612</td>
<td>817.234</td>
<td>Unlawful solicitation of persons involved in motor vehicle accidents. (8)(b) &amp; (c)</td>
</tr>
<tr>
<td>3613</td>
<td>817.234(11)(a)</td>
<td>Insurance fraud; property value less than $20,000.</td>
</tr>
<tr>
<td>3614</td>
<td>817.236</td>
<td>Filing a false motor vehicle insurance application.</td>
</tr>
<tr>
<td>3615</td>
<td>817.2361</td>
<td>Creating, marketing, or presenting a false or fraudulent motor vehicle insurance card.</td>
</tr>
<tr>
<td>3616</td>
<td>817.413(2)</td>
<td>Sale of used goods as new.</td>
</tr>
<tr>
<td>3617</td>
<td>828.12(2)</td>
<td>Tortures any animal with intent to inflict intense pain, serious physical injury, or death.</td>
</tr>
<tr>
<td>3618</td>
<td>831.28(2)(a)</td>
<td>Counterfeiting a payment instrument with intent to</td>
</tr>
</tbody>
</table>
defraud or possessing a
counterfeit payment instrument.

831.29  2nd Possession of instruments for
counterfeiting driver licenses
or identification cards.

838.021(3)(b)  3rd Threatens unlawful harm to
public servant.

843.19  3rd Injure, disable, or kill police
dog or horse.

860.15(3)  3rd Overcharging for repairs and
parts.

870.01(2)  3rd Riot; inciting or encouraging.

893.13(1)(a)2.  3rd Sell, manufacture, or deliver
cannabis (or other s.
893.03(1)(c), (2)(c)1.,
(2)(c)2., (2)(c)3., (2)(c)5.,
(2)(c)6., (2)(c)7., (2)(c)8.,
(2)(c)9., (2)(c)10., (3), or (4)
drugs).

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893.13(1)(d)2.  2nd  Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of university.

893.13(1)(f)2.  2nd  Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of public housing facility.

893.13(4)(c)  3rd  Use or hire of minor; deliver to minor other controlled substances.

893.13(6)(a)  3rd  Possession of any controlled substance other than felony possession of cannabis.
<table>
<thead>
<tr>
<th>Section</th>
<th>Code</th>
<th>3rd</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>893.13(7)(a)8.</td>
<td>3630</td>
<td>3rd</td>
<td>Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.</td>
</tr>
<tr>
<td>893.13(7)(a)9.</td>
<td>3631</td>
<td>3rd</td>
<td>Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.</td>
</tr>
<tr>
<td>893.13(7)(a)10.</td>
<td>3632</td>
<td>3rd</td>
<td>Affix false or forged label to package of controlled substance.</td>
</tr>
<tr>
<td>893.13(7)(a)11.</td>
<td>3633</td>
<td>3rd</td>
<td>Furnish false or fraudulent material information on any document or record required by chapter 893.</td>
</tr>
<tr>
<td>893.13(8)(a)1.</td>
<td>3634</td>
<td>3rd</td>
<td>Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner's practice.</td>
</tr>
</tbody>
</table>
893.13(8)(a)2. 3rd Employ a trick or scheme in the practitioner's practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.

893.13(8)(a)3. 3rd Knowingly write a prescription for a controlled substance for a fictitious person.

893.13(8)(a)4. 3rd Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.

918.13(1)(a) 3rd Alter, destroy, or conceal investigation evidence.

944.47 3rd Introduce contraband to correctional facility.

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CODING: Words stricken are deletions; words underlined are additions.
<table>
<thead>
<tr>
<th>Florida Statute</th>
<th>Felony Degree</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>944.47(1)(c)</td>
<td>2nd</td>
<td>Possess contraband while upon the grounds of a correctional institution.</td>
</tr>
<tr>
<td>985.721</td>
<td>3rd</td>
<td>Escapes from a juvenile facility (secure detention or residential commitment facility).</td>
</tr>
<tr>
<td>316.1935(3)(a)</td>
<td>2nd</td>
<td>Driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.</td>
</tr>
</tbody>
</table>
F L O R I D A   H O U S E   O F   R E P R E S E N T A T I V E S

ENROLLED
CS/CS/HB 21, Engrossed 2 2018 Legislature

499.0051(1)  3rd Failure to maintain or deliver transaction history, transaction information, or transaction statements.

499.0051(5)  2nd Knowing sale or delivery, or possession with intent to sell, contraband prescription drugs.

517.07(1)  3rd Failure to register securities.

517.12(1)  3rd Failure of dealer, associated person, or issuer of securities to register.

784.07(2)(b)  3rd Battery of law enforcement officer, firefighter, etc.

784.074(1)(c)  3rd Battery of sexually violent predators facility staff.

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CODING: Words struck are deletions; words underlined are additions.
<table>
<thead>
<tr>
<th>Section</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>784.075</td>
<td>3rd</td>
<td>Battery on detention or commitment facility staff.</td>
</tr>
<tr>
<td>784.078</td>
<td>3rd</td>
<td>Battery of facility employee by throwing, tossing, or expelling certain fluids or materials.</td>
</tr>
<tr>
<td>784.08(2)(c)</td>
<td>3rd</td>
<td>Battery on a person 65 years of age or older.</td>
</tr>
<tr>
<td>784.081(3)</td>
<td>3rd</td>
<td>Battery on specified official or employee.</td>
</tr>
<tr>
<td>784.082(3)</td>
<td>3rd</td>
<td>Battery by detained person on visitor or other detainee.</td>
</tr>
<tr>
<td>784.083(3)</td>
<td>3rd</td>
<td>Battery on code inspector.</td>
</tr>
<tr>
<td>784.085</td>
<td>3rd</td>
<td>Battery of child by throwing, tossing, projecting, or expelling certain fluids or materials.</td>
</tr>
</tbody>
</table>
ENROLLED
CS/CS/HB 21, Engrossed 2
2018 Legislature

F L O R I D A  H O U S E  O F  R E P R E S E N T A T I V E S

materials.

3661
787.03(1)  3rd  Interference with custody; wrongly takes minor from appointed guardian.

3662
787.04(2)  3rd  Take, entice, or remove child beyond state limits with criminal intent pending custody proceedings.

3663
787.04(3)  3rd  Carrying child beyond state lines with criminal intent to avoid producing child at custody hearing or delivering to designated person.

3664
787.07  3rd  Human smuggling.

3665
790.115(1)  3rd  Exhibiting firearm or weapon within 1,000 feet of a school.

3666
790.115(2)(b)  3rd  Possessing electric materials.
weapon or device, destructive device, or other weapon on school property.

790.115(2)(c) 3rd Possessing firearm on school property.

800.04(7)(c) 3rd Lewd or lascivious exhibition; offender less than 18 years.

810.02(4)(a) 3rd Burglary, or attempted burglary, of an unoccupied structure; unarmed; no assault or battery.

810.02(4)(b) 3rd Burglary, or attempted burglary, of an unoccupied conveyance; unarmed; no assault or battery.

810.06 3rd Burglary; possession of tools.
810.08(2)(c) 3rd Trespass on property, armed with firearm or dangerous weapon.

812.014(2)(c)3. 3rd Grand theft, 3rd degree $10,000 or more but less than $20,000.

812.014(2)(c)4.-10. 3rd Grand theft, 3rd degree, a will, firearm, motor vehicle, livestock, etc.

812.0195(2) 3rd Dealing in stolen property by use of the Internet; property stolen $300 or more.

817.505(4)(a) 3rd Patient brokering.

817.563(1) 3rd Sell or deliver substance other than controlled substance agreed upon, excluding s. 893.03(5)
ENROLLED
CS/CS/HB 21, Engrossed 2 2018 Legislature

CODING: Words stricken are deletions; words underlined are additions.

3678 817.568(2)(a) 3rd Fraudulent use of personal identification information.

3679 817.625(2)(a) 3rd Fraudulent use of scanning device, skimming device, or reencoder.

3680 817.625(2)(c) 3rd Possess, sell, or deliver skimming device.

3681 828.125(1) 2nd Kill, maim, or cause great bodily harm or permanent breeding disability to any registered horse or cattle.

3682 837.02(1) 3rd Perjury in official proceedings.

3683 837.021(1) 3rd Make contradictory statements in official proceedings.

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<table>
<thead>
<tr>
<th>Code</th>
<th>Section</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>838.022</td>
<td>3rd</td>
<td>Official misconduct.</td>
</tr>
<tr>
<td>839.13(2)(a)</td>
<td>3rd</td>
<td>Falsifying records of an individual in the care and custody of a state agency.</td>
</tr>
<tr>
<td>839.13(2)(c)</td>
<td>3rd</td>
<td>Falsifying records of the Department of Children and Families.</td>
</tr>
<tr>
<td>843.021</td>
<td>3rd</td>
<td>Possession of a concealed handcuff key by a person in custody.</td>
</tr>
<tr>
<td>843.025</td>
<td>3rd</td>
<td>Deprive law enforcement, correctional, or correctional probation officer of means of protection or communication.</td>
</tr>
<tr>
<td>843.15(1)(a)</td>
<td>3rd</td>
<td>Failure to appear while on bail for felony (bond estreature or bond jumping).</td>
</tr>
</tbody>
</table>

CODING: Words **stricken** are deletions; words *underlined* are additions.
847.0135(5)(c) 3rd Lewd or lascivious exhibition using computer; offender less than 18 years.

874.05(1)(a) 3rd Encouraging or recruiting another to join a criminal gang.

893.13(2)(a)1. 2nd Purchase of cocaine (or other s. 893.03(1)(a), (b), or (d), (2)(a), (2)(b), or (2)(c)5. (2)(c)4. drugs).

914.14(2) 3rd Witnesses accepting bribes.

914.22(1) 3rd Force, threaten, etc., witness, victim, or informant.

914.23(2) 3rd Retaliation against a witness, victim, or
informant, no bodily injury.

3696  

918.12  3rd  Tampering with jurors.

3697

934.215  3rd  Use of two-way communications device to facilitate commission of a crime.

3698

3699

3700

3701

3702

3703  (e) LEVEL 5

3704

3705

Florida Statute  Felony Degree Description

3706

316.027(2)(a)  3rd  Accidents involving personal injuries other than serious bodily injury, failure to stop; leaving scene.

3707

316.1935(4)(a)  2nd  Aggravated fleeing or eluding.
<table>
<thead>
<tr>
<th>Section</th>
<th>Version</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>316.80(2)</td>
<td>2nd</td>
<td>Unlawful conveyance of fuel; obtaining fuel fraudulently.</td>
</tr>
<tr>
<td>322.34(6)</td>
<td>3rd</td>
<td>Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.</td>
</tr>
<tr>
<td>327.30(5)</td>
<td>3rd</td>
<td>Vessel accidents involving personal injury; leaving scene.</td>
</tr>
<tr>
<td>379.365(2)(c)1</td>
<td>3rd</td>
<td>Violation of rules relating to: willful molestation of stone crab traps, lines, or buoys; illegal bartering, trading, or sale, conspiring or aiding in such barter, trade, or sale, or supplying, agreeing to supply, aiding in supplying, or giving away stone crab trap tags or certificates; making, altering, forging, counterfeiting, or reproducing stone crab trap tags; possession of forged, counterfeit, or imitation stone</td>
</tr>
</tbody>
</table>
crab trap tags; and engaging in the commercial harvest of stone crabs while license is suspended or revoked.

<table>
<thead>
<tr>
<th>Statute</th>
<th>Section</th>
<th>Law Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>379.367(4)</td>
<td></td>
<td>3rd</td>
<td>Willful molestation of a commercial harvester's spiny lobster trap, line, or buoy.</td>
</tr>
<tr>
<td>379.407(5)(b)3.</td>
<td></td>
<td>3rd</td>
<td>Possession of 100 or more undersized spiny lobsters.</td>
</tr>
<tr>
<td>381.0041(11)(b)</td>
<td></td>
<td>3rd</td>
<td>Donate blood, plasma, or organs knowing HIV positive.</td>
</tr>
<tr>
<td>440.10(1)(g)</td>
<td></td>
<td>2nd</td>
<td>Failure to obtain workers' compensation coverage.</td>
</tr>
<tr>
<td>440.105(5)</td>
<td></td>
<td>2nd</td>
<td>Unlawful solicitation for the purpose of making workers' compensation claims.</td>
</tr>
</tbody>
</table>
| 440.381(2)  |         | 2nd      | Submission of false, misleading, or incomplete information with the purpose of avoiding or
reducing workers' compensation premiums.

624.401(4)(b)2. 2nd Transacting insurance without a certificate or authority; premium collected $20,000 or more but less than $100,000.

626.902(1)(c) 2nd Representing an unauthorized insurer; repeat offender.

790.01(2) 3rd Carrying a concealed firearm.

790.162 2nd Threat to throw or discharge destructive device.

790.163(1) 2nd False report of bomb, explosive, weapon of mass destruction, or use of firearms in violent manner.

790.221(1) 2nd Possession of short-barreled shotgun or machine gun.

790.23 2nd Felons in possession of...
firearms, ammunition, or electronic weapons or devices.

3725
796.05(1) 2nd Live on earnings of a prostitute; 1st offense.

3726
800.04(6)(c) 3rd Lewd or lascivious conduct; offender less than 18 years of age.

3727
800.04(7)(b) 2nd Lewd or lascivious exhibition; offender 18 years of age or older.

3728
806.111(1) 3rd Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.

3729
812.0145(2)(b) 2nd Theft from person 65 years of age or older; $10,000 or more but less than $50,000.

3730
812.015(8) 3rd Retail theft; property stolen is valued at $300 or more and one
3731
812.019(1) 2nd Stolen property; dealing in or trafficking in.

3732
812.131(2)(b) 3rd Robbery by sudden snatching.

3733
812.16(2) 3rd Owning, operating, or conducting a chop shop.

3734
817.034(4)(a)2. 2nd Communications fraud, value $20,000 to $50,000.

3735
817.234(11)(b) 2nd Insurance fraud; property value $20,000 or more but less than $100,000.

3736
817.2341(1), (2)(a) & (3)(a) 3rd Filing false financial statements, making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity.

3737
817.568(2)(b) 2nd Fraudulent use of personal
identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $5,000 or more or use of personal identification information of 10 or more persons.

3738  
817.611(2)(a)  2nd  Traffic in or possess 5 to 14 counterfeit credit cards or related documents.

3739  
817.625(2)(b)  2nd  Second or subsequent fraudulent use of scanning device, skimming device, or reencorder.

3740  
825.1025(4)  3rd  Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.

3741  
827.071(4)  2nd  Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a
child.

827.071(5) 3rd Possess, control, or intentionally view any photographic material, motion picture, etc., which includes sexual conduct by a child.

839.13(2)(b) 2nd Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.

843.01 3rd Resist officer with violence to person; resist arrest with violence.

847.0135(5)(b) 2nd Lewd or lascivious exhibition using computer; offender 18 years or older.

847.0137 (2) & (3) 3rd Transmission of pornography by electronic device or equipment.
<table>
<thead>
<tr>
<th>Section</th>
<th>Amendment</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>847.0138</td>
<td>(2) &amp; (3)</td>
<td>3rd</td>
<td>Transmission of material harmful to minors to a minor by electronic device or equipment.</td>
</tr>
<tr>
<td>874.05(1)(b)</td>
<td></td>
<td>2nd</td>
<td>Encouraging or recruiting another to join a criminal gang; second or subsequent offense.</td>
</tr>
<tr>
<td>874.05(2)(a)</td>
<td></td>
<td>2nd</td>
<td>Encouraging or recruiting person under 13 years of age to join a criminal gang.</td>
</tr>
<tr>
<td>893.13(1)(a)1.</td>
<td></td>
<td>2nd</td>
<td>Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. (2)(c)4. drugs).</td>
</tr>
<tr>
<td>893.13(1)(c)2.</td>
<td></td>
<td>2nd</td>
<td>Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs) within 1,000 feet of a</td>
</tr>
</tbody>
</table>

CODING: Words **stricken** are deletions; words **underlined** are additions.
child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.

3752

893.13(1)(d)1. 1st Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. (2)(c)4. drugs) within 1,000 feet of university.

3753

893.13(1)(e)2. 2nd Sell, manufacture, or deliver cannabis or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.

3754

893.13(1)(f)1. 1st Sell, manufacture, or deliver cocaine (or other s.
893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)5.
(2)(e)4. drugs) within 1,000 feet of public housing facility.

893.13(4)(b)  2nd  Use or hire of minor; deliver to minor other controlled substance.

893.1351(1)  3rd  Ownership, lease, or rental for trafficking in or manufacturing of controlled substance.

(g) LEVEL 7

Florida Statute  Felony  Degree  Description

316.027(2)(c)  1st  Accident involving death, failure to stop; leaving scene.
<table>
<thead>
<tr>
<th>Section</th>
<th>Offense Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>316.193(3)(c)2.</td>
<td>3rd DUI resulting in serious bodily injury.</td>
</tr>
<tr>
<td>316.1935(3)(b)</td>
<td>1st Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.</td>
</tr>
<tr>
<td>327.35(3)(c)2.</td>
<td>3rd Vessel BUI resulting in serious bodily injury.</td>
</tr>
<tr>
<td>402.319(2)</td>
<td>2nd Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.</td>
</tr>
<tr>
<td>409.920</td>
<td>3rd</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>(2)(b)1.a.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>409.920</th>
<th>2nd</th>
<th>Medicaid provider fraud; more than $10,000, but less than $50,000.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2)(b)1.b.</td>
<td></td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>456.065(2)</th>
<th>3rd</th>
<th>Practicing a health care profession without a license.</th>
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</thead>
</table>

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<thead>
<tr>
<th>456.065(2)</th>
<th>2nd</th>
<th>Practicing a health care profession without a license which results in serious bodily injury.</th>
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<tr>
<th>458.327(1)</th>
<th>3rd</th>
<th>Practicing medicine without a license.</th>
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<tr>
<th>459.013(1)</th>
<th>3rd</th>
<th>Practicing osteopathic medicine without a license.</th>
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<tr>
<th>460.411(1)</th>
<th>3rd</th>
<th>Practicing chiropractic</th>
</tr>
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medicine without a license.

461.012(1) 3rd Practicing podiatric medicine without a license.

462.17 3rd Practicing naturopathy without a license.

463.015(1) 3rd Practicing optometry without a license.

464.016(1) 3rd Practicing nursing without a license.

465.015(2) 3rd Practicing pharmacy without a license.

466.026(1) 3rd Practicing dentistry or dental hygiene without a license.

467.201 3rd Practicing midwifery without a license.
468.366  3rd  Delivering respiratory care services without a license.

483.828(1)  3rd  Practicing as clinical laboratory personnel without a license.

483.901(7)  3rd  Practicing medical physics without a license.

484.013(1)(c)  3rd  Preparing or dispensing optical devices without a prescription.

484.053  3rd  Dispensing hearing aids without a license.

494.0018(2)  1st  Conviction of any violation of chapter 494 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.
560.123(8)(b)1. 3rd Failure to report currency or payment instruments exceeding $300 but less than $20,000 by a money services business.

560.125(5)(a) 3rd Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.

655.50(10)(b)1. 3rd Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.

775.21(10)(a) 3rd Sexual predator; failure to register; failure to renew driver license or identification card; other registration violations.
<table>
<thead>
<tr>
<th>Section</th>
<th>Code</th>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>775.21(10)(b)</td>
<td>3rd</td>
<td></td>
<td>Sexual predator working where children regularly congregate.</td>
</tr>
<tr>
<td>775.21(10)(g)</td>
<td>3rd</td>
<td></td>
<td>Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.</td>
</tr>
<tr>
<td>782.051(3)</td>
<td>2nd</td>
<td></td>
<td>Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.</td>
</tr>
<tr>
<td>782.07(1)</td>
<td>2nd</td>
<td></td>
<td>Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).</td>
</tr>
</tbody>
</table>
| 782.071        | 2nd          |      | Killing of a human being or unborn child by the operation of a motor vehicle in a
Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).

Aggravated battery; intentionally causing great bodily harm or disfigurement.

Aggravated battery; using deadly weapon.

Aggravated battery; perpetrator aware victim pregnant.

Aggravated stalking; violation of injunction or court order.
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<tr>
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<th>Description</th>
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<tr>
<td>784.07(2)(d)</td>
<td>1st Aggravated battery on law enforcement officer.</td>
</tr>
<tr>
<td>784.074(1)(a)</td>
<td>1st Aggravated battery on sexually violent predators facility staff.</td>
</tr>
<tr>
<td>784.08(2)(a)</td>
<td>1st Aggravated battery on a person 65 years of age or older.</td>
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<tr>
<td>784.081(1)</td>
<td>1st Aggravated battery on specified official or employee.</td>
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<tr>
<td>784.082(1)</td>
<td>1st Aggravated battery by detained person on visitor or other detainee.</td>
</tr>
<tr>
<td>784.083(1)</td>
<td>1st Aggravated battery on code inspector.</td>
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</tbody>
</table>
787.06(3)(a)2. 1st Human trafficking using coercion for labor and services of an adult.

787.06(3)(e)2. 1st Human trafficking using coercion for labor and services by the transfer or transport of an adult from outside Florida to within the state.

790.07(4) 1st Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).

790.16(1) 1st Discharge of a machine gun under specified circumstances.

790.165(2) 2nd Manufacture, sell, possess, or deliver hoax bomb.

