NORTH DAKOTA BOARD OF MEDICINE
Established 1890

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2026 SPECIAL SESSION
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TESTIMONY OF
NORTH DAKOTA BOARD OF MEDICINE
SENATE BILL 2402

Chair Lee, Chair Ruby, and members of the Joint Policy Committee, I'm Sandra DePountis, Executive Director of the North Dakota Board of Medicine, appearing on behalf of the Board to provide information and testimony regarding Senate Bill 2402.

The Board appreciates the work done by the Rural Health Transformation Committee in obtaining federal funding for rural practice in North Dakota and the Board supports professionals practicing within the full scope of their education and training. Currently, health care providers continually collaborate with pharmacists who expertly advice on various drugs and prescriptions. The bill expands this scope to allow pharmacists to independently test, prescribe, and substitute medications prescribed by a health care provider "for a therapeutically equivalent drug." However, a pharmacist does not have access to the patient's medical records, is not examining the patient, and was not part of the discussion between the patient and their healthcare provider on a treatment plan. The central question is how can prescriptive decisions be safely made when the decision maker does not have access to this critical information?

To balance public protection with the critical needs this bill seeks to address, the Board respectfully requests the following 4 amendments.

AMENDMENT 1

SECTION 3 - PRESCRIPTIVE AUTHORITY - Subsection 1(h)

Recommendation: Require pharmacists to communicate test results and prescriptive activities to the patient's primary care provider and prescriber of record.

Rationale: Maintaining a clear and complete medical record on a patient is essential for continuity of care. When a pharmacist prescribes medication for influenza, strep throat, or any other condition, that pharmaceutical encounter - including symptoms assessed, tests performed, medications prescribed, and patient education provided – must become part of the patient's medical history. Without documentation flowing back to the primary care provider and prescriber of record:

- Duplicate testing and treatment may occur
- The prescriber and PCP would not have a full picture of the medical care of the patient which could affect future care, treatment, potential drug interactions, and how to manage care if subsequent adverse reactions occur.
- Pattern recognition is lost - recurrent conditions may indicate that other medical issues are present. For example, continued motion sickness could mean there is a neurological condition that needs to be addressed.

AMENDMENT 2

SECTION 3 - PRESCRIPTIVE AUTHORITY - Subsection (2) and (3)

Recommendation: Add language to clarify that a pharmacist can prescribe medications for the prevention of motion sickness and to allow a pharmacist to prescribe auto injections for patients with documented history of allergies or anaphylaxis. Remove "uncomplicated urinary tract infections" from the list of conditions for which pharmacists may independently prescribe.

Rationale for removal of UTI: The Board's primary concern is centered on patient safety when critical medical information is unavailable to the pharmacist. Without access to medical records and without examining the patient, pharmacists cannot determine whether a UTI is truly "uncomplicated."

Why "Uncomplicated" Status Cannot Be Determined Without Full Medical Records:
Examples of critical risk factors that make UTIs complicated which are documented in medical records that pharmacists cannot access during a pharmacy encounter include:

- Pregnancy (all pregnant UTI are complicated that require different antibiotic selection, dosing, and monitoring as certain antibiotics can cause serious fetal harm)
- Anatomic abnormalities (kidney stones, neurogenic bladder)
- Immunosuppression (chemotherapy, transplant recipients, uncontrolled diabetes)
- Recent procedures or catheterization
- Recurrent UTIs (≥3 in past year may indicate other complications such as kidney problems, blood infection, bladder cancer, etc. that require further testing)

Not all UTIs are appropriately treated by first line antibiotic therapy. Even if a CLIA waive test is administered, depending on medical history, a culture would be needed to identify the specific bacteria causing the infection to determine the most effective antibiotic, which is not under the purview of the pharmacist to order.

AMENDMENT 3

SECTION 3 - PRESCRIPTIVE AUTHORITY - Subsection 6(a)

Recommendation: Remove the provision allowing pharmacists to prescribe statins for "closing gaps in clinical guidelines."

Rationale: Pharmacists already have authority under N.D.C.C. § 43-15-01(12) to provide emergency prescription refills. This section, however, would allow issuance of new prescriptions for medications that the patient's provider specifically chose not to prescribe.

Why Absence of a Prescription May Reflect Informed Clinical Decision-Making:
If a diabetic patient does not have a current statin prescription, there is usually a documented clinical reason:

- **Previous adverse reaction:** Patient experienced rhabdomyolysis, severe myalgias, or hepatotoxicity on prior statin trials (documented in medical record, not visible to pharmacist)

- **Contraindications:** Active liver disease, pregnancy planning, drug-drug interactions, or genetic factors increasing statin toxicity risk
- **Informed refusal:** After extensive counseling about cardiovascular risk reduction, patient declined statin therapy
- **Adherence concerns:** Provider tried statins multiple times; patient repeatedly stopped due to side effects

Pharmacists do not have access to this information, raising concerns about whether this could therefore safely be prescribed.