790.165(3) 2nd Possessing, displaying, or threatening to use any hoax bomb while committing or
<table>
<thead>
<tr>
<th>Section</th>
<th>1st/PBL</th>
<th>Type</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>790.23</td>
<td></td>
<td>1st</td>
<td>Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.</td>
</tr>
<tr>
<td>794.08(4)</td>
<td></td>
<td>3rd</td>
<td>Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18 years of age.</td>
</tr>
</tbody>
</table>

attempts to commit a felony.

Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.

Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
<table>
<thead>
<tr>
<th>Section</th>
<th>Degree of Offense</th>
<th>Description</th>
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<tbody>
<tr>
<td>796.05(1)</td>
<td>1st</td>
<td>Live on earnings of a prostitute; 2nd offense.</td>
</tr>
<tr>
<td>796.05(1)</td>
<td>1st</td>
<td>Live on earnings of a prostitute; 3rd and subsequent offense.</td>
</tr>
<tr>
<td>800.04(5)(c)1.</td>
<td>2nd</td>
<td>Lewd or lascivious molestation; victim younger than 12 years of age; offender younger than 18 years of age.</td>
</tr>
<tr>
<td>800.04(5)(c)2.</td>
<td>2nd</td>
<td>Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years of age; offender 18 years of age or older.</td>
</tr>
<tr>
<td>800.04(5)(e)</td>
<td>1st</td>
<td>Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years;</td>
</tr>
</tbody>
</table>
offender 18 years or
older; prior conviction
for specified sex offense.

806.01(2)  2nd Maliciously damage structure
by fire or explosive.

810.02(3)(a)  2nd Burglary of occupied
dwelling; unarmed; no
assault or battery.

810.02(3)(b)  2nd Burglary of unoccupied
dwelling; unarmed; no
assault or battery.

810.02(3)(d)  2nd Burglary of occupied
conveyance; unarmed; no
assault or battery.

810.02(3)(e)  2nd Burglary of authorized
emergency vehicle.

812.014(2)(a)1.  1st Property stolen, valued
at $100,000 or more or
a semitrailer deployed
b by a law enforcement
officer; property
stolen while causing
other property damage;
1st degree grand theft.

812.014(2)(b)2. 2nd Property stolen,
cargo valued at
less than $50,000,
grand theft in 2nd
degree.

812.014(2)(b)3. 2nd Property stolen,
emergency medical
equipment; 2nd degree
grand theft.

812.014(2)(b)4. 2nd Property stolen, law
enforcement equipment
from authorized
emergency vehicle.

812.0145(2)(a) 1st Theft from person
65 years of age or
older; $50,000 or
3834 812.019(2) 1st Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.

3835 812.131(2)(a) 2nd Robbery by sudden snatching.

3836 812.133(2)(b) 1st Carjacking; no firearm, deadly weapon, or other weapon.

3837 817.034(4)(a)1. 1st Communications fraud, value greater than $50,000.

3838 817.234(8)(a) 2nd Solicitation of motor vehicle accident victims with intent to defraud.

3839 817.234(9) 2nd Organizing, planning, or participating in an

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intentional motor vehicle collision.

3840
817.234(11)(c) 1st Insurance fraud; property value $100,000 or more.

3841
817.2341 Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.

(2)(b) & (3)(b)

3842
817.535(2)(a) 3rd Filing false lien or other unauthorized document.

3843
817.611(2)(b) 2nd Traffic in or possess 15 to 49 counterfeit credit cards or related documents.

3844
825.102(3)(b) 2nd Neglecting an elderly person

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<tr>
<th>Section</th>
<th>Degree</th>
<th>Offense Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>825.103(3)(b)</td>
<td>2nd</td>
<td>Exploiting an elderly person or disabled adult and property is valued at $10,000 or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>more, but less than $50,000.</td>
</tr>
<tr>
<td>827.03(2)(b)</td>
<td>2nd</td>
<td>Neglect of a child causing great bodily harm, disability, or disfigurement.</td>
</tr>
<tr>
<td>827.04(3)</td>
<td>3rd</td>
<td>Impregnation of a child under 16 years of age by person 21 years of age or older.</td>
</tr>
<tr>
<td>837.05(2)</td>
<td>3rd</td>
<td>Giving false information about alleged capital felony to a law enforcement officer.</td>
</tr>
</tbody>
</table>
838.015 2nd Bribery.

838.016 2nd Unlawful compensation or reward for official behavior.

838.021(3)(a) 2nd Unlawful harm to a public servant.

838.22 2nd Bid tampering.

843.0855(2) 3rd Impersonation of a public officer or employee.

843.0855(3) 3rd Unlawful simulation of legal process.

843.0855(4) 3rd Intimidation of a public officer or employee.

847.0135(3) 3rd Solicitation of a child, via a computer service, to commit an unlawful sex act.

847.0135(4) 2nd Traveling to meet a minor to commit an
unlawful sex act.

872.06 2nd Abuse of a dead human body.

874.05(2)(b) 1st Encouraging or recruiting person under 13 to join a criminal gang; second or subsequent offense.

874.10 1st,PBL Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.

893.13(1)(c)1. 1st Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. (2)(c)4. within 1,000 feet of a child care facility, school, or
state, county, or municipal park or publicly owned recreational facility or community center.

893.13(1)(e)1.
1st Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. (2)(e)4., within 1,000 feet of property used for religious services or a specified business site.

893.13(4)(a)
1st Use or hire of minor; deliver to minor other controlled substance.

893.135(1)(a)1.
1st Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
893.135  1st  Trafficking in cocaine, more than 28 grams, less than 200 grams.
     (1)(b)1.a.

893.135  1st  Trafficking in illegal drugs, more than 4 grams, less than 14 grams.
     (1)(c)1.a.

893.135  1st  Trafficking in hydrocodone, 14 grams or more, less than 28 grams.
     (1)(c)2.a.

893.135  1st  Trafficking in hydrocodone, 28 grams or more, less than 50 grams.
     (1)(c)2.b.

893.135  1st  Trafficking in oxycodone, 7 grams or more, less than 14 grams.
     (1)(c)3.a.

893.135  1st  Trafficking in oxycodone, 14 grams or more, less than 25 grams.
     (1)(c)3.b.
893.135 (1)(c)4.b.(I) 1st Trafficking in fentanyl, 4 grams or more, less than 14 grams.

893.135 (1)(d)1.a. 1st Trafficking in phencyclidine, 28 grams or more, less than 200 grams.

893.135(1)(e)1. 1st Trafficking in methaqualone, 200 grams or more, less than 5 kilograms.

893.135(1)(f)1. 1st Trafficking in amphetamine, 14 grams or more, less than 28 grams.

893.135 (1)(g)1.a. 1st Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.

893.135 (1)(h)1.a. 1st Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
kilocentimeters.

3877 893.135 1st Trafficking in 1,4-
(1)(j)1.a. Butanediol, 1 kilogram or
more, less than 5 kilogram.

3878 893.135 1st Trafficking in Phenethylamines,
(1)(k)2.a. 10 grams or more, less than 200 grams.

3879 893.135 1st Trafficking in synthetic
(1)(m)2.a. cannabinoids, 280 grams or
more, less than 500 grams.

3880 893.135 1st Trafficking in synthetic
(1)(m)2.b. cannabinoids, 500 grams or
more, less than 1,000 grams.

3881 893.135 1st Trafficking in n-benzyl
(1)(n)2.a. phenethylamines, 14 grams or
more, less than 100 grams.

3882 893.1351(2) 2nd Possession of place for
itrafficking in or

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<th>Code</th>
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<th>Description</th>
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<tbody>
<tr>
<td>3883</td>
<td></td>
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<td>制造受控物质的物质。</td>
</tr>
<tr>
<td>896.101(5)(a)</td>
<td></td>
<td>3rd</td>
<td>洗钱罪，金融交易超过300美元但低于20,000美元。</td>
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<tr>
<td>3884</td>
<td></td>
<td>3rd</td>
<td>结构交易，以逃避报告或登记要求，金融交易超过300美元但低于20,000美元。</td>
</tr>
<tr>
<td>896.104(4)(a)1.</td>
<td></td>
<td></td>
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<tr>
<td>3885</td>
<td></td>
<td>2nd</td>
<td>性犯罪者搬离永久居住地；违反报告要求。</td>
</tr>
<tr>
<td>943.0435(4)(c)</td>
<td></td>
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<tr>
<td>3886</td>
<td></td>
<td>2nd</td>
<td>性犯罪者；在表示离开意向后，留在该州；违反报告要求。</td>
</tr>
<tr>
<td>943.0435(8)</td>
<td></td>
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<tr>
<td>Section</td>
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<tr>
<td>943.0435(9)(a)</td>
<td>Sexual offender; failure to comply with reporting requirements.</td>
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</tr>
<tr>
<td>943.0435(13)</td>
<td>Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.</td>
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<td></td>
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<tr>
<td>943.0435(14)</td>
<td>Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.</td>
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<tr>
<td>944.607(9)</td>
<td>Sexual offender; failure to comply with reporting requirements.</td>
<td></td>
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<tr>
<td>944.607(10)(a)</td>
<td>Sexual offender; failure to submit to the taking</td>
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3892

944.607(12) 3rd Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.

3893

944.607(13) 3rd Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.

3894

985.4815(10) 3rd Sexual offender; failure to submit to the taking of a digitized photograph.

3895

985.4815(12) 3rd Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
offender.

3896

985.4815(13)  3rd Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.

3897

3898

3899

3900 Section 20. For the 2018-2019 fiscal year:

3901 (1) The nonrecurring sum of $27,035,532 is appropriated from the Federal Grants Trust Fund to the Department of Children and Families for expenditure of funds related to the second year of the State Targeted Response to the Opioid Crisis grant, to increase access to treatment, reduce unmet treatment needs, and reduce opioid overdose-related deaths through prevention, treatment, and recovery activities.

3908 (2) To enhance the entire substance abuse continuum of care, the sum of $14,626,911 in recurring funds is appropriated from the General Revenue Fund to the Department of Children and Families for community-based services to address the opioid crisis, including, but not limited to, outreach, addiction treatment, and recovery support services. Funding under this...
subsection shall be used to expand capacity to increase access
to and reduce waitlists for treatment; increase efforts to
effectively engage and retain in treatment youth, pregnant
women, high-risk populations, and high utilizers of acute care
services; and further develop a recovery-based model of care.
Funding for specific services may include, but are not limited
to, case management, residential services, outpatient services,
aftercare services, and medication-assisted treatment.
Medication-assisted treatment may include, but is not limited
to, methadone, buprenorphine, and naltrexone extended release
injectable.

(3) The recurring sum of $5,000,000 from the General
Revenue Fund is appropriated to the Department of Health for the
purchase of emergency opioid antagonists to be made available to
emergency responders.

(4) The recurring sum of $6 million from the General
Revenue Fund is appropriated to the Office of State Court
Administrator for medication-assisted treatment of substance
abuse disorders in individuals involved in the criminal justice
system, individuals who have a high likelihood of becoming
involved in the criminal justice system, or individuals who are
in court-ordered, community-based drug treatment. Such
medication-assisted treatment may include, but is not limited
to, methadone, buprenorphine, and naltrexone extended release
injectable.
(5) The sums of $873,089 in recurring funds and $117,700 in nonrecurring funds are appropriated from the General Revenue Fund to the Department of Health for improvements to the Prescription Drug Monitoring Program system pursuant to s. 893.055, Florida Statutes.

Section 21. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2018.
An act relating to pharmacies; amending s. 465.003, F.S.; revising and providing definitions; amending s. 465.004, F.S.; revising the membership of the Board of Pharmacy; amending s. 465.019, F.S.; establishing Class III institutional pharmacies; providing requirements for such pharmacies; conforming provisions to changes made by the act; amending s. 465.0252, F.S.; revising notice requirements to conform to changes made by the act; amending s. 499.003, F.S.; providing and revising definitions; amending s. 499.01, F.S.; authorizing the distribution of medicinal drugs and prepackaged drug products without a specified permit under certain conditions; deleting a provision exempting certain drug repackagers from specified permit requirements; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (7) and (13) of section 465.003, Florida Statutes, are amended, and subsections (21) and (22) are added to that section, to read:

465.003 Definitions.—As used in this chapter, the term:

(7) "Institutional formulary system" means a method
whereby the medical staff evaluates, appraises, and selects
those medicinal drugs or proprietary preparations which in the
medical staff's clinical judgment are most useful in patient
care, and which are available for dispensing by a practicing
pharmacist in a Class II or Class III institutional pharmacy.

(13) "Practice of the profession of pharmacy" includes
compounding, dispensing, and consulting concerning contents,
therapeutic values, and uses of any medicinal drug; consulting
concerning therapeutic values and interactions of patent or
proprietary preparations, whether pursuant to prescriptions or
in the absence and entirely independent of such prescriptions or
orders; and conducting other pharmaceutical services. For
purposes of this subsection, "other pharmaceutical services"
means the monitoring of the patient's drug therapy and assisting
the patient in the management of his or her drug therapy, and
includes review of the patient's drug therapy and communication
with the patient's prescribing health care provider as licensed
under chapter 458, chapter 459, chapter 461, or chapter 466, or
similar statutory provision in another jurisdiction, or such
provider's agent or such other persons as specifically
authorized by the patient, regarding the drug therapy. However,
nothing in this subsection may be interpreted to permit an
alteration of a prescriber's directions, the diagnosis or
treatment of any disease, the initiation of any drug therapy,
the practice of medicine, or the practice of osteopathic
medicine, unless otherwise permitted by law. "Practice of the
profession of pharmacy" also includes any other act, service,
operation, research, or transaction incidental to, or forming a
part of, any of the foregoing acts, requiring, involving, or
employing the science or art of any branch of the pharmaceutical
profession, study, or training, and shall expressly permit a
pharmacist to transmit information from persons authorized to
prescribe medicinal drugs to their patients. The practice of the
profession of pharmacy also includes the administration of
vaccines to adults pursuant to s. 465.189 and the preparation of
prepackaged drug products in facilities holding Class III
institutional pharmacy permits.

(21) "Central distribution facility" means a facility
under common control with a hospital holding a Class III
institutional pharmacy permit that may dispense, distribute,
compound, or fill prescriptions for medicinal drugs; prepare
prepackaged drug products; and conduct other pharmaceutical
services.

(22) "Common control" means the power to direct or cause
the direction of the management and policies of a person or an
organization, whether by ownership of stock, voting rights,
contract, or otherwise.

Section 2. Subsection (2) of section 465.004, Florida
Statutes, is amended to read:

465.004 Board of Pharmacy.—
(2) Seven members of the board must be licensed pharmacists who are residents of this state and who have been engaged in the practice of the profession of pharmacy in this state for at least 4 years and, to the extent practicable, represent the various pharmacy practice settings. Of the pharmacist members, two must be currently engaged in the practice of pharmacy in a community pharmacy, two must be currently engaged in the practice of pharmacy in a Class II, institutional pharmacy or a Modified Class II, or Class III institutional pharmacy, and three must be pharmacists licensed in this state irrespective of practice setting. The remaining two members must be residents of the state who have never been licensed as pharmacists and who are in no way connected with the practice of the profession of pharmacy. No person may be appointed as a consumer member who is in any way connected with a drug manufacturer or wholesaler. At least one member of the board must be 60 years of age or older. The Governor shall appoint members to the board in accordance with this subsection as members' terms expire or as a vacancy occurs until the composition of the board complies with the requirements of this subsection.

Section 3. Subsections (4) and (6) of section 465.019, Florida Statutes, are amended, and paragraph (d) is added to subsection (2) of that section, to read:

465.019 Institutional pharmacies; permits.—
(2) The following classes of institutional pharmacies are established:

   (d)1. "Class III institutional pharmacies" are those institutional pharmacies, including central distribution facilities, affiliated with a hospital that provide the same services that are authorized by a Class II institutional pharmacy permit. Class III institutional pharmacies may also:

   a. Dispense, distribute, compound, and fill prescriptions for medicinal drugs.

   b. Prepare prepackaged drug products.

   c. Conduct other pharmaceutical services for the affiliated hospital and for entities under common control that are each permitted under this chapter to possess medicinal drugs.

   d. Provide the services in sub-subparagraphs a.–c. to an entity under common control which holds an active health care clinic establishment permit as required under s. 499.01(2)(r).

2. A Class III institutional pharmacy shall maintain policies and procedures addressing:

   a. The consultant pharmacist responsible for pharmaceutical services.

   b. Safe practices for the preparation, dispensing, prepackaging, distribution, and transportation of medicinal drugs and prepackaged drug products.

   c. Recordkeeping to monitor the movement, distribution,
and transportation of medicinal drugs and prepackaged drug products.

d. Recordkeeping of pharmacy staff responsible for each step in the preparation, dispensing, prepackaging, transportation, and distribution of medicinal drugs and prepackaged drug products.

e. Medicinal drugs and prepackaged drug products that may not be safely distributed among Class III institutional pharmacies.

(4) Medicinal drugs shall be dispensed in an institutional pharmacy to outpatients only when that institution has secured a community pharmacy permit from the department. However, an individual licensed to prescribe medicinal drugs in this state may dispense up to a 24-hour supply of a medicinal drug to any patient of an emergency department of a hospital that operates a Class II or Class III institutional pharmacy, provided that the physician treating the patient in such hospital's emergency department determines that the medicinal drug is warranted and that community pharmacy services are not readily accessible, geographically or otherwise, to the patient. Such dispensing from the emergency department must be in accordance with the procedures of the hospital. For any such patient for whom a medicinal drug is warranted for a period to exceed 24 hours, an individual licensed to prescribe such drug must dispense a 24-hour supply of such drug to the patient and must provide the
patient with a prescription for such drug for use after the initial 24-hour period. The board may adopt rules necessary to carry out the provisions of this subsection.

(6) In a Class II or Class III institutional pharmacy, an institutional formulary system may be adopted with approval of the medical staff for the purpose of identifying those medicinal drugs, proprietary preparations, biologics, biosimilars, and biosimilar interchangeables that may be dispensed by the pharmacists employed in such institution. A facility with a Class II or Class III institutional pharmacy permit which is operating under the formulary system shall establish policies and procedures for the development of the system in accordance with the joint standards of the American Hospital Association and American Society of Hospital Pharmacists for the utilization of a hospital formulary system, which formulary shall be approved by the medical staff.

Section 4. Subsection (3) of section 465.0252, Florida Statutes, is amended to read:

465.0252 Substitution of interchangeable biosimilar products.—

(3) A pharmacist who practices in a Class II, Modified Class II, or Class III institutional pharmacy shall comply with the notification provisions of paragraph (2)(c) by entering the substitution in the institution's written medical record system or electronic medical record system.
Section 5. Subsection (39) of section 499.003, Florida Statutes, is amended, and paragraphs (w) and (x) are added to subsection (48) of that section, to read:

499.003 Definitions of terms used in this part.—As used in this part, the term:

(39) "Prepackaged drug product" means a drug that originally was in finished packaged form sealed by a manufacturer and that is placed in a properly labeled container by a pharmacy or practitioner authorized to dispense pursuant to chapter 465 for the purpose of dispensing or by a facility holding a Class III institutional pharmacy permit in the establishment in which the prepackaging occurred.

(48) "Wholesale distribution" means the distribution of a prescription drug to a person other than a consumer or patient, or the receipt of a prescription drug by a person other than the consumer or patient, but does not include:

(w) A hospital covered by s. 340B of the Public Health Service Act, 42 U.S.C. s. 256b, that arranges for a prescription drug wholesale distributor to distribute prescription drugs covered under that act directly to a contract pharmacy. Such hospital is exempt from obtaining a restricted prescription drug distributor permit under s. 499.01(2)(h).

(x) The dispensing or distribution of a medicinal drug by a Class III institutional pharmacy pursuant to s. 465.019.
subsection (5) of section 499.01, Florida Statutes, are amended
to read:

499.01 Permits.—
(2) The following permits are established:
(b) Prescription drug repackager permit.—A prescription
drug repackager permit is required for any person that
repackages a prescription drug in this state.
   1. A person that operates an establishment permitted as a
prescription drug repackager may engage in distribution of
prescription drugs repackaged at that establishment and must
comply with all of the provisions of this part and the rules
adopted under this part that apply to a prescription drug
manufacturer.
   2. A prescription drug repackager must comply with all
appropriate state and federal good manufacturing practices.
   3. A prescription drug repackager permit is not required
for distributing medicinal drugs or prepackaged drug products
between entities under common control which each hold either an
active Class III institutional pharmacy permit under chapter 465
or an active health care clinic establishment permit under
paragraph (2)(r). For purposes of this subparagraph, the term
"common control" has the same meaning as in s. 499.003(48)(a)3.
(h) Restricted prescription drug distributor permit.—
   1. A restricted prescription drug distributor permit is
required for:
a. Any person located in this state who engages in the distribution of a prescription drug, which distribution is not considered "wholesale distribution" under s. 499.003(48)(a).

b. Any person located in this state who engages in the receipt or distribution of a prescription drug in this state for the purpose of processing its return or its destruction if such person is not the person initiating the return, the prescription drug wholesale supplier of the person initiating the return, or the manufacturer of the drug.

c. A blood establishment located in this state which collects blood and blood components only from volunteer donors as defined in s. 381.06014 or pursuant to an authorized practitioner's order for medical treatment or therapy and engages in the wholesale distribution of a prescription drug not described in s. 499.003(48)(j) to a health care entity. A mobile blood unit operated by a blood establishment permitted under this sub-subparagraph is not required to be separately permitted. The health care entity receiving a prescription drug distributed under this sub-subparagraph must be licensed as a closed pharmacy or provide health care services at that establishment. The blood establishment must operate in accordance with s. 381.06014 and may distribute only:

   (I) Prescription drugs indicated for a bleeding or clotting disorder or anemia;

   (II) Blood-collection containers approved under s. 505 of
the federal act;

   (III) Drugs that are blood derivatives, or a recombinant
or synthetic form of a blood derivative;

   (IV) Prescription drugs that are identified in rules
adopted by the department and that are essential to services
performed or provided by blood establishments and authorized for
distribution by blood establishments under federal law; or

   (V) To the extent authorized by federal law, drugs
necessary to collect blood or blood components from volunteer
blood donors; for blood establishment personnel to perform
therapeutic procedures under the direction and supervision of a
licensed physician; and to diagnose, treat, manage, and prevent
any reaction of a volunteer blood donor or a patient undergoing
a therapeutic procedure performed under the direction and
supervision of a licensed physician,

as long as all of the health care services provided by the blood
establishment are related to its activities as a registered
blood establishment or the health care services consist of
collecting, processing, storing, or administering human
hematopoietic stem cells or progenitor cells or performing
diagnostic testing of specimens if such specimens are tested
together with specimens undergoing routine donor testing. The
blood establishment may purchase and possess the drugs described
in this sub-subparagraph without a health care clinic
establishment permit.

2. Storage, handling, and recordkeeping of these distributions by a person required to be permitted as a restricted prescription drug distributor must be in accordance with the requirements for wholesale distributors under s. 499.0121.

3. A person who applies for a permit as a restricted prescription drug distributor, or for the renewal of such a permit, must provide to the department the information required under s. 499.012.

4. The department may adopt rules regarding the distribution of prescription drugs by hospitals, health care entities, charitable organizations, other persons not involved in wholesale distribution, and blood establishments, which rules are necessary for the protection of the public health, safety, and welfare.

5. A restricted prescription drug distributor permit is not required for distributions between pharmacies that each hold an active permit under chapter 465, have a common ownership, and are operating in a freestanding end-stage renal dialysis clinic, if such distributions are made to meet the immediate emergency medical needs of specifically identified patients and do not occur with such frequency as to amount to the regular and systematic supplying of that drug between the pharmacies. The department shall adopt rules establishing when the distribution...
of a prescription drug under this subparagraph amounts to the regular and systematic supplying of that drug.

6. A restricted prescription drug distributor permit is not required for distributing medicinal drugs or prepackaged drug products between entities under common control that each hold either an active Class III institutional pharmacy permit under chapter 465 or an active health care clinic establishment permit under paragraph (2)(r). For purposes of this subparagraph, the term "common control" has the same meaning as in s. 499.003(48)(a)3.

(5) A prescription drug repackager permit issued under this part is not required for a restricted prescription drug distributor permitholder that is a health care entity to repackage prescription drugs in this state for its own use or for distribution to hospitals or other health care entities in the state for their own use, pursuant to s. 499.003(48)(a)3., if:

(a) The prescription drug distributor notifies the department, in writing, of its intention to engage in repackaging under this exemption, 30 days before engaging in the repackaging of prescription drugs at the permitted establishment;

(b) The prescription drug distributor is under common control with the hospitals or other health care entities to which the prescription drug distributor is distributing
prescription drugs. As used in this paragraph, "common control" means the power to direct or cause the direction of the management and policies of a person or an organization, whether by ownership of stock, voting rights, contract, or otherwise;

(c) The prescription drug distributor repackages the prescription drugs in accordance with current state and federal good manufacturing practices; and

(d) The prescription drug distributor labels the prescription drug it repackages in accordance with state and federal laws and rules.

The prescription drug distributor is exempt from the product registration requirements of s. 499.015 with regard to the prescription drugs that it repackages and distributes under this subsection. A prescription drug distributor that repackages and distributes prescription drugs under this subsection to a not-for-profit rural hospital, as defined in s. 395.602, is not required to comply with paragraph (c) or paragraph (d), but must provide to each health care entity for which it repackages, for each prescription drug that is repackaged and distributed, the information required by department rule for labeling prescription drugs. The department shall adopt rules to ensure the safety and integrity of prescription drugs repackaged and distributed under this subsection, including rules regarding prescription drug manufacturing and labeling requirements.
Section 7. This act shall take effect July 1, 2018.
TAB #2
Toward uniform standards for pharmacy technicians: Summary of the 2017 Pharmacy Technician Stakeholder Consensus Conference

William A. Zellmer, Everett B. McAllister*, Janet A. Silvester, Peter H. Vlasses

In pursuit of a path toward resolving unsettled issues related to pharmacy technicians, the Pharmacy Technician Certification Board (PTCB) sponsored a stakeholder consensus conference on February 14–16, 2017, in Irving, Texas. Planned in collaboration with the Accreditation Council for Pharmacy Education (ACPE) and the American Society of Health-System Pharmacists (ASHP) and under the guidance of an advisory committee representing all major branches of pharmacy, this invitational event yielded important recommendations concerning the definition, education, entry-level requirements, advanced practice, certification, and regulation of pharmacy technicians.

The 89 invited participants in the conference (eAppendix A) included pharmacists and technicians from various types of practice and educational settings, pharmacy association executives, regulators, and representatives of the general public.

Design of the conference

In consultation with the advisory committee, the conference planners established objectives for the event (sidebar), designed a preconference survey that was sent to pharmacy opinion leaders and conference participants, established the event agenda, selected speakers, identified invitees, and recommended readings for participant review in advance of the event. (Some key readings are cited here.1-4) Individuals engaged in planning and conducting the conference are listed in eAppendix B.

The program consisted of 5 plenary sessions (each focused on separate facets of the conference objectives), 3 work-group sessions (during which conferees divided into 4 groups to discuss specific issues and draft related recommendations), and a final session for polling of conference attendees on level of agreement or disagreement with recommendations from the work groups.

Conference opening

Everett B. McAllister, chief executive officer and executive director of PTCB, reviewed the objectives of the conference and referred to “the struggles boards of pharmacy, technician educators, and employers face...partly because we don’t have a good career plan for technicians.” He added, “The time has come to identify realistic and achievable pathways for
SPECIAL FEATURE PHARMACY TECHNICIAN STAKEHOLDER CONSENSUS CONFERENCE

W.A. Zellmer et al. / Journal of the American Pharmacists Association 57 (2017) e1–e14

**Conference Objectives**

The aim of the conference was to explore consensus on

1. The necessity of public confidence in pharmacy’s process for ensuring the competency of pharmacy technicians.
2. An optimal level of basic (“generalist”) knowledge, skills, and abilities that pharmacy technicians should have regardless of practice site.
3. An optimal definition of entry-level (generalist) pharmacy technician practice with respect to (a) legally recognized scope of practice, (b) educational requirements, (c) training requirements, (d) certification requirements, and (e) state board of pharmacy registration or licensure.
4. The desirability and feasibility of developing a process for recognizing competencies of pharmacy technicians beyond entry-level practice.
5. The desirability and feasibility of minimizing variability among the states in the definition and regulation of pharmacy technicians.
6. The entities that potentially could take responsibility for any changes in pharmacy’s process for ensuring the competency of pharmacy technicians.

**Conference Advisory Committee**

- Jason Ausili, Pharm.D.
  - Director, Pharmacy Affairs
  - National Association of Chain Drug Stores
- Malcolm Broussard, B.S.
  - Executive Director
  - Louisiana Board of Pharmacy
- Al Carter, Pharm.D., M.S.
  - Senior Director, Pharmacy Regulatory Affairs
  - CVS Health
- Charles E. Daniels, B.S., Pharm., Ph.D.
  - Pharmacist-In-Chief and Associate Dean
  - University of California San Diego
- Kenneth Mark Ey, B.S., Pharm.
  - Vice President of Operations
  - CARE Pharmacies Cooperative
- Diane Halvorson, RPhTech, CPhT
  - Lead Pharmacy Technician
  - Vibra Hospital Fargo
- Pharmacy Technician Member
  - North Dakota State Board of Pharmacy
- Timothy R. Koch, B.S., Pharm., P.D., C.H.C.
  - Senior Director, Pharmacy Practice Compliance
  - Walmart Corporate Office
- Janet M. Liles, M.S., CPhT
  - Executive Director
  - Pharmacy Technician Educators Council
- Scott A. Meyers, B.S., Pharm., M.S., FASHP
  - Executive Vice President
  - Illinois Council of Health-System Pharmacists
- Matthew Osterhaus, B.S., Pharm.
  - Coowner
  - Osterhaus Pharmacy
- Jon Roth, B.S., M.S., FAPhA, FASHP
  - Chief Executive Officer
  - California Pharmacists Association
- Steve Rough, B.S., Pharm., M.S., FASHP
  - Director of Pharmacy
  - University of Wisconsin, Madison School of Pharmacy
- Rafael Saenz, Pharm.D., M.S., FASHP
  - Administrator, Pharmacy Services
  - University of Virginia Health System

Technicians that support medication safety and protect our patients.” Commenting on PTCB’s decision to suspend implementation of its 2020 accredited-education requirement for technicians seeking PTCB certification, McAllister said that the results of the conference will help determine future plans for PTCB program changes.

**Framing key issues**

Two speakers framed the key issues of the conference from separate perspectives—those of the pharmacy profession and the public. The first perspective was provided by Michael A. Moné, a vice president at Cardinal Health, president of the Ohio Board of Pharmacy, and a member of the ACPE board of directors. Moné said, “Pharmacists must facilitate the advancement of pharmacy technicians…further enabling pharmacists to achieve their rightful place as healthcare providers.” Commenting on the profession’s obligation to assure the public of the competency of technicians, Moné remarked, “The process of providing the public with guarantees of trustworthiness already exists in the form of the accreditation, education, examination, and licensure model” that is applied to pharmacists. He concluded, “Our charge at this conference is to come to consensus [on what the public expects], how to meet those expectations, and what we must implement in order to deliver the value we promise to the healthcare system, the profession, and patients.” (The full text of Moné’s remarks is published in *AJHP*.)

Christopher Jerry, head of the Emily Jerry Foundation, spoke from the public perspective and drew on the personal tragedy of having lost a young daughter to a fatal compounding error by a pharmacy technician. Commenting on the history of pharmacy-related medication errors, Jerry said that opportunities for such errors are likely to increase given the risks associated with new medications and the expanded use of medications. Jerry said that although the public expects all healthcare workers to be well educated, this basic expectation is not being met in the case of pharmacy technicians. He was critical of the fact that there are no uniform state requirements for ensuring the competency of technicians, which he attributed in part to a lack of public awareness about the scope of technician responsibilities. Jerry said that uniformly trained, competent pharmacy technicians would free up pharmacists to provide more patient consultations, which are proven to reduce medication errors.
Insights from preconference surveys

William A. Zellmer, a consultant who helped plan the conference, summarized the results of the preconference surveys. The opinion-leader survey showed strong agreement, across all sectors of pharmacy, with 7 statements; these statements were considered “foundational precepts” for the conference (sidebar). The 9 survey items that had substantial variability in level of agreement among sectors of pharmacy were taken into account when planning the agenda of the conference. Zellmer said that the comments many respondents made to supplement their answers to the survey suggest that there is room for finding common ground on unsettled technician issues.

Snapshots of the pharmacy technician workforce

“Optimizing the contributions of technicians in pharmacy practice” was the theme of talks by Michael A. Moné (left), speaking from the perspective of the pharmacy profession, and Christopher Jerry, speaking from the public-interest perspective.

Key Points

- A national consensus conference engaged all sectors of pharmacy in identifying points of agreement regarding entry-level requirements for pharmacy technicians.
- State variability in the regulation of pharmacy technicians poses risks for patients and the profession of pharmacy.
- Conferees were polled on their extent of agreement or disagreement with 59 statements related to unsettled pharmacy technician issues.
- Conferees agreed that a task analysis should be the basis for accredited technician education, technician certification, and state regulation of technicians.
- Conferees recommended the creation of a broad coalition to pursue the recommendations of the conference.

Trends in technician education

ASHP’s vice president of accreditation services, Janet A. Silvester, pointed out that there is no single defined path for an individual to prepare to become a pharmacy technician, and there is no uniform national educational requirement. Most pharmacy technicians have received primarily on-the-job training. This is in sharp contrast to the educational requirements for comparable healthcare occupations (e.g., clinical laboratory technician, 2–4 years of education; dental assistant, 1–2 years; physical therapy assistant, 2 years).

Accredited distance-education programs for pharmacy technicians are increasing access to standards-based education. The accreditation standard was recently amended for flexibility related to the number of experiential sites and the pharmacy compounding requirement. The 271 accredited programs are estimated to represent about one fourth of pharmacy technician education programs. Accredited programs graduate approximately 18,000 technicians per year; based on a 2016 ASHP survey, these programs appear to have capacity to expand enrollment by 60%.

Technician education by chain drugstores

The director of pharmacy affairs for the National Association of Chain Drug Stores (NACDS), Jason Ausili, reported on a
small survey of NACDS members. Among the 24 respondents, 3 said they used primarily an accredited program for educating technicians, 12 used primarily standardized nonaccredited on-the-job training, and 9 provided on-the-job training (no standardization indicated). Sixteen respondents indicated that the number of candidates for technician positions was insufficient to meet their business needs. With respect to the turnover rate among technicians, 10 respondents said it was a nonissue; 9, a manageable issue; and 5, excessive. Fifteen respondents said that their needs were not being met with respect to hiring educated technicians.

**Optimal requirements for entry-level practice**

Three speakers from different sectors of pharmacy addressed the question, “What knowledge, skills, and abilities must be achieved by individuals who wish to be credentialed as a pharmacy technician for entry-level practice?” The goals in the accreditation standards for pharmacy technician education were a point of reference for their remarks.

**Timothy R. Koch,** senior director of pharmacy practice compliance for Walmart, explained that his company has 2 types of technician education programs: 1 designed specifically to satisfy its business needs (160 hours didactic, 80 hours experiential, 3.5 hours simulated skills development) and another accredited by ASHP—ACPE (minimum of 160 hours didactic, 80 hours simulated skills development, 160 hours experiential education, and 200 hours allocated among didactic, simulated, and experiential education). The didactic portion of both programs is the same. The accredited program, which is used to meet requirements in 2 states, mandates education in sterile compounding, which is not relevant to the company’s current or future retail pharmacy operations, according to Koch. He said that the requirements for the accredited program have helped the company improve its shorter, primary program. Because of the certification success rate of graduates of the shorter program, it has not been feasible to justify accredited education for all technicians. Koch voiced support for standardization of entry-level education for technicians but not at the level required in the current accreditation standards. He supported technician certification but expressed doubt about the necessity of the full scope of knowledge, skills, and abilities currently covered in the certification exam. He said that registration or licensure of technicians should absolutely be required.

**Rafael Saenz,** administrator of pharmacy services at the University of Virginia Health System, based his remarks on the belief that the value of pharmacists “lies primarily in their ability and time spent in direct patient care, touching patients, patient education, and ensuring better patient outcomes.” From the perspective of a pharmacy practice leader who wants to free up pharmacists for patient care, Saenz outlined technician knowledge and skills in “must have” and “like to have” categories. Noting that it is common for pharmacy technicians to move from one sector of practice to another, he argued that fundamental concepts in the compounding of nonsterile, sterile, and chemotherapy/hazardous products should be included in entry-level education. Saenz said he believes the various sectors of practice are not far apart in their thinking about a single entry-level standard for pharmacy technician education, certification, and registration.
Matthew Osterhaus, pharmacist and owner of an independent pharmacy in a small community in Iowa, said that personal and interpersonal skills of pharmacy technicians are very important in his practice setting. Other vital skills include professional knowledge and the processing and handling of medication orders. Not required for entry-level practice in his setting are education in anatomy, physiology, and pharmacology and understanding of issues in the profession, nontraditional roles, emerging therapies, and sterile and nonsterile compounding. Osterhaus believes that tech-check-tech, medication reconciliation, assistance with medication therapy management, and compounding should be considered advanced technician practice. He stated that variability in the needs among practice sites must be considered when establishing standards for technician education. Osterhaus indicated support for certification and state registration for entry-level practice; he suggested that add-on credentials should be developed for compounding and handling durable medical equipment.

Advanced pharmacy technician practice

Four speakers discussed advanced pharmacy technician practice, including whether related standards and credentials should be developed. Al Carter, senior director of pharmacy regulatory affairs for CVS Health, discussed the range of practice settings (and the related variety of technician responsibilities) in his company: retail stores (dispensing), specialty pharmacies (dispensing and collaboration with pharmacists and patients on clinical issues), home infusion (compounding), and mail order (central processing and dispensing). Potential advanced responsibilities for technicians in large corporate pharmacy environments include tech-check-tech, accepting oral orders, transferring prescriptions, remote order processing, point-of-care testing, and vaccine administration. Carter said there would be immense value in greater uniformity among the states in how they address technician issues. He asked the audience to consider whether the time will come when technicians have authority to perform whatever tasks pharmacists delegate to them.

Dan Luce, national director of pharmacy affairs for Walgreens, discussed potential advanced roles for pharmacy technicians based on his perspectives as a chain drugstore executive and former board of pharmacy member. He stated that many experienced technicians are capable of performing advanced roles in pharmacy department management, using barcode technology for product verification, triaging pharmacist-administered services, administering vaccines, and managing call centers and centralized dispensing operations. Luce said that fears about potential pharmacist job loss and compromised safety stemming from an increased technician-to-pharmacist ratio have proved to be unfounded in states where ratios have increased. He suggested that it may be necessary to establish education and credentialing requirements for advanced-practice technicians to address concerns that regulators or legislators are likely to have about expanding technicians’ scope of practice. Advanced roles would help with career development among technicians and allow pharmacists to focus to a greater extent on patient care. He asked rhetorically if pharmacy will be ready to allow pharmacists to delegate any nonjudgmental task to technicians and, if that is done, who will hold liability for the technicians’ work.

Steve Rough, director of pharmacy at University of Wisconsin Health, described the 700-hour accredited technician education program at his health system. The health system’s 4-level career ladder for technicians is designed to foster professional commitment and provide increased compensation as individuals take on more responsibility. Training is provided for technicians who desire to advance to a higher level. Rough advocated (1) accredited education, certification, and licensure for all technicians, (2) certification as a prerequisite for advanced practice, (3) maintenance of entry-level certification after moving into advanced practice, and (4) development of credentials (accredited education and certification) for advanced roles. He suggested that some supportive positions in pharmacy that do not involve handling medications could be given a title other than “technician” (e.g., “pharmacy clerk”) in the interest of moving toward consensus.

Anthony Pudlo, vice president of professional affairs for the Iowa Pharmacy Association, described the demonstration project in his state to assess tech-check-tech (more appropriately designated as “technician product verification”) in the community pharmacy prescription dispensing process. Thus far in the research, there has been no difference in error rate compared with baseline, and greater pharmacist time has been devoted to patient care activities. Community pharmacists in Iowa, through multiple avenues, are experiencing increased opportunities for payment for patient care services, and they will require more time for providing such services, which warrants an expansion of technician product verification. Because of the success of the demonstration project, legislation will be pursued to expand pharmacy technician product verification to include community pharmacy practice in Iowa.

Models for moving forward

Susan James, director of competence programs for the Ontario College of Pharmacists (a registering and regulating body for pharmacy), was the lead speaker on a panel showcasing how certain provinces or states have advanced their requirements for pharmacy technicians. As the result of a process that began around 2005, pharmacy technicians in Ontario now must complete a nationally accredited education program (minimum of 940 hours) and pass a national entry-to-practice examination. Pharmacy technicians (a title restricted to registered individuals) are able to perform all technical aspects of product preparation and drug distribution, including independent checking of the final product for release to the patient; they are held accountable as autonomous health professionals. Technicians are not allowed to
provide therapeutic or clinical services that are within the scope of the pharmacist. Pharmacies in Canada are estimated to employ about 8 times as many pharmacy assistants as pharmacy technicians; there are no standards for pharmacy assistants. Pharmacy technicians can check and manage the work of pharmacy assistants.

Diane Halvorson, lead pharmacy technician at Vibra Hospital, Fargo, and a member of the North Dakota State Board of Pharmacy, said that it was through the leadership of pharmacy technicians that her state was able to achieve mandatory registration as a pharmacy technician. In making its changes, Idaho said that in order to move toward uniform national standards, pharmacy technicians should be an active part of the change process, and there should be sharp focus on patient safety.

Malcolm Broussard, executive director of the Louisiana Board of Pharmacy, noted that his state will require (effective January 2018) accredited education and PTCB certification for registration as a pharmacy technician. He suggested that the way forward, nationally, will depend on the answers to 3 questions: (1) What pharmacy tasks should be restricted to pharmacists? (2) What pharmacy tasks should be restricted to pharmacists or technicians? and (3) Should the standards for technician education cover the gamut of technician roles or should a distinction be made between entry-level tasks and advanced tasks? Broussard said that pharmacy should have only 1 accreditation process for technician education and only 1 certification process.

Alex Adams, executive director, Idaho State Board of Pharmacy, discussed his state’s recent expansion of the scope of practice for certified technicians. In making its changes, Idaho considered evidence that 44% of pharmacists’ time was spent on tasks that could be delegated to competent technicians. Tasks that pharmacists are permitted to delegate to certified technicians (in some cases requiring special training) are in 2 categories: medication dispensing support (accept oral prescriptions, clarify technical elements of prescriptions, transfer prescriptions, search the prescription drug monitoring program database, and perform final verification of filled prescriptions that have undergone drug-use review by a pharmacist) and technical support for pharmacist clinical services (administer vaccines, administer simple [Clinical Laboratory Improvement Amendment-waived] clinical tests, conduct basic physical assessments, and conduct medication histories).

Consensus recommendations

Four work groups involving all invited conferees met in 3 sessions throughout the conference to formulate recommendations on issues related to pharmacy technicians. Each group had balanced representation from all sectors of pharmacy and was led by a facilitator—recorder team. The topic assignments were the same for all groups. After the last work group session, the facilitator—recorder teams met with other conference staff to consolidate and prepare recommendations for polling.

At the final plenary session, participants indicated their level of agreement or disagreement with 59 recommendations created by the work groups. Using a Web-based application, polling was conducted on a 4-point scale: strongly agree, agree, disagree, or strongly disagree. The polling results are presented in Tables 1–7.

Defining pharmacy technicians

Most conferees agreed with the need to create a legal definition of pharmacy technicians (Table 1, items 1.1 and 1.2) and to restrict the use of that occupational title to those who have met specified qualifications (item 1.3). In consideration of 2 alternative approaches for technician task analyses (as the basis for national standards), there was greater support for an inclusive all-settings assessment (item 1.4) versus separate assessments for different sectors of practice (item 1.5).

Education of pharmacy technicians

Most conferees agreed that national standards should guide technician education (Table 2, item 2.1) and that technician education programs should be accredited (item 2.4). There was further agreement that the national standards should focus on the outcomes of education, allowing a certain degree of programmatic flexibility in how those outcomes are achieved (item 2.3).

Entry-level knowledge, skills, and abilities

Conferees voted on the specific knowledge, skills, and abilities that should be achieved by those who wish to be credentialed as a pharmacy technician for entry-level practice (Table 3). These domains apply to education and to competency assessment (certification) of pharmacy technicians. All of the 18 areas polled received majority agreement, but about one third of conferees disagreed with 2 areas—“demonstrate understanding of nontraditional roles” (item 3.5) and “billing” (item 3.12).

Certification of pharmacy technicians

There was strong support for requiring national certification of technicians ahead of state board of pharmacy

5 Individuals who were involved in planning or staffing the conference were excluded from the polling.
6 The 2 attendees from NACDS excused themselves from the polling.
7 There was no predetermined definition of consensus related to level of agreement on polling items. The conference organizers will be guided by the overall polling results in planning how to pursue uniform standards for pharmacy technicians.
registration or licensure (Table 4, item 4.1), and there was clear disagreement that this should be done without a specified educational requirement (item 4.2). Maintenance of national certification as a requirement for continued registration or licensure was supported (item 4.3).

State laws and regulations on pharmacy technicians

Nearly all conferees agreed that variability in state regulations regarding technicians should be minimized (Table 5, item 5.1) and that technician practice should be under the purview of the pharmacist (item 5.5). Most conferees agreed that national standards should not prevent states from innovating and expanding technicians’ scope of practice beyond established entry-level standards in the interest of improving patient safety and care (item 5.3).

Advanced pharmacy technician practice

Conferees generally agreed that the profession of pharmacy’s immediate priority, with respect to technician issues, should be development of standards related to entry-level education (Table 6, item 6.2) and that advanced roles for technicians (and related education and credentials) will evolve over time (items 6.3 and 6.4).

Moving forward on pharmacy technician issues

All participants in the polling agreed that the conference planners should establish a coalition of stakeholders to pursue the consensus recommendations from the conference (Table 7, item 7.5). Most conferees agreed that participants in this stakeholder event have a responsibility to work toward achieving the consensus recommendations (item 7.7).

### Table 1

<table>
<thead>
<tr>
<th>Issue</th>
<th>% Respondents&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 The profession of pharmacy should develop a contemporary definition of entry-level pharmacy technicians that differentiates them from other pharmacy supportive personnel.</td>
<td>Strongly Agree 61  Agree 33  Disagree 4  Strongly Disagree 1</td>
</tr>
<tr>
<td>1.2 State boards of pharmacy should adopt standardized terminology that defines different categories of pharmacy supportive personnel and their associated scope of work.</td>
<td>Strongly Agree 48  Agree 35  Disagree 8  Strongly Disagree 8</td>
</tr>
<tr>
<td>1.3 State boards of pharmacy should protect the title of pharmacy technician, ensuring that only those that have completed required education may use the title.</td>
<td>Strongly Agree 63  Agree 28  Disagree 7  Strongly Disagree 3</td>
</tr>
<tr>
<td>1.4 A national task analysis should be used to inform the development of national standards, in an objective and data-driven manner, related to the competencies/credentials of entry-level pharmacy technicians.</td>
<td>Strongly Agree 68  Agree 30  Disagree 1  Strongly Disagree 0</td>
</tr>
<tr>
<td>1.5 A separate task analysis of pharmacy technicians should be conducted within different pharmacy practice sectors to develop a cross-walk process for determination of common core competencies.</td>
<td>Strongly Agree 34  Agree 44  Disagree 15  Strongly Disagree 7</td>
</tr>
</tbody>
</table>

<sup>a</sup> The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

### Table 2

<table>
<thead>
<tr>
<th>Issue</th>
<th>% Respondents&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 The profession of pharmacy should move urgently towards the development and adoption of national standards for pharmacy technician education.</td>
<td>Strongly Agree 72  Agree 23  Disagree 4  Strongly Disagree 1</td>
</tr>
<tr>
<td>2.2 The profession of pharmacy should set a target for implementation of the national standard for pharmacy technician education at 3 to 5 years after adoption of the standard.</td>
<td>Strongly Agree 51  Agree 35  Disagree 13  Strongly Disagree 1</td>
</tr>
<tr>
<td>2.3 Technician education programs should be based on national standards, be foundational across all practice settings, and provide room for innovation and flexibility.</td>
<td>Strongly Agree 79  Agree 17  Disagree 4  Strongly Disagree 0</td>
</tr>
<tr>
<td>2.4 Technician education programs should be accredited and based on defensible standards developed using stakeholder input, taking into account diversity of practice environments.</td>
<td>Strongly Agree 71  Agree 26  Disagree 3  Strongly Disagree 0</td>
</tr>
<tr>
<td>2.5 In the development of national standards for technician education, there should be a focus on outcomes and flexibility in terms of process.</td>
<td>Strongly Agree 46  Agree 51  Disagree 3  Strongly Disagree 0</td>
</tr>
<tr>
<td>2.6 The number of required education hours for pharmacy technicians should be determined based upon the defined entry-level core knowledge, skills, and abilities.</td>
<td>Strongly Agree 51  Agree 39  Disagree 6  Strongly Disagree 4</td>
</tr>
<tr>
<td>2.7 The entrustable professional activities that can be performed by an entry-level pharmacy technician after completion of a standardized education program should be defined.</td>
<td>Strongly Agree 40  Agree 35  Disagree 15  Strongly Disagree 10</td>
</tr>
<tr>
<td>2.8 Employees seeking the entry-level pharmacy technician designation should be required to complete a nationally accredited education program. (See also item 4.2.)</td>
<td>Strongly Agree 63  Agree 21  Disagree 8  Strongly Disagree 8</td>
</tr>
<tr>
<td>2.9 Employees seeking the entry-level pharmacy technician designation should be considered technicians-in-training during the period of completion of education and certification, all of which must be completed in less than 2 years.</td>
<td>Strongly Agree 44  Agree 44  Disagree 7  Strongly Disagree 4</td>
</tr>
</tbody>
</table>

<sup>a</sup> The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.
Table 3
Required Knowledge, Skills, and Abilities of Entry-Level Pharmacy Technicians: Results of Conference Polling

<table>
<thead>
<tr>
<th>Issue</th>
<th>% Respondents&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Personal and interprofessional knowledge and skills</td>
<td>70</td>
<td>24</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.2 Professional knowledge and skills</td>
<td>70</td>
<td>20</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>3.3 Calculations</td>
<td>83</td>
<td>15</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3.4 Basic pharmacology</td>
<td>55</td>
<td>35</td>
<td>7</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.5 Demonstrate understanding of nontraditional roles</td>
<td>19</td>
<td>45</td>
<td>27</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>3.6 Processing orders</td>
<td>85</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3.7 Patient and medication safety</td>
<td>87</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3.8 Understanding sterile and non-sterile compounding</td>
<td>39</td>
<td>49</td>
<td>6</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>3.9 Medication use process</td>
<td>67</td>
<td>31</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3.10 Screen prescriptions for completion and accuracy, but not crossing the line into clinical topics such as drug interactions, dosage range, etc.</td>
<td>62</td>
<td>34</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.11 Information technology in general and in the context of medication safety elements</td>
<td>58</td>
<td>31</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3.12 Billing</td>
<td>28</td>
<td>41</td>
<td>24</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>3.13 Quality principles</td>
<td>58</td>
<td>39</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3.14 Regulatory</td>
<td>66</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3.15 Maintenance of confidentiality</td>
<td>97</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3.16 Ability to reconstitute and compound simple non-sterile preparations using USP’s definitions</td>
<td>59</td>
<td>34</td>
<td>4</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>3.17 Proper handling of hazardous drugs</td>
<td>66</td>
<td>28</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3.18 Inventory management</td>
<td>47</td>
<td>42</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

Conference wrap-up

The following 5 conferees offered brief reflections on the conference: **Anthony Provenzano** (vice president, pharmacy compliance and government affairs, Albertsons Companies), **Lisa Schwartz** (senior director, professional affairs, National Community Pharmacists Association), **Charles Daniels** (pharmacist-in-chief and associate dean, University of California San Diego), **Janet Liles** (executive director, Pharmacy Technician Educators Council), and **Carmen Catizone** (executive director, National Association of Boards of Pharmacy). They commented on the event’s value in candidly exploring unsettled issues and reaching conceptual agreement on important changes that should be pursued relating to the education, certification, and registration or licensure of pharmacy technicians. They emphasized the urgency of building on this stakeholder consensus event and not allowing momentum to diminish.

Representatives of the conference planning organizations—**Everett B. McAllister**, **Janet A. Silvester**, and **Peter H. Vlasses** (ACPE executive director)—thanked the participants for their constructive engagement and expressed commitment to marshaling forces for pursuing the changes identified at the conference in the interest of patient safety and pharmacy’s service to the public.

**Larry Wagenknecht**, chief executive officer of the Michigan Pharmacists Association and chair of the PTCB board of governors, alluded to numerous previous attempts to build national consensus on standards for pharmacy technicians and asked, “What will be different this time?” His answer: “We now have a different understanding of where we need to be as a profession and the important role that well-qualified pharmacists play.”

Table 4
Certification of Pharmacy Technicians: Results of Conference Polling

<table>
<thead>
<tr>
<th>Issue</th>
<th>% Respondents&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 State boards of pharmacy should require new pharmacy technicians to obtain national certification for registration or licensure.</td>
<td>75</td>
<td>14</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>4.2 Entry-level pharmacy technicians should be required to complete a national pharmacy technician certification program, without a specified education requirement. (See also item 2.8.)</td>
<td>7</td>
<td>10</td>
<td>28</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>4.3 State boards of pharmacy should require pharmacy technicians to maintain national certification for continued registration or licensure.</td>
<td>60</td>
<td>19</td>
<td>12</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>4.4 PTCB should initiate conversations with boards of pharmacy regarding the recent updates in the PTCB exam blueprint, i.e., the decreased number of domains from nine to four, and the modification in the level of emphasis on sterile compounding.</td>
<td>33</td>
<td>48</td>
<td>12</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>4.5 State boards of pharmacy should provide a system to recognize experienced pharmacy technicians while not compromising the basic competencies required of a certified pharmacy technician.</td>
<td>29</td>
<td>49</td>
<td>19</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.
pharmacy technicians must play in helping us reach that place." He declared that PTCB is committed to collaborating with the full range of stakeholders to achieve uniform nationwide standards for pharmacy technicians.

Disclosures

Mr. Zellmer provides contractual services for the American Society of Health-System Pharmacists (ASHP), serves on the AJHP Editorial Board, and consulted on the planning of the Pharmacy Technician Stakeholder Consensus Conference. Mr. McAllister is employed by the Pharmacy Technician Certification Board (PTCB). Dr. Silvester is employed by ASHP. Dr. Vlasses is employed by the Accreditation Council for Pharmacy Education (ACPE).

The PTCB certifies pharmacy technicians and provided financial support for the 2017 Pharmacy Technician Stakeholder Consensus Conference. ASHP provides continuing education for pharmacy technicians, is an owner of PTCB, and holds a permanent seat on the PTCB board of directors. ASHP and ACPE jointly sponsor the Pharmacy Technician Accreditation Commission, which is the accrediting review committee for pharmacy technician education programs.

Additional information

This article will also appear as a Web publication of the Journal of the American Pharmacists Association.

Table 5

<table>
<thead>
<tr>
<th>Issue</th>
<th>% Respondents†</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 The variability of state regulations regarding pharmacy technicians should be minimized, while maintaining the required standards to ensure patient safety.</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td>5.2 The level of urgency for achieving state-to-state consistency in regulation of pharmacy technicians’ scope of practice, education, certification, and licensure or regulation is high.</td>
<td>63</td>
</tr>
<tr>
<td>5.3 National standards should not prevent states from innovating and expanding technicians’ scope of practice beyond established entry-level standards in the interest of improving patient safety and care.</td>
<td>87</td>
</tr>
<tr>
<td>5.4 Evolution of state-level laws and regulations regarding pharmacy technicians should be founded on ensuring patient/public safety.</td>
<td>87</td>
</tr>
<tr>
<td>5.5 National standards should be framed in the context of pharmacy technician practice being under the purview of the pharmacist.</td>
<td>68</td>
</tr>
<tr>
<td>5.6 State boards of pharmacy should require pharmacy technicians to be licensed based on specific criteria including accountability and administrative liability.</td>
<td>30</td>
</tr>
<tr>
<td>5.7 Registration should be required for all individuals who embark upon their initial entry into the profession of pharmacy.</td>
<td>58</td>
</tr>
<tr>
<td>5.8 State boards of pharmacy should require that pharmacy technicians complete continuing education or other professional development activities for continued registration or licensure.</td>
<td>72</td>
</tr>
<tr>
<td>5.9 State boards of pharmacy should include a pharmacy technician on the board.</td>
<td>59</td>
</tr>
</tbody>
</table>

† The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

Table 6

<table>
<thead>
<tr>
<th>Issue</th>
<th>% Respondents†</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 The pharmacy profession should clearly articulate and communicate the vision for advanced pharmacy technician practice and disseminate the vision to appropriate stakeholders.</td>
<td>67</td>
</tr>
<tr>
<td>6.2 The pharmacy profession should maintain focus and energy toward developing entry-level standards for technician education, with the expectation that advanced-level competencies will evolve over time.</td>
<td>67</td>
</tr>
<tr>
<td>6.3 Bridging programs should be developed and offered to build competencies of pharmacy technicians who are currently in the workforce and who would like to advance their skills.</td>
<td>56</td>
</tr>
<tr>
<td>6.4 Specific advanced-level educational programming for pharmacy technicians is needed, available, and will continue to evolve as needs within the profession are identified (e.g., sterile compounding, controlled substances, risk management, quality assurance, informatics).</td>
<td>66</td>
</tr>
<tr>
<td>6.5 In developing standards for advanced pharmacy technicians, the pharmacy profession must recognize that there are technicians currently practicing at this level and acknowledge the appropriate pathway for their continued development.</td>
<td>67</td>
</tr>
<tr>
<td>6.6 The profession of pharmacy should develop credentials for technicians who perform advanced roles beyond entry-level practice.</td>
<td>43</td>
</tr>
</tbody>
</table>

† The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.
Table 7
Moving Forward on Pharmacy Technician Issues: Results of Conference Polling

<table>
<thead>
<tr>
<th>Issue</th>
<th>% Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 The profession of pharmacy must be transparent in its message about pharmacy technicians, communicating the priority of public/patient safety, taking ownership of identified issues, assuming commitment to change, ensuring accountability, and reinforcing the positive contributions of pharmacy technicians to achieving optimal medication use.</td>
<td>75 22 1 1</td>
</tr>
<tr>
<td>7.2 The profession of pharmacy should develop a communications plan to disseminate its vision for pharmacy technicians and achieve buy-in from all stakeholders (e.g., pharmacists, pharmacy technicians, legislative and regulatory bodies, employers, payers, public, etc.).</td>
<td>73 26 2 0</td>
</tr>
<tr>
<td>7.3 The profession of pharmacy should advocate for the removal of pharmacist-to-technician ratios based on existing evidence.</td>
<td>52 25 15 7</td>
</tr>
<tr>
<td>7.4 Encourage pharmacy technician inclusion, representation, and membership in professional pharmacy organizations (at state and national levels).</td>
<td>73 24 2 2</td>
</tr>
<tr>
<td>7.5 The conference planners should establish a coalition with broad representation to take forth the recommendations from the Pharmacy Technician Stakeholder Consensus Conference.</td>
<td>77 23 0 0</td>
</tr>
<tr>
<td>7.6 The Joint Commission of Pharmacy Practitioners should take responsibility for ensuring appropriate priority and accountability in follow-up of conference recommendations, possibly collaborating with organizations such as the Council on Credentialing in Pharmacy, the Institute for Safe Medication Practices, and the National Conference of State Legislators.</td>
<td>39 49 1 10</td>
</tr>
<tr>
<td>7.7 All participants in the Pharmacy Technician Stakeholder Consensus Conference have a responsibility to work toward achieving the consensus recommendations from the conference.</td>
<td>62 27 8 3</td>
</tr>
</tbody>
</table>

* The number of respondents for polling items ranged from 65 to 75. For some items, percentages do not total 100% because of rounding.

References


William A. Zellmer, BSPharm, MPH, Pharmacy Foresight Consulting, Bethesda, MD
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Janet A. Silvester, PharmD, MBA, FASHP, American Society of Health-System Pharmacists, Bethesda, MD
Peter H. Vlasses, PharmD, DSc (Hon), FCCP, Accreditation Council for Pharmacy Education, Chicago, IL
eAppendix A—Invited participants of the Pharmacy Technician Stakeholder Consensus Conference

- **Alex J. Adams, Pharm.D., M.P.H.**
  Executive Director
  Idaho State Board of Pharmacy

- **Nancy Alvarez, Pharm.D., BCPS**
  President-elect
  American Pharmacists Association

- **Daniel Ashby, B.S.Pharm., M.S., FASHP**
  Chief Pharmacy Officer
  The Johns Hopkins Health System

- **Jason Ausili, Pharm.D.**
  Director, Pharmacy Affairs
  National Association of Chain Drug Stores

- **Cynthia Boyle, Pharm.D., FAPhA**
  AACP Immediate Past President
  Professor and Chair, Department of Pharmacy Practice and Administration
  University of Maryland Eastern Shore School of Pharmacy and Health Professions

- **Lynette Bradley-Baker, RPh, Ph.D.**
  Vice President of Public Affairs and Engagement
  American Association of Colleges of Pharmacy

- **David Bright, Pharm.D., BCACP**
  President, PTCB Certification Council
  Associate Professor
  Ferris State University

- **Malcolm Broussard, B.S.**
  Executive Director
  Louisiana Board of Pharmacy

- **Karen Brouwere, CPhT**
  Pharmacy Procurement Technician
  Department of Veterans Affairs

- **Mike Brownlee, Pharm.D., M.S., FASHP**
  Chief Pharmacy Officer
  University of Iowa Health Care

- **Phil Brummond, Pharm.D., M.S.**
  Director of Pharmacy
  Froedtert and the Medical College of Wisconsin

- **Barbara Burch, Ed.D.**
  Provost Emeritus
  Western Kentucky University

- **Paul Bush, Pharm.D., M.B.A., BCPS, FASHP**
  Chief Pharmacy Officer
  Duke University Hospital

- **Donnie Calhoun, B.Pharm., FACA, FACVP**
  Chief Executive Officer and Executive Vice President
  American College of Apothecaries

- **Liz Cardello, RPh**
  Senior Director, Corporate Alliances
  American Pharmacists Association

- **Al Carter, Pharm.D., M.S.**
  Senior Director, Pharmacy Regulatory Affairs
  CVS Health

- **Carmen Catizone, RPh, M.S., D.Ph.**
  Executive Director
  National Association of Boards of Pharmacy

- **Adam Chesler, Pharm.D.**
  Director, Regulatory Affairs
  Cardinal Health

- **Ulric Chung, Ph.D.**
  Chief Executive Officer
  American Board of Industrial Hygiene

- **Justin Coyle, Pharm.D.**
  Senior Director, Pharmacy Operations
  Walgreens

- **Charles Daniels, B.S.Pharm., Ph.D.**
  Pharmacist-In-Chief and Associate Dean
  University of California San Diego

- **Shane Deselle, Ph.D.**
  Professor
  Touro University

- **John Diem, CPhT, RPT**
  Director, Pharmacy Technician Programs
  Orange Technical College

- **Andrew Funk, Pharm.D.**
  Executive Director
  Iowa Board of Pharmacy

- **MSgt Robert George, USAF, CPhT**
  Senior Enlisted Leader, Department of Defense Pharmacy Training
  Medical Education and Training Campus

- **Lisa Gersema, Pharm.D.**
  President, American Society of Health-System Pharmacists
  Director of Pharmacy
  United Hospital, part of Allina Health

- **Sherrill Giddens, CTE**
  Career and Technology Education Specialist
  Medical Education and Training Campus

- **Harold Godwin, RPh, M.S.**
  Chair, Board of Pharmacy Specialties, and Professor Emeritus
  University of Kansas School of Pharmacy

- **Steven Gray, Pharm.D., J.D.**
  National Pharmacy Professional Affairs Leader
  Kaiser Permanente

- **Curtis Haas, Pharm.D.**
  Director of Pharmacy
  University of Rochester Medical Center

- **Diane Halvorson, RPhTech, CPhT**
  Lead Pharmacy Technician
  Vibra Hospital
  Member, North Dakota State Board of Pharmacy

- **Mark Hardy, Pharm.D.**
  Executive Director
  North Dakota State Board of Pharmacy

- **Randy Hitchens, B.Pharm., M.B.A.**
  Executive Vice President
  Indiana Pharmacists Alliance

- **Donna Horn, RPh, D.Ph.**
  Director, Patient Safety—Community Pharmacy Institute for Safe Medication Practices

- **Scott Jacobson, B.S.Pharm.**
  Vice President, Pharmacy Operations
  Rite Aid Corporation

- **Susan James, B.Sc.O.T., M.P.A.**
  Director, Competence Programs
  Ontario College of Pharmacists

- **Christopher Jerry**
  President and Chief Executive Officer
  The Emily Jerry Foundation
Sam Johnson, Pharm.D.
Director, Health Policy and Interprofessional Affairs
American College of Clinical Pharmacy

Mike Johnston, CPhT
Chief Executive Officer
National Pharmacy Technician Association

Donna Kiss, CPhT
Pharmacy Conversion Manager, Thrifty White Pharmacy
Chairperson, Northland Association of Pharmacy Technicians

Timothy R. Koch, B.S.Pharm., P.D., CHC
Senior Director, Pharmacy Practice Compliance
Walmart Corporate Office

Harold Kornfuhrer, RPh
Contract Lead Surveyor
American Society of Health-System Pharmacists

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Pharmacy Director
Northwestern Medicine

Brian Kramer, RPh, M.B.A.
President and Chief Information Officer
Forum Extended Care Services

Diana Kwan, Pharm.D.
Scientific Liaison
United States Pharmacopeial Convention

Barbara Lacher, B.S., RPhT, CPhT
Associate Professor and Assistant Program Director
North Dakota State College of Science

Anne LaVance, CPhT
Pharmacy Technician Program Director
Delgado Community College

Brian Lawson, Pharm.D.
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Board of Pharmacy Specialties

Donald Letendre, Pharm.D.
Dean and Professor
University of Iowa

Janet Liles, M.S., CPhT
Executive Director
Pharmacy Technician Educators Council

Deepti Loharikar, J.D.
Director, Federal and State Public Policy
National Association of Chain Drug Stores

Paul Lott, RPh
Region 4 Director
American Society of Consultant Pharmacists

Dan Luce, B.S.Pharm., M.B.A., FAPhA
National Director, Pharmacy Affairs
Walgreens

Lisa McCartney, M.Ed., CPhT, PhTR
Department Chair, Pharmacy Technician Program
Austin Community College-Eastview Campus

LuGina Mendez-Harper, Pharm.D.
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Board of Directors

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Cardinal Health

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University of Nebraska Medical Center College of Pharmacy

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Tufts Medical Center

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Osterhaus Pharmacy

Tony Palmer, D.B.A.
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LLW Consulting

Sidney Phillips, Pharm.D., M.B.A.
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Texas Society of Health-System Pharmacists

Rico Powell, CPhT
Pharmacy Automations Analyst
LeBonheur Childrens Hospital

Anthony Provenzano, Pharm.D.
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Advancing technician practice: Deliberations of a regulatory board

ABSTRACT

In 2016, the Idaho State Board of Pharmacy (U.S.) undertook a major rulemaking initiative to advance pharmacy practice by broadening the ability of pharmacists to delegate tasks to pharmacy technicians. The new rules of the Board thus moved the locus of control in technician scope of practice from law to pharmacist delegation. Pharmacist delegation is individualistic and takes into account the individual technician’s capabilities, the pharmacist’s comfort level, facility policies, and the risk mitigation strategies present at the facility, among other factors. State law limits, by contrast, are rigid and can mean that pharmacists are unable to delegate tasks that are or could otherwise be within the abilities of their technicians.

The expanded technician duties are in two domains: 1) medication dispensing support (e.g., tech-check-tech, accepting verbal prescriptions, transferring prescriptions, and performing remote data entry); and 2) technical support for pharmacist clinical services (e.g., administering immunizations). This commentary reviews the evidence behind these expanded duties, as well as the key regulatory decision points for each task. The Board’s rules and approach may prove useful to other states and even other governing bodies outside the U.S. as they consider similar issues.

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In 2016, the Idaho State Board of Pharmacy undertook a major rulemaking initiative to advance pharmacy practice in the state. Specifically, the new rules broaden the ability of pharmacists to delegate tasks to technicians under their supervision. The expanded technician duties are in two domains: 1) medication dispensing support (e.g., tech-check-tech, accepting verbal prescriptions, transferring prescriptions, and performing remote data entry); and 2) technical support for pharmacist clinical services (e.g., administering immunizations). This manuscript describes the Board’s approach to its rulemaking in hopes that it will be helpful to other jurisdictions considering similar issues.

1. Regulating technician practice

The regulation of pharmacy technicians is broadly focused on promoting safe and effective pharmacy practice while protecting the public health. States typically regulate technicians in two ways: 1) entry barriers; and 2) scope of practice restrictions.

1.1. Entry barriers

Entry barriers are designed to ensure a minimum level of competency of individuals holding a license or registration. Currently, Idaho law requires pharmacy technicians to meet the following requirements as a condition of registration: minimum age (18 years), education (high school graduate or equivalent), and training (hold a national certification through one of two national certifying bodies). Some exceptions are made on a case-by-case basis, and a technician-in-training registration category offers individuals up to three years to obtain the requisite certification.

1.2. Scope of practice restrictions

In a traditional sense, “there are no functions unique to pharmacy technicians;” rather, all technician roles are a subset of pharmacist roles and occur under the supervision of a pharmacist. For a technician to perform a task, it must be legally permissible and delegated to him or her by a supervising pharmacist. In general, the legal scope of technician practice is defined in prohibitive terms in that pharmacists are prohibited from delegating – and thus technicians are prohibited from performing – certain roles and responsibilities that may be otherwise performed by pharmacists or interns. Idaho is consistent with most U.S. states in that technicians are prohibited from performing tasks that require professional judgment (drug utilization review, clinical conflict resolution, and patient counseling). States vary to the extent they restrict other activities. Thus there are two levels of control on technician scope of practice: state law limits and pharmacist delegation decisions. Even if state law does not prohibit delegation of a specific task or function to a technician, a pharmacist may use his or her professional judgment to decide not to delegate a specific task to a specific technician.

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2. Approach to advancing technician scope of practice

While Idaho law has increased the entry barriers for technicians over time, the scope of practice restrictions had remained generally unchanged since the 1970's. To begin the process of modernization, Board staff performed an environmental scan to identify what activities technicians were performing in other states that were expressly prohibited in Idaho law. A series of eight listening sessions were then held throughout the state in March and April 2016 to gain public feedback early in the process. Board staff reviewed the expanded technician duties, described the existing literature and findings from other state boards of pharmacy, and asked attendees their feedback. Several key themes emerged across the listening sessions:

1. Pharmacists generally reflected support for expanding the role of appropriately trained technicians. Some pharmacists did note concerns for their own liability as technician roles expand. To sort out these concerns, the Board engaged a former executive of a national pharmacist liability insurer. The executive noted that liability insurance rates have not increased for either pharmacist or pharmacies in the states that have already expanded technician roles as Idaho is considering.3

2. Pharmacists reported variability in technician qualifications for expanded duties, and noted that it is critical to ensure assignment of function remains with the pharmacist. The Board agreed with this sentiment, and retained its existing rule that a technician must not perform and task or function connected unless the technician is authorized by the assigning pharmacist. The Board occasionally would hear from a pharmacist who stated they would never trust their technicians to perform specific duties under consideration. The assignment of function rule offered them a simple solution: do not delegate the task. Similarly, an occasional technician would indicate they would not want to perform a specific task. In both instances, it did not seem reasonable to not allow any technician in the state to perform a specific task just because some pharmacists or technicians were uncomfortable with the thought. Such regulation to the lowest common denominator is rarely in the public interest.

3. Technicians reflected excitement about the prospects of new roles and career opportunities. Many saw new tasks as an opportunity to grow and develop. Some envisioned the development of a career ladder that would help recruit and retain top technician talent, and that technicians would be rewarded for taking on value-added skills. Of note, some technicians expressed frustration that they had maxed out in their current roles despite being willing to learn new tasks.

3. Core elements of new rules

The Board's new rules focus on two domains: 1) medication dispensing support and 2) technical support for pharmacist clinical services. To be clear, the tasks enumerated in the new rules for technicians are not designed to be exhaustive. The Board's focus was on loosening restrictions currently listed in rule. It is known that technicians can and do play more extensive tasks, particularly with regard to clinical service support (medication reconciliation, basic physical assessment, point-of-care testing). There were no restrictions on these activities in existing Idaho law, and thus the Board determined no changes were necessary to enable delegation of these tasks.

The Board was committed to letting evidence drive decision-making. A summary of the available evidence for each task is provided in Table 1.4–11 The availability of published literature varied by task, though some states have successful track records with each task – in some instances for up to forty years. The Board rules enabled each of the expanded duties to be delegated to certified technicians (not trainees) at the discretion of the supervising pharmacist. Key decision points regarding each task are reviewed in Table 2.20–23

1. Tech-Check-Tech (e.g., “Accuracy Checking”)

Tech-check-tech (TCT) is a practice model in which an advanced pharmacy technician performs final verification on a product for floor and ward stock, or for products that have previously been reviewed for clinical appropriateness by a pharmacist.1 Idaho's rules now allow tech-check-tech in any practice setting, not just acute care hospitals (as was previously the case).1 Accuracy checking may only be conducted by a certified technician who has undergone site-specific training. Technicians may perform TCT on any drug except compound products. Pharmacies must adopt a quality assurance program that includes unannounced monitoring and evaluation of each accuracy checking technician at least quarterly for the first year and then annually thereafter. Pharmacies must remediate or remove from checking duty any technician who

<table>
<thead>
<tr>
<th>Task</th>
<th>Brief Summary of Evidence</th>
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<tr>
<td>Tech-Check-Tech</td>
<td>The literature base supporting tech-check-tech in institutional settings spans nearly four decades. Across 11 studies in a systematic review, pharmacy technicians performed as accurately as pharmacists in final verification duties (99.6% vs. 99.3%, respectively) while freeing pharmacists for advanced clinical services (10 hours per month to 1 hour per day).1,11 Two additional studies on institutional TCT have been published since the systematic review, demonstrating similar safety-related outcomes while achieving even greater yields in terms of time available for pharmacist clinical services (50 hours more per month to 5.75 hours more per day).5,7 Published evidence on TCT in community pharmacy settings spans 14 years and four studies.8 In the two studies that reported explicit accuracy rates, pharmacy technicians performed on par with pharmacists in one, and statistically outperformed pharmacists in the other (99.44% vs. 99.73%, p = 0.484; 99.95 vs. 99.74, p &lt; 0.05) while simultaneously increasing the amount of time pharmacists have available for providing clinical services (5.3%–19.18% of the pharmacists’ workload).8,10,11</td>
</tr>
<tr>
<td>Accept Verbal Prescriptions</td>
<td>Wakefield and Wakefield found the topic of verbal orders has not been studied in depth and the current body of evidence is anecdotal.12 The lone study connecting verbal orders to safety found that verbal orders actually decreased the risk of error compared to handwritten orders.13 Given that 17 states have allowed these activities (in some instances for up to 40 years), and apparently high uptake of this activity by technicians in practice (63% in one study), the lack of evidence on patient safety issues gave the Board comfort that these activities may be safely and appropriately delegated if paired with strong practice policies and procedures.14,15</td>
</tr>
<tr>
<td>Transfer Prescription Orders</td>
<td>The Board was committed to letting evidence drive decision-making. A summary of the available evidence for each task is provided in Table 1.4–11 The availability of published literature varied by task, though some states have successful track records with each task – in some instances for up to forty years. The Board rules enabled each of the expanded duties to be delegated to certified technicians (not trainees) at the discretion of the supervising pharmacist. Key decision points regarding each task are reviewed in Table 2.20–23</td>
</tr>
<tr>
<td>Administer Immunizations</td>
<td>Given that no states currently allow technicians to administer vaccines, it should be of little surprise that we were unable to find any technician-specific immunizations studies.16 Parallels can still be drawn from the literature however. Studies have demonstrated that untrained laypersons can safely and effectively self-administer intranasal and intradermal vaccines while achieving statistically similar levels of immune response.17–19 Laypersons also successfully self-administer medication through intramuscular and subcutaneous routes (e.g., patients with diabetes).18</td>
</tr>
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Table 1
Summary of evidence on expanded technician roles.
Summary of key decision points in rulemaking.

<table>
<thead>
<tr>
<th>Service</th>
<th>Key Decision Points</th>
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<tr>
<td>Tech-Check-Tech</td>
<td></td>
</tr>
<tr>
<td>a. Nomenclature</td>
<td>The rule update rebranded TCT as an “accuracy checking technician program” and the technicians performing final product verification were termed “accuracy checking technicians (ACT).” This terminology was adopted from a recent pilot project in New Zealand, and was chosen as the Board felt it more accurately captures the spirit of such a program. For example, TCT implies a technician can only check a fellow technician, whereas the Board envisions a technician having the ability to also check a student pharmacist, an automated dispensing system, or other technology-assisted filling equipment.</td>
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<tr>
<td>b. Practice Setting</td>
<td>Previous Board rule allowed TCT in “acute care” hospitals, though a waiver had also been granted to allow it in a psychiatric hospital as well. The Board decided to make this rule practice-site agnostic as product verification is functionally the same regardless of setting. Frost and Adams reviewed the conceptual differences in TCT programs between institutional and community settings (unit dose vs. bulk container) and decided the requirement was unnecessary. The Board requested that the DEA, the agency’s policy staff agreed with the Board’s interpretation that a technician could accept a verbal or perform a transfer if technicians are specifically authorized by the state to perform this activity. Thus, the Board put no restrictions on drugs in law and instead left this to the discretion of the supervising pharmacist.</td>
</tr>
<tr>
<td>c. Covered Drugs</td>
<td>The previous rule was limited to unit dose medications and this requirement was struck, enabling TCT to be leveraged for any medications (including those in bulk containers). The only drugs excluded by law are compounded products, given the potential safety risk these present. While other states carve out controlled substances from TCT, the Idaho rules do not. In addition, prior rule language exempted medications “of the alteration of a unit dose or the combination of unit doses is required.” This language was struck, opening the door for TCT to be used for innovative packaging models (e.g., daily blister packs).</td>
</tr>
<tr>
<td>d. Student Pharmacist Participation</td>
<td>In general, student pharmacists can perform any activity under the supervision of a pharmacist with the exception of final verification. Rule language was added to specifically enable student pharmacists to participate fully in the ACT program with the same limitations and requirements as ACTs.</td>
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<tr>
<td>Accepting Verbal Prescriptions and Transferring Prescriptions</td>
<td></td>
</tr>
<tr>
<td>a. Controlled Substances</td>
<td>Federal law seemed ambiguous on if a technician could accept a verbal or perform a transfer for controlled substances. In communicating with the DEA, the agency’s policy staff agreed with the Board’s interpretation that a technician could accept a verbal or perform a transfer if technicians are specifically authorized by the state to perform this activity. Thus, the Board put no restrictions on drugs in law and instead left this to the discretion of the supervising pharmacist.</td>
</tr>
<tr>
<td>b. Practice Policies and Procedures</td>
<td>The Board heard concerns that verbal orders have the potential to be misunderstood or misheard, creating an error cascade that is difficult for the pharmacist to catch during drug utilization review. Most concerns revolve around the technician reducing to writing the wrong drug name or wrong drug dose. The Institute for Safe Medication Practice has shared best practices for receiving verbal orders that may mitigate the risk of these events occurring, such as requiring read-back, spell-back techniques, referencing the indication, etc.25 The Board did not require such practices in law, and instead left these to the discretion of the supervising pharmacist.</td>
</tr>
<tr>
<td>c. Parties to Communication</td>
<td>The prior Board rule allowed student pharmacists to transfer prescriptions as long as one of the parties involved in the communication was a pharmacist. This was amended, and in the revised rule a technician could communicate a transfer to another technician or a student pharmacist.</td>
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<tr>
<td>Remote Data Entry</td>
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</tr>
<tr>
<td>a. Ratio</td>
<td>Idaho currently has a maximum ratio of six technicians and interns per pharmacist. As such, one decision point was if a remote data entry technician should count against this ratio. The Board ultimately carved technicians working in a such a manner out of the ratio as the goal is to defray workload on pharmacists, and it would be logistically difficult to identify whose ratio the technician should count against since they may be servicing multiple pharmacies simultaneously.</td>
</tr>
<tr>
<td>b. Pharmacist on Duty</td>
<td>Current law states that a pharmacist must not enter a pharmacy unless the pharmacist is on duty. The Board discussed whether or not a remote data entry technician could perform work if a pharmacist was not a duty. The Board determined that a technician practicing in such a manner could perform work before a pharmacy is open for business or after hours. All of the work completed ultimately feeds into a queue that a pharmacist must check, hence the exemption.</td>
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<tr>
<td>c. Inspection</td>
<td>All pharmacy locations are subject to inspection by Board staff, remote data entry locations included. Because some remote entry sites may be at an individual’s home, specific language was added to the rule to set clear expectations that such sites could be subject to unannounced inspections, albeit unlikely.</td>
</tr>
<tr>
<td>Administer Immunizations</td>
<td></td>
</tr>
<tr>
<td>a. Training</td>
<td>Existing Board rule set forth in granular detail the training requirements necessary for pharmacists to immunize. The most commonly used program is a 20-h certificate training program hosted by the American Pharmacists Association. This course covers basic immunology, recommended vaccine schedules, immunization assessment and counseling, etc.26 Only a small portion of this program is devoted to actual immunization administration technique. Given that pharmacists play a much broader role with vaccines than technicians — making the clinical decision to prescribe the right vaccine to the right patient at the right time — the Board felt that a program that was more targeted to the actual administration step would likely be more appropriate and thus opened the door to the development of new training programs more targeted to the administration role technicians would actually play. In addition, the rules require a technician to hold a current certification in basic life support by the American Heart Association or a comparable provider. The training must include cardiopulmonary resuscitation and automated electronic defibrillator training. Further, the program must have a hands-on skills assessment by an authorized instructor.</td>
</tr>
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</table>

Idaho's new rules allow a certified technician to receive a verbal prescription drug order from a prescriber or their agent and reduce the order to writing. The rule also permits a certified technician to transfer prescription drug order information for the purpose of filing or refilling the medication. Such a transfer may occur verbally, electronically, or via fax. No restrictions were placed in law, but several extra-legal factors may come into play. For example, the Joint Commission standards deter the use of verbal orders for high-risk products such as chemotherapy.24 The Board heard more concerns from pharmacists about technicians accepting verbal orders than any other task under consideration, but the Board believed that robust practice policies and procedures do not meet minimum performance standards of the facility.

2. Accepting Verbal Prescriptions and Transferring Prescriptions

Idaho's new rules allow a certified technician to receive a verbal prescription drug order from a prescriber or their agent and reduce the order to writing. The rule also permits a certified technician to transfer prescription drug order information for the purpose of filing or refilling the medication. Such a transfer may occur verbally, electronically, or via fax. No restrictions were placed in law, but several extra-legal factors may come into play. For example, the Joint Commission standards deter the use of verbal orders for high-risk products such as chemotherapy. The Board heard more concerns from pharmacists about technicians accepting verbal orders than any other task under consideration, but the Board believed that robust practice policies and procedures.
such as read-back/spell-back, requiring the indication, etc., can be instituted to reduce the risk for error.20–22

3. Remote Data Entry

The Idaho rules would allow a pharmacy located in Idaho to employ one or more certified technicians to perform data entry in remote practice sites (e.g., a home) located in Idaho. No drug inventory may be kept at a remote practice site, and audit trail documentation shall be maintained to identify the person responsible for each aspect of the prescription preparation. The computer used at a remote data entry site must be able to establish a secure connection to the home pharmacy system, and no patient information can be stored at the remote site. The allowance to work from a home setting or a non-pharmacy setting differentiates remote data entry from workload balancing efforts that allow staff located in other pharmacies to pick up the slack for allied pharmacies. While three states currently allow remote data entry by technicians, interest in this area is likely to grow in the years ahead as a resolution supporting the concept was passed at the 2016 NABP Annual Meeting.23

4. Administer Immunizations

Idaho’s new rules allow pharmacists to delegate the technical task of vaccine administration (inserting the syringe into the patient’s arm and pressing down on the plunger) to a certified technician who has completed training in appropriate immunization administration techniques and who holds certification in basic life support for healthcare professionals. Idaho is the first state to allow technicians to administer vaccines. Technicians already play critical roles related to vaccine advocacy and perform nearly every other technical task including selecting the proper needle gauge and length, loading the syringe, and safely disposing of needles and syringes, among other duties.26–28 Thus it was not a stretch to add the administration step. In addition, the Board heard from technicians who previously served as medical assistants and were entrusted to administer immunizations in physician offices, but were not permitted to do the same in a pharmacy.

4. Discussion

Regulating pharmacy technician scope of practice is a balancing act. It is imperative to ensure that the tasks performed by technicians are safe and appropriate for their level of education and training. If a state is too strict in law, however, it can mean that pharmacists spend a substantial fraction of their workday performing technician-like duties, denying patients the clinical expertise of pharmacists.

The new rules of the Board moved the locus of control in technician scope of practice from law to pharmacist delegation. Pharmacist delegation is individualistic, and takes into account the individual technician’s capabilities, the pharmacist’s comfort level, facility policies, the risk mitigation strategies present at the facility, among other factors.29 State law limits, by contrast, are one-size-fits-all, and can mean that pharmacists are unable to delegate tasks that are or could otherwise be within the abilities of their technicians.

A unique aspect of the Board’s discussions was that they focused on scope of practice, and not on additional entry barriers (specifically education or training). It was even acknowledged that technicians are not currently trained for some of the tasks under consideration. The Board felt that limitations on scope of practice may prevent technicians or employers from investing time and money into training on tasks that are legally prohibited from being performed. As one example, once technicians were allowed to administer immunizations, a training program was quickly developed and marketed by an academic institution.20 The Board envisaged additional education and training programs emerging to meet the other tasks included in the rules.

Permissive rules enabling pharmacist discretion in delegation can create additional opportunities to divide the labor that occurs in the pharmacy in a manner that optimally deploys both professions in the interest of patient care. The Board’s overall approach to rulemaking was to remove legal barriers and empower the pharmacist as the decision-maker with respect to delegation. This approach more closely reflects the medical model of practice, and avoids the rabbit hole of over-regulating technician practice to the detriment of patient care. The Board’s rules and approach may prove useful to other states as they consider similar issues.

Conflicts of interest

None.

Disclaimer

The views expressed in this manuscript are those of the author alone, and do not necessarily reflect those of their employer.

References


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11 February 2017
Pharmacy technician self-efficacies: Insight to aid future education, staff development, and workforce planning

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ABSTRACT

Background: The roles of pharmacy technicians are increasingly prominent given pharmacy’s transition to patient-centered activities and evolving scopes of practice in many U.S. states and throughout the world.

Objectives: The aims of this study were to assess U.S. pharmacy technicians’ self-efficacies for and attitudes toward performing current and emerging roles in hospital and in community pharmacy and to identify factors related to pharmacy technician self-efficacies in these roles.

Methods: A total of 5000 pharmacy technicians from 8 U.S. states were sent an electronic survey eliciting data on current involvement, self-efficacies, and attitudes for practicing in an expansive list of practice activities. The 8 states from which the sample was drawn were selected from a stratified randomized procedure using U.S. Census Bureau geographically defined regions. Pre-notification and response reminders were employed. Data were analyzed descriptively and with univariate, inferential tests, as appropriate, to determine associations with commitment, practice environment, experience level, and other variables.

Results: Of the 612 participants who responded, 494 were currently working as a technician and not enrolled in a PharmD program of study. Participants reported various activities in which they were highly engaged. Overall, attitudes toward performing most of the activities and self-efficacies were quite favorable, even for those activities in which technicians were currently less involved. There were some notable differences between technicians practicing in community versus hospital settings. Years of experience, profession commitment, and advanced employee ranking were associated with higher levels of self-efficacy, overall.

Conclusions: This initial examination of pharmacy technician self-efficacies identified areas that along with other factors could help employers with further expanding technician practice activities and vocational institutions with considerations for education and development of these key members of the workforce. The results would suggest technicians to be ready for continued evolution in their practice.

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1. Introduction

Attention has been recently afforded to pharmacy technicians and other workforce cadres in discussions of pharmacy practice. This attention comes after years of relative omission, particularly when considering that the practice of support staff would naturally mature if pharmacists are to delegate some of their previous responsibilities to engage in more patient-centered care. Much recent literature has focused on role expansions for technicians in the United States (U.S.), this has most recently been codified in various State Board of Pharmacy statutes allowing for “check-tech-check”, wherein technicians have the final review of refill prescription orders for accuracy. This follows a designated CheckTech position authorized in the United Kingdom (U.K.) for nearly a decade and a study in New Zealand demonstrating the effectiveness of a similar program with evidence that as a result, pharmacists actually shifted considerable amounts of time in practice from dispensing to patient-focused activities. Recently, some U.S. states have either passed or are considering legislative rules allowing technicians to administer immunizations, such as for influenza inoculation.
The recent expansion of legal and regulatory scopes of practice for technicians follows a couple of decades where the roles of technicians were piloted and implemented on a limited basis, often to a particular health system. Examples of such roles include technician involvement in tobacco cessation programs, medication safety director, medication reconciliation, and medication-history taking, to name but a few. These roles all represent expansions of technician responsibility and autonomy, even if not necessarily emblematic of regulatory or legal practice change.

Whether regulatory or not, and even whether the expanded role(s) underscore significant increases in cognitive workload and judgment, there is debate about technician education, training, and skills development that has been ongoing for quite some time. On a global level, this can be witnessed by the myriad approaches taken in both developed and in developing nations, where education requirements vary from standardized education in Denmark to some technicians being the only dispenser of medication in certain under-developed nations, to others where they have taken on a more clinical role examined specifically in their performance of current responsibilities.

While preliminary evidence suggests technicians generally embrace new roles and are effective in their performance, there has been no research evaluating on a broader scale their willingness to take on emerging responsibilities and their confidence in doing so. For that matter, there has been very little if any research evaluating technicians’ self-efficacy in their performance of current responsibilities. Self-efficacy is an important construct implicated in attitude, performance, and behavior change. Self-efficacy has been examined in pharmacists and demonstrated to be critical in their proficiency for delivering patient care. Additionally, identification of areas where self-efficacy is lacking can become the backbone of future educational interventions and perhaps even help identify areas for restructure of technician vocational education, on-the-job training, and professional revalidation.

These lines of thought regarding self-efficacy in technician practice come in light of emerging data on pharmacy workforce cadres. Pharmacy support staff have varied roles worldwide, where some technicians are basically the only dispenser of medication in certain under-developed nations, to others where they have taken on a more clinical role examined specifically for their part in safety within the medication use process. From a global perspective, technicians take on varied roles and education training in certain settings, even while in some countries such as Denmark, all technicians (pharmacists) are educated entirely at one institution nationwide, regardless of setting. In the U.S., technicians ostensibly have different roles than other pharmacy support staff, such as clerical personnel; however, it has been noted that at least among the lay clients (patients), there is often difficulty distinguishing one staff member type from another and that their roles might not always be clearly delineated.

Very few studies have examined, or compared responsibilities and attitudes between technicians in various practice settings. While some technicians might have practiced in various settings throughout their career, others might very well have been in either hospital or community practice for an extensive period of time. The two settings vary considerably, with the pharmacy technician, particularly in the U.S., responsible for customer service and an integrated series of steps involved in the prescription dispensing process, whereas hospital pharmacy technicians interact little with the public/patients, yet have a wider range of responsibilities beyond medication dispensing, owing to the complexity of distribution, storage, inventory, and record-keeping inherent to the hospital setting.

To that end, the aims of this study were to assess U.S. pharmacy technicians’ self-efficacies for and attitudes toward performing current and emerging roles in hospital and in community pharmacy and to identify factors related to pharmacy technician self-efficacies in these roles.

2. Methods

2.1. Design and sample

Institutional review board (IRB) exemption for study procedures were granted by the universities home to the investigators of this study. The study design was cross-sectional, featuring use of a survey to a stratified randomized sample of technicians from 8 U.S. states. Using a sample size calculation recommended by Dillman et al., an estimated 384 respondents were deemed required to meet the study objectives. Assuming a response rate of approximately 10%, the researchers conservatively sought contact information from 5000 subjects from these states. Selection at the state level was performed with geographic diversity as a key tenet. The U.S. is divided into 4 geographic regions by the U.S. Census Bureau: Northeast, Southeast, Midwest, and West. Two states from each of those regions were sampled. The State Boards of Pharmacy from those states selected were contacted to provide its registry of technicians. If the State Board was unable to provide such a registry in an appropriate form (e.g. Excel spreadsheet or comma, delimited electronic format), or if the registry was cost-prohibitive (over $500), then another state from that geographic region was sampled. Once the registry of all technicians from all 8 states was acquired, the total number of registrants (eligible respondents) was determined by summing them; and that sum served as a denominator to calculate an equal proportion of the sample from each state. The study subjects were then selected from each state using a random number generator program that provided the numbers corresponding to the record number of each state registry.

The survey was designed and implemented using Qualtrics technology. The procedures for survey conduct were in accordance with recommendations by Dillman et al. to maximize rate of return. Sampled subjects received a pre-notification email approximately 9–10 days prior to launch of the survey, with an option to contact a research investigator to opt out with their preference not to participate. In doing so, those who opted out were replaced by the next individual from their same state of residence by the next registrant from the random number generator. Eleven respondents opted out and were replaced, in addition to another 94 whose pre-notification were returned as undeliverable. Respondents then received the survey via an email link along with a cover letter. The cover letter explained the salience of the study in advancing pharmacy technician professionalism, education, and preparation for future practice, as well as proper consent and assurances via IRB approval. The sampled technicians then received three additional reminder emails approximately one week apart, with the survey coming to a close on 1 March 2017.

2.2. Study variables

Self-efficacy in performing roles/activities was assessed using 10-point scales of confidence wherein respondents indicated such as it pertains to them currently performing the role. This mechanism of measurement is adopted from Bandura’s self-efficacy theory using a similar approach to assess confidence specific to a certain task or behavior. This is apt for measuring affinity toward roles or tasks that are situation-specific and takes into account perceived difficulty, as opposed to self-esteem, which is an overall evaluation of one’s worth, otherwise known as the self-concept. For the same set of tasks/roles (36 for community pharmacy and 36 for hospital pharmacy, with those like totals being coincidental),
respondents also indicated the extent to which they are currently involved in that activity, the extent they would like to be involved in that activity, and their attitude toward that activity. These variables are components of the theory of planned behavior (TPB).27 While this study was not aimed to test the explanatory power of TPB among technicians, it was believed that current involvement and attitude toward the role/activity would provide key insights into their self-efficacy for performing it. Level of involvement was measured on a 4-point scale from “not at all” to “very often”, as was their desire for level of involvement. Attitude toward the activity was measured on a 4-point scale of importance (“not at all important” to “very important”). A list of activities upon which to measure self-efficacy was derived from the literature, borrowing much from a previous study of pharmacist workforce, which itself was taken from a previous Pharmacy Technician Certification Board (PTCB) task analysis unique for technicians in institutional and community practice settings. This list of activities was derived in conjunction with members of PTCB, American Association of Colleges of Pharmacy, American Pharmacists Association, and American Society of Health-System Pharmacists, all comprising the Pharmacy Workforce Center. This was supplemented with additional activities suggested in recent literature, specifically responsibilities identified in a study of technicians from developed nations globally28 and from one U.S. state (Idaho) whose Board of Pharmacy had just recently updated the scope of practice for technicians to be among the most progressive in the U.S. Total self-efficacy scores were derived by summing the individual self-efficacy responses to each of the activities for hospital and for community pharmacy technicians. Using skip logic, technicians from community pharmacy were automatically directed to only the community pharmacy list of activities, as was the case similarly for those in hospital practice. Level of involvement and preference for level of involvement was also summed across all activities. Technicians in other practice environments did not participate in this component of the survey; the Qualtrics technology employed skip logic to take respondents from these other settings directly to the end of the survey.

In addition to the aforementioned, demographic and work environment data were captured. This included employment status (currently working, part- or full-time), state of residence, practice setting, job rank (eg, entry-level versus advanced or specialty technician), gender, age, and measures of organizational and profession commitment used previously on an entirely different sample of U.S. pharmacy technicians.3 This measure, rather than attempting to gauge an amount of the time in the future the respondent plans to stay with the organization and profession, proposes contexts on an ordinal continuum as to whether the respondent is firmly rooted, could be easily provoked to make an employment change, or feels entrenched for the long haul.

2.3. Data analysis

The data were prepared for analysis on SPSS, Version 21.0 following export from Qualtrics. Frequency distributions were tabulated for all relevant questions. Survey scales were subjected to a principal components analysis with oblique rotation, item analysis, and internal consistency reliability analysis to evidence construct validity, internal consistency reliability, and appropriateness of each item prior to their use in inferential statistics. Correlation analysis (Pearson’s r) was undertaken to determine relationships between continuous variables, particularly self-efficacy variables with years of experience, attitude toward the activities, and level of involvement in those activities. This included an examination of relationships between level of involvement, preference for involvement, and self-efficacies. Independent t tests and one-way analyses of variance (ANOVs, F test), were conducted to determine any relationships between the demographic/practice setting variables with self-efficacy and with performance ability.

3. Results

3.1. Participant characteristics

Out of 5000 surveys distributed, responses were obtained from 612 participants (12.2% response rate). Respondent employment status and other characteristics are provided in Table 1. Of the 612 respondents, 494 were currently working as a pharmacy technician and not enrolled as a PharmD student. The ensuing analyses and discussion is restricted only to those individuals. Nearly ¾ of those were working full-time, and over ¾ were female. Responses were received from all 8 states sampled and generally in line with the population of those states, respectively. For example, the population of Florida is approximately twice that of New Jersey, both of which exceed all other states.31 Louisiana’s population is a bit higher than Oregon’s; however, the response rate from Louisiana was somewhat lower. As such, the response rates from each state might have differed only slightly. “Other” respondents came from various states, usually bordering one of the sampled states. Nearly 2/3 of respondents had earned some sort of higher tier or specialty technician designation. The majority of respondents came from community pharmacy, with 16.4% from the hospital setting. Respondents had been working as a technician for 8.15 years and had been with the current employer for 5.64 years. Most respondents reported at least modest commitment toward their employer. They also reported high levels of commitment to the profession, although more than ¼ of respondents indicated either looking to leave or stating that it might not take much to get them to change their career.

3.2. Community pharmacy technician self-efficacies

Table 2 provides the list of tasks/activities investigated for community pharmacy technicians (all community pharmacy settings combined), the respondents’ level of involvement, their attitude about those tasks/activities, and their level of self-efficacy in performing them. Participants reported high levels of involvement around the entire task for prescription acquisition and initial filling, which incidentally loaded together on the principal components analysis. Likewise, their attitudes toward performing these activities and their self-efficacies for doing so were very high. There were a number of activities wherein respondents indicated being less involved but still having a positive, to very positive attitude regarding their conduct and reported a relatively high level of self-efficacy. Examples of such activities include compounding prescriptions, maintaining equipment, supervising other technicians, checking the work of other technicians, receiving prescriptions from prescribers, and maintaining files of habit-forming drugs. Activities that respondents reported positive attitudes but with somewhat lower self-efficacy included communicating lifestyle changes to patients, discussing effectiveness of treatment plans for returning patients, collaborating with other health professionals to monitor drug therapy effectiveness, providing information to providers and patients on medication issues, transferring prescriptions, and administering immunizations. Overall, respondents’ attitudes toward most of the activities were above the scale midpoint 2.50, with notable exceptions for administering immunizations and entering prescription data remotely from home. These were activities in which the participants were less involved, along with transferring prescriptions to another pharmacy, accepting verbal prescription orders, and assuming responsibility.

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Those with lower standard deviations included administering immunizations, entering data remotely from home, assessing prescription for completeness, and identifying problems with a prescription, indicative of those tasks being performed at either a consistently low or consistently high level among the respondents. With respect to self-efficacies, overall, on 36 items (tasks/activities), with a potential range of self-efficacy scores of 36–360 (10-point scale), the lowest response total was 84 and the highest was 360, with an overall mean of 251.95 ± 19.99, well above the scale’s midpoint of 198. Female respondents from community practice reported an overall self-efficacy of 258.71 ± 24.71, versus that of 247.62 for males (t = 2.74, p < 0.05). Those working full-time reported an overall self-efficacy of 261.33 ± 47, versus 240.24 for those working part-time (t = 2.92, p < 0.05). Respondents with a rank of Technician II and III reported self-efficacies of 268.51 ± 22.37 and 270.12 ± 28.21, respectively, versus a mean self-efficacy of 239.14 ± 21.84 for those with a Technician I rank (F = 5.02, p < 0.01).

3.3. Hospital pharmacy technician self-efficacies

Table 3 provides the list of tasks/activities investigated for hospital pharmacy technicians, the respondents’ level of involvement, their attitude about those tasks/activities, and their level of self-efficacy in performing them. The level of involvement in the various tasks/activities for hospital pharmacy technicians was more disparate between the tasks than was the case for community pharmacy technicians. Participants reported high levels of involvement around replenishing dose carts, ensuring proper storage of medication, assisting with medication distribution, and maintaining automated dispensing technology. They reported low levels of involvement in many of the activities, including oversight of medical assistance programs, preparation of clinical monitoring information, administering immunizations, providing information to patients, and collaborating with other health professionals to evaluate the effectiveness of medication therapy. In spite of low levels of current involvement, respondents reported rather positive attitudes about the performance of most of the tasks, in general, with exceptions being preparation of clinical monitoring information, updating medication administration records, assisting with transitions of care, and administering immunizations. Activities with relatively positive attitudes wherein respondents were only moderately involved included purchasing and inventory management, controlled substances systems management, supervising, and checking the work of other technicians. On the other hand, attitude toward assistance with medication distribution was only modest, in spite of a relatively high level of involvement in that activity. Activities involvement with higher standard deviations included maintaining files of habit-forming drugs, evaluating labels and packaging of drugs, checking the work of other technicians, assuming responsibility for quality assurance activities, and following up on medication distribution problems. Those with lower standard deviations included entering prescription orders, oversight of medication assistance programs, preparation of clinical monitoring information, assisting with hiring other technicians, and running medication utilization reports, all of which saw respondents involved rather consistently at a low level. With respect to self-efficacies, overall, on 36 items (tasks/activities), with a potential range of self-efficacy scores of 36–360 (10-point scale), the lowest response total was 71 and the highest was 360, with an overall mean of 242.22 ± 24.56, still above the scale’s midpoint of 198. Males reported an overall self-efficacy of 249.35 ± 36.82 versus that of 239.82 ± 25.11 for females (t = 2.11, p < 0.05). Respondents with a rank of Technician II and Technician III reported self-efficacies of 259.12 ± 29.19 and 257.38 ± 28.94, respectively, versus those with a rank of Technician I reporting a mean self-efficacy of 233.76 (F = 4.81, p < 0.01).

### Table 1

Descriptive characteristics of study respondents.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%) or mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
</tr>
<tr>
<td>Currently working as a pharmacy technician</td>
<td>494 (80.7%)</td>
</tr>
<tr>
<td>Enrolled in a pharmacy school, but also employed as a</td>
<td>23 (3.8%)</td>
</tr>
<tr>
<td>technician</td>
<td></td>
</tr>
<tr>
<td>Employed in some capacity other than a pharmacy</td>
<td>55 (9.0%)</td>
</tr>
<tr>
<td>technician</td>
<td></td>
</tr>
<tr>
<td>Unemployed (seeking employment)</td>
<td>22 (3.6%)</td>
</tr>
<tr>
<td>Unemployed (not seeking employment)</td>
<td>14 (2.3%)</td>
</tr>
<tr>
<td>Retired</td>
<td>4 (0.7%)</td>
</tr>
<tr>
<td><strong>Work hours</strong></td>
<td></td>
</tr>
<tr>
<td>Full-time</td>
<td>336 (71.5%)</td>
</tr>
<tr>
<td>Part-time</td>
<td>134 (28.5%)</td>
</tr>
<tr>
<td><strong>State of residence</strong></td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>159 (33.8%)</td>
</tr>
<tr>
<td>Louisiana</td>
<td>27 (5.7%)</td>
</tr>
<tr>
<td>Maine</td>
<td>18 (3.8%)</td>
</tr>
<tr>
<td>Nebraska</td>
<td>43 (9.1%)</td>
</tr>
<tr>
<td>New Jersey</td>
<td>85 (18.1%)</td>
</tr>
<tr>
<td>North Dakota</td>
<td>10 (2.1%)</td>
</tr>
<tr>
<td>Oregon</td>
<td>60 (12.8%)</td>
</tr>
<tr>
<td>Utah</td>
<td>48 (10.2%)</td>
</tr>
<tr>
<td>Other</td>
<td>20 (4.3%)</td>
</tr>
<tr>
<td><strong>Position</strong></td>
<td></td>
</tr>
<tr>
<td>Entry-level technician (as per my employer, eg, “Tech II”)</td>
<td>158 (33.6%)</td>
</tr>
<tr>
<td>Advanced tier technician (as per my employer, eg, “Tech II”)</td>
<td>123 (26.2%)</td>
</tr>
<tr>
<td>Highest tier technician (as per my employer, eg, “Tech III”)</td>
<td>110 (23.4%)</td>
</tr>
<tr>
<td>Specialty technician</td>
<td>79 (16.8%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>171 (79.9%)</td>
</tr>
<tr>
<td>Male</td>
<td>43 (20.1%)</td>
</tr>
<tr>
<td><strong>Work Setting</strong></td>
<td></td>
</tr>
<tr>
<td>Community pharmacy large organization (eg, chain,</td>
<td>256 (54.5%)</td>
</tr>
<tr>
<td>discount, mass merchandiser, grocery store pharmacy)</td>
<td></td>
</tr>
<tr>
<td>Community pharmacy small organization (eg,</td>
<td>62 (13.2%)</td>
</tr>
<tr>
<td>independently owned, 5 or fewer stores under same</td>
<td></td>
</tr>
<tr>
<td>ownership)</td>
<td></td>
</tr>
<tr>
<td>Hospital or other inpatient facility</td>
<td>77 (16.4%)</td>
</tr>
<tr>
<td>Nursing home/long-term care</td>
<td>19 (4.0%)</td>
</tr>
<tr>
<td>Home health care</td>
<td>5 (1.1%)</td>
</tr>
<tr>
<td>Mail order pharmacy</td>
<td>10 (2.1%)</td>
</tr>
<tr>
<td>Other</td>
<td>41 (8.7%)</td>
</tr>
<tr>
<td><strong>Employer Commitment</strong></td>
<td></td>
</tr>
<tr>
<td>I would have left or am looking to leave at the first</td>
<td>101 (16.3%)</td>
</tr>
<tr>
<td>opportunity</td>
<td></td>
</tr>
<tr>
<td>I do not feel much commitment, and keep my options</td>
<td></td>
</tr>
<tr>
<td>open</td>
<td>25 (4.1%)</td>
</tr>
<tr>
<td>I feel modest commitment and do no plan significant</td>
<td></td>
</tr>
<tr>
<td>changes unless something unexpected happens</td>
<td>101 (16.3%)</td>
</tr>
<tr>
<td>I feel strong commitment to the organization and am</td>
<td></td>
</tr>
<tr>
<td>planning my career/work future with them for the</td>
<td>100 (16.3%)</td>
</tr>
<tr>
<td>long haul</td>
<td></td>
</tr>
<tr>
<td><strong>Profession Commitment</strong></td>
<td></td>
</tr>
<tr>
<td>I am looking or plan to leave this career, altogether</td>
<td>28 (11.6%)</td>
</tr>
<tr>
<td>I do not have other plans currently, but it might not</td>
<td>42 (17.4%)</td>
</tr>
<tr>
<td>take much For me to change careers</td>
<td></td>
</tr>
<tr>
<td>In spite of challenges or shortcomings, I feel good</td>
<td>70 (29.0%)</td>
</tr>
<tr>
<td>about this line of work and hope to make a career of</td>
<td></td>
</tr>
<tr>
<td>it for quite some time</td>
<td></td>
</tr>
<tr>
<td>I feel completely committed and am definitely in</td>
<td>101 (41.9%)</td>
</tr>
<tr>
<td>this career for my entire work life</td>
<td></td>
</tr>
<tr>
<td><strong>Number of years worked as a pharmacy technician</strong></td>
<td>8.15 ± 8.07</td>
</tr>
<tr>
<td><strong>Number of years worked for current employer</strong></td>
<td>5.64 ± 6.01</td>
</tr>
</tbody>
</table>

for disaster preparedness. Activities involvement with high standard deviations included repackaging non-sterile products, maintaining equipment, and assisting with prescription assistance program for patients; this would be indicative of consistency in either high or very low levels of involvement for these activities. Those with lower standard deviations included administering immunizations, entering data remotely from home, assessing

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4. Discussion

To the authors’ best knowledge, this is the first study to closely examine the self-efficacy beliefs of pharmacy technicians. The salience of self-efficacy beliefs has been underscored in pharmacists, for example, by their ability to communicate effectively with patients, particularly those of varied backgrounds and other vulnerable populations like those at-risk of or currently engaging in substance abuse. In fact, pharmacist self-efficacy was paramount in determining their readiness for embracing new practice roles, such as ameliorating the deleterious outcomes of illicit drug dependence. Lack of self-efficacy has been cited as a major impediment to implementation of pharmaceutical care and suggested to be a critical factor in the training of pharmacists for designing interventions. The salience of self-efficacy in care delivery is also well reported outside of pharmacy.

The continued transition of pharmacy to a more patient-centered philosophy of practice hinges upon the readiness and competence of pharmacists and their support personnel. Technicians play key roles in pharmacy care all throughout the world, and initial evidence would suggest they are vital in helping to ensure patient safety, all the while promoting efficiency in pharmacy operations. Logically, then, an evaluation of technicians’ self-efficacy and preparedness to engage in current and emerging roles is critical.

When evaluating technicians’ roles, respondents from this study in community pharmacy reported relatively high levels of involvement, self-efficacy in, and positive attitudes toward a large number of tasks, many of which revolved around prescription receipt and dispensing processes. Still, there were a number of activities for which they reported positive attitudes and self-efficacies but were only marginally or moderately involved. These are activities for the most part that are legal for practice, with some exceptions in certain states. Technicians would like to be involved furthering their involvement in a variety of areas, particularly medication preparation and dissemination being more compartmentalized. Still, it would appear as though opportunities exist for reducing the deleterious outcomes of illicit drug dependence. Lack of self-efficacy has been cited as a major impediment to implementation of pharmaceutical care and suggested to be a critical factor in the training of pharmacists for designing interventions. The salience of self-efficacy in care delivery is also well reported outside of pharmacy.

For hospital pharmacy technicians, level of involvement in activities was more diffuse, which might owe to technicians in that setting being more specialized and the tasks involved around medication preparation and dissemination being more compartmentalized. Still, it would appear as though opportunities exist for furthering their involvement in a variety of areas, particularly where attitudes and self-efficacy are high. Of course, some of these areas require more experience and arguably some degree of clinical judgment, depending upon how that task is configured, and there might be a number of barriers and rationale why hospitals would not want to deploy certain technicians, particularly more junior ones, in activities requiring at least some level of clinical

### Table 2

Hospital pharmacy technician involvement in, attitude toward, and self-efficacy for performing various tasks:

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Involvement</th>
<th>Attitude</th>
<th>Self-efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter prescription orders in computer</td>
<td>3.18 ± 0.85</td>
<td>2.30 ± 0.84</td>
<td>6.17 ± 3.89</td>
</tr>
<tr>
<td>Replenish dose carts and floor stock</td>
<td>3.26 ± 1.14</td>
<td>2.86 ± 0.44</td>
<td>9.17 ± 2.32</td>
</tr>
<tr>
<td>Maintain automated dispensing technology</td>
<td>3.07 ± 1.20</td>
<td>2.73 ± 0.58</td>
<td>8.60 ± 2.74</td>
</tr>
<tr>
<td>Help to maintain pharmacy equipment</td>
<td>2.98 ± 1.14</td>
<td>2.87 ± 0.35</td>
<td>8.30 ± 2.51</td>
</tr>
<tr>
<td>Compound sterile products</td>
<td>2.79 ± 1.28</td>
<td>2.80 ± 0.55</td>
<td>8.07 ± 3.06</td>
</tr>
<tr>
<td>Compound non-sterile products</td>
<td>2.63 ± 1.16</td>
<td>2.67 ± 0.66</td>
<td>8.07 ± 2.84</td>
</tr>
<tr>
<td>Perform packaging/packaging activities</td>
<td>2.88 ± 1.14</td>
<td>2.52 ± 0.74</td>
<td>8.10 ± 3.03</td>
</tr>
<tr>
<td>Purchasing and inventory management</td>
<td>2.40 ± 1.21</td>
<td>2.77 ± 0.57</td>
<td>6.90 ± 3.55</td>
</tr>
<tr>
<td>Communicate with wholesale suppliers and vendors</td>
<td>1.74 ± 1.04</td>
<td>2.40 ± 0.77</td>
<td>7.27 ± 2.77</td>
</tr>
<tr>
<td>Oversee activities related to medication assistance programs</td>
<td>1.36 ± 0.73</td>
<td>2.10 ± 0.76</td>
<td>3.67 ± 3.18</td>
</tr>
<tr>
<td>Controlled substances system management</td>
<td>2.56 ± 1.22</td>
<td>2.77 ± 0.50</td>
<td>7.50 ± 3.16</td>
</tr>
<tr>
<td>Billing and other accounting functions</td>
<td>2.00 ± 1.29</td>
<td>2.48 ± 0.79</td>
<td>5.10 ± 3.39</td>
</tr>
<tr>
<td>Engage in continuous professional development</td>
<td>2.84 ± 1.07</td>
<td>2.57 ± 0.63</td>
<td>7.38 ± 2.84</td>
</tr>
<tr>
<td>Check the work of other technicians (check-tech-check)</td>
<td>1.98 ± 1.26</td>
<td>2.53 ± 0.73</td>
<td>7.60 ± 3.24</td>
</tr>
<tr>
<td>Supervise other technicians</td>
<td>1.79 ± 1.03</td>
<td>2.41 ± 0.83</td>
<td>7.10 ± 3.59</td>
</tr>
<tr>
<td>Encourage professional development of other technicians</td>
<td>2.14 ± 1.08</td>
<td>2.52 ± 0.74</td>
<td>7.27 ± 3.11</td>
</tr>
<tr>
<td>Assist with hiring other technicians</td>
<td>1.62 ± 0.91</td>
<td>2.37 ± 0.81</td>
<td>6.87 ± 3.36</td>
</tr>
<tr>
<td>Determine future staffing needs</td>
<td>1.67 ± 1.02</td>
<td>2.28 ± 0.92</td>
<td>6.13 ± 3.62</td>
</tr>
<tr>
<td>Reconcile errors or other issues with medication administration records</td>
<td>1.95 ± 1.13</td>
<td>2.43 ± 0.77</td>
<td>5.53 ± 3.71</td>
</tr>
<tr>
<td>Update medication administration record or patient’s profile</td>
<td>1.69 ± 1.05</td>
<td>2.20 ± 0.95</td>
<td>4.47 ± 3.40</td>
</tr>
<tr>
<td>Preparation of clinical monitoring information for pharmacist review</td>
<td>1.31 ± 0.72</td>
<td>1.97 ± 0.93</td>
<td>3.67 ± 3.37</td>
</tr>
<tr>
<td>Assist with or facilitate patient transitions of care</td>
<td>1.55 ± 1.00</td>
<td>2.20 ± 0.85</td>
<td>4.73 ± 3.78</td>
</tr>
<tr>
<td>Run medication utilization reports</td>
<td>2.05 ± 0.92</td>
<td>2.33 ± 0.84</td>
<td>5.83 ± 3.86</td>
</tr>
<tr>
<td>Assist with distribution of medications throughout facility</td>
<td>3.05 ± 1.20</td>
<td>2.70 ± 0.65</td>
<td>7.80 ± 3.41</td>
</tr>
<tr>
<td>Follow-up on medication distribution issues or problems</td>
<td>2.63 ± 1.27</td>
<td>2.63 ± 0.72</td>
<td>7.40 ± 3.56</td>
</tr>
<tr>
<td>Communicate with nurses and other professionals regarding patient therapy</td>
<td>2.07 ± 1.17</td>
<td>2.37 ± 0.81</td>
<td>5.50 ± 3.70</td>
</tr>
<tr>
<td>Ensure proper storage of medications</td>
<td>3.30 ± 0.96</td>
<td>2.77 ± 0.57</td>
<td>8.87 ± 2.27</td>
</tr>
<tr>
<td>Participate in protocol or guideline adherence monitoring activities</td>
<td>2.27 ± 1.25</td>
<td>2.23 ± 0.86</td>
<td>5.47 ± 3.56</td>
</tr>
<tr>
<td>Communication medication storage issues with nurses</td>
<td>2.81 ± 1.22</td>
<td>2.57 ± 0.68</td>
<td>6.80 ± 2.78</td>
</tr>
<tr>
<td>Assume responsibility for quality assurance activities</td>
<td>2.28 ± 1.28</td>
<td>2.23 ± 0.86</td>
<td>6.24 ± 3.44</td>
</tr>
<tr>
<td>Participate in disaster preparedness activities</td>
<td>2.16 ± 1.19</td>
<td>2.33 ± 0.80</td>
<td>6.37 ± 3.31</td>
</tr>
<tr>
<td>Provide information to patients on drug interactions, side effects, and medication storage</td>
<td>1.48 ± 0.92</td>
<td>2.38 ± 0.86</td>
<td>4.90 ± 3.63</td>
</tr>
<tr>
<td>Collaborate with other health professionals to plan, monitor, review and evaluate the effectiveness of medication therapy</td>
<td>1.64 ± 0.98</td>
<td>2.24 ± 0.87</td>
<td>4.79 ± 3.44</td>
</tr>
<tr>
<td>Maintain files of narcotics and habit-forming drugs in accordance with legal requirements</td>
<td>2.02 ± 1.28</td>
<td>2.48 ± 0.83</td>
<td>6.21 ± 3.45</td>
</tr>
<tr>
<td>Evaluate labels, packaging and advertising of drug products</td>
<td>2.24 ± 1.25</td>
<td>2.25 ± 0.84</td>
<td>6.52 ± 3.58</td>
</tr>
<tr>
<td>Administer immunizations</td>
<td>1.10 ± 0.37</td>
<td>1.87 ± 0.90</td>
<td>3.41 ± 3.08</td>
</tr>
</tbody>
</table>

* Possible respondents (N) = 77. Actual number of respondents ranged from 68 to 75 on various questions.

* 4-point scale anchored from less (1) to more (4) involved or more positive.

* 10-point scale.
Table 3
Community pharmacy technician involvement in, attitude toward, and self-efficacy for performing various tasks.a

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Involvementb</th>
<th>Attitudec</th>
<th>Self-efficacyc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect or communicate patient information</td>
<td>3.57 ± 0.83</td>
<td>2.91 ± 0.29</td>
<td>8.95 ± 1.81</td>
</tr>
<tr>
<td>Assess prescription for completeness, accuracy, authenticity, and legality</td>
<td>3.63 ± 0.72</td>
<td>2.95 ± 0.26</td>
<td>8.95 ± 1.58</td>
</tr>
<tr>
<td>Input prescriptions into computer</td>
<td>3.44 ± 0.98</td>
<td>2.84 ± 0.48</td>
<td>8.73 ± 2.20</td>
</tr>
<tr>
<td>Provide prescription to patient</td>
<td>3.41 ± 1.02</td>
<td>2.72 ± 0.60</td>
<td>8.93 ± 2.35</td>
</tr>
<tr>
<td>Triage patient needs for referral to pharmacist</td>
<td>3.10 ± 1.14</td>
<td>2.68 ± 0.63</td>
<td>8.20 ± 2.77</td>
</tr>
<tr>
<td>Identify any problems with prescription (eg, dosage, patient instructions, misinformation, medication name, other)</td>
<td>3.33 ± 0.88</td>
<td>2.89 ± 0.36</td>
<td>8.71 ± 1.72</td>
</tr>
<tr>
<td>Discuss over-the-counter medication options with patients</td>
<td>2.21 ± 1.13</td>
<td>2.38 ± 0.72</td>
<td>6.55 ± 3.11</td>
</tr>
<tr>
<td>Repackage or reconstitute non-sterile products</td>
<td>2.62 ± 1.30</td>
<td>2.56 ± 0.72</td>
<td>7.61 ± 3.35</td>
</tr>
<tr>
<td>Compound prescriptions</td>
<td>1.76 ± 1.03</td>
<td>2.30 ± 0.82</td>
<td>5.76 ± 3.74</td>
</tr>
<tr>
<td>Inventory management</td>
<td>3.04 ± 1.09</td>
<td>2.73 ± 0.54</td>
<td>8.31 ± 2.45</td>
</tr>
<tr>
<td>Manage medications currently in stock, including organization, storage, and stock rotation</td>
<td>3.38 ± 0.97</td>
<td>2.78 ± 0.52</td>
<td>8.87 ± 2.17</td>
</tr>
<tr>
<td>Maintain automated dispensing technology and other equipment</td>
<td>2.37 ± 1.26</td>
<td>2.38 ± 0.82</td>
<td>6.52 ± 3.52</td>
</tr>
<tr>
<td>Communicate with insurance companies regarding patient eligibility and other issues</td>
<td>3.09 ± 1.15</td>
<td>2.71 ± 0.55</td>
<td>7.86 ± 2.97</td>
</tr>
<tr>
<td>Explain use of medical equipment, appliances, or other devices to the patient</td>
<td>1.91 ± 1.00</td>
<td>2.34 ± 0.74</td>
<td>5.84 ± 3.19</td>
</tr>
<tr>
<td>Communicate lifestyle changes to patients</td>
<td>1.70 ± 1.06</td>
<td>2.23 ± 0.84</td>
<td>5.04 ± 3.61</td>
</tr>
<tr>
<td>Engage in your own continuous professional development</td>
<td>3.07 ± 0.58</td>
<td>2.70 ± 0.58</td>
<td>8.18 ± 2.48</td>
</tr>
<tr>
<td>Supervise other technicians</td>
<td>2.24 ± 1.27</td>
<td>2.34 ± 0.83</td>
<td>6.91 ± 3.33</td>
</tr>
<tr>
<td>Discuss effectiveness of treatment plan for returning patients</td>
<td>1.72 ± 1.12</td>
<td>2.23 ± 0.88</td>
<td>4.96 ± 3.77</td>
</tr>
<tr>
<td>Accounting and record-keeping</td>
<td>2.55 ± 1.22</td>
<td>2.50 ± 0.73</td>
<td>7.14 ± 3.20</td>
</tr>
<tr>
<td>Disposal of expired or adulterated medications</td>
<td>2.90 ± 1.12</td>
<td>2.71 ± 0.60</td>
<td>8.16 ± 2.56</td>
</tr>
<tr>
<td>Assist with prescription assistance programs</td>
<td>2.23 ± 1.28</td>
<td>2.33 ± 0.79</td>
<td>6.28 ± 3.67</td>
</tr>
<tr>
<td>Assume responsibility for quality assurance activities</td>
<td>2.44 ± 1.26</td>
<td>2.50 ± 0.73</td>
<td>6.70 ± 3.27</td>
</tr>
<tr>
<td>Assume responsibility for disaster preparedness</td>
<td>1.79 ± 1.13</td>
<td>2.20 ± 0.83</td>
<td>5.57 ± 3.54</td>
</tr>
<tr>
<td>Receive prescriptions from medical doctors or other prescribers</td>
<td>2.29 ± 1.35</td>
<td>2.48 ± 0.78</td>
<td>6.79 ± 3.55</td>
</tr>
<tr>
<td>Check patients’ medication histories</td>
<td>3.07 ± 1.05</td>
<td>2.67 ± 0.59</td>
<td>8.05 ± 2.68</td>
</tr>
<tr>
<td>Ensure proper dosage and drug compatibility before dispensing</td>
<td>2.71 ± 1.24</td>
<td>2.63 ± 0.69</td>
<td>7.07 ± 3.33</td>
</tr>
<tr>
<td>Label liquid medicines, ointments, powders, and other medicines before dispensing</td>
<td>3.48 ± 0.96</td>
<td>2.81 ± 0.51</td>
<td>8.80 ± 2.21</td>
</tr>
<tr>
<td>Provide information to providers and patients on drug interactions, side effects, and medication storage</td>
<td>2.08 ± 1.22</td>
<td>2.47 ± 0.79</td>
<td>6.07 ± 3.50</td>
</tr>
<tr>
<td>Collaborate with other health professionals to plan, monitor, review and evaluate the effectiveness of medication therapy</td>
<td>1.61 ± 1.03</td>
<td>2.23 ± 0.87</td>
<td>4.91 ± 3.71</td>
</tr>
<tr>
<td>Maintain prescription files of narcotics and habit-forming drugs in accordance with legal requirements</td>
<td>2.76 ± 1.22</td>
<td>2.66 ± 0.65</td>
<td>7.79 ± 2.90</td>
</tr>
<tr>
<td>Evaluate labels, packaging, and advertising of drug products</td>
<td>2.28 ± 1.24</td>
<td>2.24 ± 0.79</td>
<td>6.23 ± 3.53</td>
</tr>
<tr>
<td>Administer immunizations</td>
<td>1.17 ± 0.65</td>
<td>2.03 ± 0.95</td>
<td>3.91 ± 1.69</td>
</tr>
<tr>
<td>Accept verbal prescription orders from a physician or other prescriber</td>
<td>1.45 ± 0.92</td>
<td>2.23 ± 0.90</td>
<td>5.32 ± 3.83</td>
</tr>
<tr>
<td>Transfer a prescription from on pharmacy to another</td>
<td>1.63 ± 1.09</td>
<td>2.23 ± 0.90</td>
<td>5.66 ± 3.86</td>
</tr>
<tr>
<td>Check the work of other technicians (check-tech-check)</td>
<td>2.51 ± 1.23</td>
<td>2.50 ± 0.73</td>
<td>7.51 ± 3.17</td>
</tr>
<tr>
<td>Enter prescription data remotely from home</td>
<td>1.23 ± 0.70</td>
<td>1.91 ± 0.59</td>
<td>5.10 ± 4.06</td>
</tr>
</tbody>
</table>

a Possible respondents (N) = 312. Actual number of respondents ranged from 290 to 302 on various questions.

b 4-point scale anchored from less (1) to more (4) involved or more positive.

c 10-point scale.

knowledge. Technicians’ involvement in some activities, such as communication with nurses, is almost unavoidable or inherent to the job; thus, the fact that self-efficacies are only low to moderate for these activities should provide insight for employing institutions, vocational training programs, and even credentialing (eg, certification) organizations for future educational and development endeavors.

These findings coincide with calls for re-examining and further leveraging the maturing of technician education and professionalization, including the potential for work redesign so that pharmacy could reach its full potential. It also reinforces the need for use of sound pedagogy when educating technicians on emerging roles such as providing immunizations to ensure that trainees are not only provided basic concepts, but are also instilled with the confidence that they can contribute effectively to the goals of the pharmacy organization, regardless of practice setting. These findings also support the most recent calls for standardizing education requirements for technicians, advocating for their certification, and more careful planning by employers to promote efficiency in pharmacy operations while at the same time helping technician practice to become a career choice rather than just a job.1

There were differences in self-efficacies reported among various groups. Females in community practice reported higher self-efficacy, while the opposite was true in hospital practice. This could possibly be owing to females having reported greater caring behaviors when dealing directly with patients, but the study design here precludes definitive conclusions in that regard. Respondents working full-time in community pharmacy reported higher self-efficacy than part-time workers in community, but not hospital settings. Again, greater experience in a more customer- or patient-oriented practice could be implicated in this finding, and this has ramifications for job training and evaluation of part-timers. Those with higher “rank” or designations (eg, Tech II or Tech III) reported much higher self-efficacies than entry-level technicians in both settings. This might suggest that employers’ job promotion efforts have been successful, and might provide evidence for even more ubiquitous career-laddering mechanisms for technicians.45

The relationship between technician commitment and self-efficacy merits some attention. While there was little association between these two constructs, there was a notable trend, with more experienced technicians reporting higher self-efficacies for performing various tasks. It is possible that this finding is due to the length of time the technicians have had to develop their skills and confidence in their abilities.

The study has several limitations. First, the sample size was relatively small, and the results may not be generalizable to the entire population of pharmacy technicians. Second, the study was cross-sectional, and therefore the temporal relationship between self-efficacy and other constructs could not be determined. Third, the measure of self-efficacy was a single-item Scale for each task, which may not be as comprehensive as a multi-item measure. Finally, the results may be influenced by the specific practice setting, which was not accounted for in the analysis.

In conclusion, this study provides valuable insights into the self-efficacy of pharmacy technicians in performing various tasks. The results suggest that there is a need for further research in this area, particularly regarding the relationship between self-efficacy and other constructs such as job satisfaction and job performance. Additional studies are needed to explore the factors that influence self-efficacy and to determine the best practices for enhancing the self-efficacy of pharmacy technicians.
environments. This finding likewise further evidences the need for leaders and educators to bolster self-efficacy among pharmacy technicians during early training and perhaps reinforcement of such throughout their careers during development and even re-certification or re-validation initiatives.

4.1. Study limitations

This study has several limitations that warrant caution when interpreting the results. The response rate, even while favorable when compared to similar survey research endeavors, is low enough so that any number of response biases could be manifest. This could include responses more likely acquired from those more highly engaged in the profession and from those very unsatisfied with their working conditions. With survey research of this sort, the prospect of respondents providing socially desirable responses cannot be precluded. Also, some caution and consideration is merited when examining the range and mean of responses around “attitude” toward certain activities. For some specialized activities, such as providing immunizations and assistance with monitoring drug therapy, the respondent would likely be either involved or not at all involved in such activities. As such, their attitude could be based upon a relative lack of knowledge for such an activity. The responses came predominately from 8 states in the U.S. randomly sampled and from which the scopes of practice might vary to some degree, but none of which are known in recent history for any groundbreaking scope of practice changes for technicians.

5. Conclusion

This study evaluated the self-efficacies of pharmacy technicians in community and hospital practice across a broad range of current and evolving job tasks/activities. Self-efficacies were generally high, especially for the tasks centered around medication order/prescription receipt, preparation, and dissemination. There are a high, especially for the tasks centered around medication order/prescription receipt, preparation, and dissemination. There are a high, especially for the tasks centered around medication order/prescription receipt, preparation, and dissemination. There are a high, especially for the tasks centered around medication order/prescription receipt, preparation, and dissemination. There are a high, especially for the tasks centered around medication order/prescription receipt, preparation, and dissemination. There are a high, especially for the tasks centered around medication order/prescription receipt, preparation, and dissemination. 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Expanded pharmacy technician roles: Accepting verbal prescriptions and communicating prescription transfers

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ABSTRACT

As the role of the clinical pharmacist continues to develop and advance, it is critical to ensure pharmacists can operate in a practice environment and workflow that supports the full deployment of their clinical skills. When pharmacy technician roles are optimized, patient safety can be enhanced and pharmacists may dedicate more time to advanced clinical services. Currently, 17 states allow technicians to accept verbal prescriptions called in by a prescriber or prescriber’s agent, or transfer a prescription order from one pharmacy to another. States that allow these activities generally put few legal limitations on them, and instead defer to the professional judgment of the supervising pharmacist whether to delegate these tasks or not. These activities were more likely to be seen in states that require technicians to be registered and certified, and in states that have accountability mechanisms (e.g., discipline authority) in place for technicians. There is little evidence to suggest these tasks cannot be performed safely and accurately by appropriately trained technicians, and in states that have accountability mechanisms (e.g., discipline authority) in place for technicians. Pharmacists can adopt strong practice policies and procedures to mitigate the risk of harm from verbal orders, such as instituting read-back/spell-back techniques, or requiring the indication for each phoned-in medication, among other strategies. Pharmacists may also exercise discretion in deciding to whom to delegate these tasks. As the legal environment becomes more permissive, we foresee investment in more robust education and training of technicians to cover these activities. Thus, with the adoption of robust practice policies and procedures, delegation of verbal orders and prescription transfers can be safe and effective, remove undue stress on pharmacists, and potentially free up pharmacist time for higher-order clinical care.

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1. Background

As the role of the clinical pharmacist continues to develop and advance, it is critical to ensure pharmacists can operate in a practice environment and workflow that supports the full deployment of their clinical skills. As it stands, pharmacists report high levels of job stress and professional dissatisfaction.¹ In a national survey, pharmacists reported the top stress events they face are “having so much work to do that everything cannot be done well” and “not being staffed with an adequate number of technicians.”²

Implicit in these responses is the critical role that appropriately trained pharmacy technicians can play in reducing workload and stresses faced by pharmacists. When technician roles are optimized, patient safety can be enhanced and pharmacists may dedicate more time to advanced clinical services. When technician roles are unnecessarily restricted, there is poor division of labor amongst the pharmacy team and pharmacists spend a substantial fraction of time devoted to non-clinical activities.²³ The legally permitted roles and responsibilities of pharmacy technicians varies greatly country to country and across state lines in the United States (U.S.).² In some respects, the U.S. lags behind other developed nations in the full deployment of the technician workforce. In Denmark, for example, “pharmaconomists” perform the final medication check, answer medication queries, and screen for allergies, among other tasks.²

A commonly reported reason for the lack of full deployment of the pharmacy technician workforce is the great variability in their education and training.²⁶ Less reported is the reciprocal: the variability in legally permissible roles and responsibilities of technicians may suppress investment in more robust education and
training. For example, why would a technician or employer invest time and money in a skill that is legally prohibited from performing in practice? Similarly, why would a technician training program integrate the teaching of such a skill into its curriculum? This chicken-or-egg scenario leads to robust debates about what the appropriate order of operations should be in terms of expanding technician roles. We personally believe the legal framework for pharmacist delegation should be more permissive than precautionary, and the onus should be on the supervising pharmacist to determine what tasks are appropriate to delegate and to whom. Such a permissive framework can spur investment in education and training that is valued by the individual or the employer.10

In that respect, an area in which some have suggested pharmacy technicians could play an increased role relates to a commonly rated pharmacist stressor: being interrupted by phone calls while performing other job duties.11 Forty percent of chain pharmacists rated this as a high stress event. Phone calls — like other sources of interruptions and distractions — can divert attention from other activities. Nursing literature has estimated that every interruption can increase the chance of medication error by 12.7%.10-12 Two common sources of phone calls that interrupt pharmacy workflow are: 1) verbal prescriptions called in by a prescriber or prescriber’s agent; and 2) requests to transfer a written prescription from the prescriber's review occurring at the pharmacy to another. The National Association of Boards of Pharmacy (NABP) Model State Pharmacy Act and Model Rules recommend prohibiting technician trainees from receiving new oral prescriptions, but it is silent on this task for certified technicians, implying assent.13

Allowing technicians to receive and handle these phone calls may serve to reduce interruptions on pharmacists, potentially increasing time for other clinical activities or reducing errors that stem from distractions. Verbal orders such as receiving prescriptions or transferring prescriptions, however, have the potential to be misunderstood or misheard, creating an error cascade that is difficult for the pharmacist to catch during drug utilization review. If handled by individuals who are less familiar with medications than pharmacists or interns, verbal orders may have the potential to introduce new errors into the dispensing process.

The purpose of this manuscript is to describe the potential role for technicians in receiving verbal prescriptions and performing prescription transfers, describe the legal and practice safeguards that may be placed on these activities, and review the existing evidence of the safety of technicians performing these roles. This information will be used as a framework to make recommendations regarding future applications of these tasks.

2. Overview of verbal prescriptions and transferred prescriptions

Verbal communication is one means by which a licensed prescriber may transmit a valid prescription drug order to a pharmacy. Alternatively the prescriber may issue an original signed and written prescription, electronically route it, or fax it to the pharmacy. For a verbal prescription drug order, the prescriber or prescriber’s agent must communicate all the information required of a valid prescription drug order except for the signature of the prescriber. Verbal prescriptions may be synchronous or asynchronous (e.g., left as a voicemail). The pharmacist receiving the verbal prescription must promptly reduce it to writing and may process the prescription as any other. Federal law prohibits verbal prescriptions for Schedule II substances, except in rare emergency situations.14 Unless a state’s law is more stringent, federal law permits a verbal prescription as a valid means of ordering a Schedule III through V controlled substance or any non-controlled medication. Extra-legal forces are also in play. For example, the Joint Commission accreditation standards prohibit the use of verbal orders for chemotherapy.15 Various groups recommend reserving the use of verbal orders to only true emergency situations.16 Still, many verbal orders are called in for prescriber or patient convenience, though their use has certainly declined with the increased rates of electronic prescribing. For example, one study found a decrease in verbal orders from 22% to 10% of total orders in the 21 months following implementation of an electronic order entry system.17

A prescription may be transferred from one pharmacy to another up to the maximum refills permitted by the issuing prescriber. There are many reasons why a patient may want to transfer a prescription to a different pharmacy, including convenience. Federal law limits the transferring of a controlled substance to a single, one-time transfer.12 The transferring pharmacist and the receiving pharmacist must record and document certain pieces of information, and the transferring pharmacist must void the original prescription either on the hard copy or in the electronic record so as not to inadvertently dispense more prescriptions than authorized by the prescriber. Functionally, the act of receiving a transferred prescription is very similar to receiving a new verbal prescription.

3. U.S. state law environmental scan

Currently, 17 U.S. states allow technicians to receive verbal prescriptions in community or institutional settings, and/or transfer prescriptions orders in community or institutional settings (Table 1).18 Ten states allow technicians to perform both of these tasks, five states allow only the receipt of verbal prescriptions, and two states allow only the transferring of prescription orders between pharmacies.18

States that allow the receipt of verbal prescriptions and/or transferring of prescription orders were compared to states that do not allow these tasks on certain variables. States that allow these tasks are more likely than states that do not allow these tasks to require either licensure or registration of technicians (88.2% vs. 83.3%, respectively), and are more likely to require that technicians obtain national certification (47.1% vs. 38.9%, respectively). Similarly, states that allow these tasks are more likely than states that do not allow these tasks to have the ability to hold technicians accountable, such as restricting, suspending, or revoking their license (47.1% vs. 33.3%, respectively). Lastly, states that allow these tasks were more likely than states that do not allow these tasks to have all three of these variables present (registration/licensure, certification, accountability capability). Specifically, 47.1% states have all three of these variables allow technicians to take verbal prescriptions and/or transfer prescriptions, compared to 33.3% of the states that do not.19 The presence of these variables may instill more confidence in the technician workforce that make the delegation of a wider variety of practice activities acceptable, and thus may represent the critical building blocks of expanded technician roles.

We reviewed the state statutes and regulations that permit verbal prescriptions in the aforementioned states. States generally were not too prescriptive in terms of adding legal limitations to when and how this task may be carried out. A few states limited this task to only certified technicians, not trainees. Louisiana was the only state that required the supervising pharmacist to review and initial an oral prescription prior to moving forward with prescription processing; all remaining states allowed the technician to begin data entry, with the pharmacist’s review occurring at the traditional drug utilization review step.20 Wisconsin’s law was the most circumscribed in that it permits the acceptance of an oral prescription only if the conversation is recorded, and the
pharmacist “listens to and verifies that transcription prior to dispensing” which likely significantly limits use.20

With respect to transferring prescription orders, states also tended to be permissive in statutes and regulations and leave the restrictions to the judgment of the supervising pharmacist. The most common limitation found in law was carving out controlled substances from the prescriptions that technicians could legally transfer between stores. A few states allowed a technician to transfer a prescription as long as the recipient on the other end of the phone was a pharmacist. Arizona had the most narrowly focused law, allowing technicians to perform only an electronic transfer between pharmacies owned by the same company and using a common or shared database.21 Thus, Arizona technicians are not permitted to verbally communicate a transfer between competitor pharmacies.

4. Existing evidence base with respect to patient safety

In a systematic review on verbal orders, Wakefield et al. found this topic has not been studied in depth and the extant literature is generally anecdotal.22 Paradoxically, Wakefield et al. noted the lone study connecting verbal orders to safety found verbal orders actually decreased the risk of error compared to handwritten orders by a factor of four!12,22 We found the paucity of available data to be true in the context of technician acceptance of verbal prescriptions and transferring prescription orders. The identified literature on pharmacy technicians accepting verbal prescriptions was limited to a single study by Friesner and Scott which documents uptake and not commenting on safety or effectiveness; no articles were identified on technicians transferring prescription orders.

Friesner and Scott conducted a survey of technicians registered to practice in North Dakota, a state that allows technicians to accept verbal prescriptions.24 Surveys were mailed to all 456 technicians in the state, and 192 (42.1%) responded in full. Respondents were queried on the extent to which they performed certain tasks, one of which was “taking new prescriptions over the telephone.” Overall, 63% of technician respondents reported taking new verbal prescriptions. Technicians working in community independent pharmacies were much more likely to perform this task than those working in towns with larger populations. This study was limited in that it did not assess the frequency with which technicians performed this task, and it did not provide any information on the safety — or perceived safety — of technicians perform this task.24

Two case studies were identified related to verbal orders were identified. In Iowa, a pharmacy technician used the verbal prescription route to create forged prescriptions for hydrocodone/acetaminophen.25 In Missouri, a technician misheard a prescription for metolazone 2.5 mg daily as methotrexate 2.5 mg daily, a case in which the patient involved died.26 The prescription was one of eleven that were called into the pharmacy at one time. A state court delivered a $2 million award against the pharmacy in a negligence suit.27

Perhaps the most interesting finding of our attempted review of evidence was what was not found. Despite 17 states allowing these activities, some for up to four decades, and apparently high uptake of this activity in practice — 63% of technicians in the Friesner and Scott study — we did not find any published studies documenting that these activities lead to widespread safety issues. Of the two cases identified, cases similar to that in Iowa are rendered moot with the reclassification of hydrocodone as a Schedule II substance which carries now only be called in emergency situations; while a technician could use the verbal route to forge other controlled substances, this is not exclusive to technicians and can and does unfortunately occur with pharmacists as well. Improvements in state prescription drug monitoring programs can mitigate the risk of this scenario occurring. The Iowa technician had her registration revoked, received a fine, and the board order further suggests that a criminal complaint was filed.28

The case identified in Missouri is tragic and highlights the consequences that can occur in pharmacy practice.26 The mix-up of metolazone and methotrexate is serious. Methotrexate is, however, typically dosed weekly whereas metolazone is typically dosed daily. That such an error could or should have been caught by the pharmacist in the drug utilization review stage may cause some to question the extent to which this error is attributable to the technician receiving the verbal order or the pharmacist who reviewed it for clinical appropriateness.

5. Implications for safety: the role of policies and procedures

Wakefield et al. reviewed common sources of error in the verbal order process.22 Errors could occur on the communicator’s end (e.g., misspeaking, confusing patient data, using unapproved communication), or on the receiver’s end (e.g., misunderstood sound-alike medications, transcription error, failure to seek clarification, etc.).29 Certainly familiarity with common medications, doses, and uses can mitigate some of the risk on the receiver’s end. Pharmacy technicians are increasingly gaining experience with this. For example, studies have recently demonstrated technicians perform accurately at medication reconciliation, often outperforming other health professionals including nurses at this activity.27–30 There is undoubtedly transferability of skill set from taking an accurate medication history and accepting a verbal prescription as the former necessitates probing to identify current and past medication names, strength, dosage form, allergies, and other related pieces of information. Practices that have leveraged technicians in medication history roles may be able to use similar training components for these new tasks.

In addition, there are practice policies and procedures that may be adopted to mitigate the potential for harm. Entities such as the Institute for Safe Medication Practice (ISMP) recommend using a prescription pad that prompts the receiver to ask for key pieces of information.31–33 Pharmacies may also institute a read-back

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**Table 1**

Review of state laws.

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technique in which the receiver reads back the order to ensure it was heard accurately, which can include a spelling back of the medication name itself. ISMP goes so far as saying that the readback technique should be a standard of practice in every setting regardless of who is receiving the verbal order. The receiver may also consider documenting the indication for the medication; this could prevent a metolazone vs. methotrexate mix-up by providing the pharmacist one additional piece of information at the drug utilization review stage that may help ward off errors. Pharmacists may also prohibit the use of new or unapproved abbreviations, and confirm doses by reading back the individual digits (e.g., “60 mg: six, zero milligrams”).

One issue that remains is the ability of technicians to seek clarification as appropriate in an instance in which the medication that is being called in is not for an appropriate dose, or in the event of a contradiction, among other patient safety issues. Given that most verbal prescriptions are now called in by an agent of the prescriber, clinical conflict resolution is unlikely to occur in real time. If the pharmacist has the right information to catch these issues at the drug utilization review stage, resolution is likely to occur within the same general time duration as if a probing question was asked up front by the pharmacist receiving the verbal order.

6. Conclusion and future direction

Currently 17 states allow technicians to accept verbal prescriptions and/or transfer prescription orders between pharmacies. States that allow these activities generally put few legal limitations on them, and instead defer to the professional judgment of the supervising pharmacist whether to delegate these tasks or not. These activities were more likely to be seen in states that require technicians to be registered and certified, and in states that have accountability mechanisms in place for technicians. Thus, these factors may be seen as critical first steps to enabling advanced pharmacy technician roles. Limiting certain expanded duties to certified technicians is consistent with the NABP Model Act.

As noted previously, the rate of verbal prescriptions has declined, and we envision this will continue as the rate of electronic prescribing continues to grow. Still, these interruptions will continue and creating opportunities to delegate these tasks to technicians will continue to represent an opportunity moving forward. While limited evidence is currently published on these tasks, there is little to suggest appropriately trained technicians cannot perform them safely and accurately, and the track record of success with these tasks spans four decades in some states. The law is, of course, just the minimum standard. Pharmacists are often required to go above and beyond what the law allows in order to provide optimal patient care, and pharmacists can adopt strong practice policies and procedures to mitigate the risk of harm from verbal orders. Such risk reduction strategies include instituting read-back, spell-back techniques, or requiring the indication for each phonend-in medication, among other risk reduction strategies. Pharmacists may also exercise discretion in deciding to whom to delegate these tasks. Pharmacists may be more comfortable with senior technicians who have more experience with medication names, or technicians who have previously conducted medication histories. In addition, extra-legal factors such as Joint Commission accreditation standards also provide checks and balances on the process.

As the legal environment becomes more permissive, we foresee investment in more robust education and training of technicians both in the mechanics of receiving a verbal prescription (e.g., simulated lab with environmental noise) and the understanding of common medication names and doses. Overall, with the adoption of robust practice policies and procedures, delegation of verbal orders and prescription transfers can be safe and effective, remove undue stress on pharmacists, and potentially free up pharmacist time for higher-order clinical care.

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Conflicts of interest

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Disclaimer

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References


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