AMENDMENT 4

SECTION 4 - THERAPEUTIC SUBSTITUTION - Subsection 1

Recommendation: Exclude the authority of pharmacist to issue therapeutic substitutions for the following 9 drug classes: antidepressants, antipsychotics, chemotherapy agents, controlled substances, immunosuppressants, anticonvulsants/antiepileptic drugs, anticoagulation drugs, antiarrhythmics, and beta blockers.

Rationale: Pharmacists already have authority under N.D.C.C. § 19-02.1-14.1(3) to substitute generic forms of medication with proper electronic communications and record keeping requirements. This section, however, allows "therapeutic substitutions" without limitation - that "*may* be established by clinical publications comparing dosages of drugs in a therapeutic class." However, a pharmacist does not have access to medical records and other critical information that drove the original prescription.

Without access to comprehensive medical records, a pharmacist cannot know:

- **Previous treatment failures**: Example: A patient with depression and a history of suicidal ideation may have already failed multiple SSRIs antidepressants before their provider prescribed a specific SSRI. Substituting to a previously ineffective medication, although "therapeutically equivalent," causes clinical deterioration and increases the patient's risk of suicide. Adult and minor psychiatric patient records are not available to the pharmacist who does not know this critical context.
- **Contraindications based on medical history**: Example: A 72-year-old with atrial fibrillation is on apixaban (Eliquis). The pharmacist substitutes to rivaroxaban

(Xarelto). Both medications are anticoagulants with the same mechanism of action and are therapeutically equivalent for the prevention of stroke. What the pharmacist doesn't know is that the patient has moderate renal impairment based on their creatinine clearance. The cardiologist specifically chose Eliquis because it's predominantly hepatically (liver) cleared, while Xarelto is renally (kidney) cleared, and this substitution causes a substantially increased risk of bleeding to the patient, who later presented with a major GI bleed requiring blood transfusions and admission to the ICU. The provider's chart contains this critical context; the pharmacy record does not.

- **Informed refusal after thorough counseling**: Example: A patient with chronic pain may have refused opioid alternatives after extensive discussion with their provider about risks, benefits, and personal/family addiction history. A therapeutic substitution could override this carefully documented shared decision-making process.
- **Pregnancy status and planning**: Example: Many patients do not disclose pregnancy status to pharmacists. Substituting to a medication that is teratogenic or requires different dosing in pregnancy could cause serious fetal harm. For example, substituting between beta blockers - some are safer in pregnancy (labetalol) while others carry significant risks (atenolol).
- **Drug to drug interactions beyond the current prescription**: Example: A patient's full medication list, including medications filled at other pharmacies or prescribed by specialists, may not be visible. A patient is switched from sertraline to fluoxetine (both SSRIs) but the pharmacist didn't know that the patient was also taking tamoxifen filled at a specialty pharmacy and this substitution decreased tamoxifen's effectiveness in treating breast cancer.
- **Specific clinical rationale**: Example: A patient who is taking propranolol is switched to metoprolol, both beta blockers and "therapeutically equivalent". What the pharmacist didn't know is that propranolol was specifically selected because it is used for both the treatment of hypertension and migraines. The pharmacist making a substitution, thinking it was only for the treatment of hypertension and not aware of this additional information that was available in the medical records, results in patient's worsening migraines causing deterioration in quality of life, missed work, and ER visits for migraine management.

In a perfect world, pharmacists and providers would continue with the current model of collaboration and a concurrent, shared decision on therapeutic substitutions. The Board recognizes that this is not always possible when a pharmacist may not be able to get a hold of the prescribing provider and needs to make a substitution of a medication based on factors such as a shortage in the medication or the medication not being available, especially in rural areas. However, there are times when a provider has issued a prescription for a specific drug based on the patient's history, genetics, comorbidities, pregnancy status, family history, etc. The pharmacist would not know this because they don't have access to the patient's medical records, history, and are not privy to the discussions in the exam room between the health care provider and their patient.

The Board is not asking to prohibit all therapeutic substitutions. To balance patient safety with addressing the sometime need of pharmacists to substitute medications, the Board recommends excluding medication classes where substitution without complete medical information can cause death, irreversible harm, or serious disability. As such, these substitutions should only be made in collaboration with the health care provider. Information on the risks associated with each of the 9 drug classes requested to be excluded is found below for your review.

Thank you for your time and attention and I would be happy to answer any questions.

Rational for Exclusion of Drug Classes

Antidepressants and Antipsychotics

- A patient with depression may have already failed multiple SSRIs before their psychiatrist prescribed a specific SSRI. Substituting back to a failed medication delays appropriate treatment and risks clinical deterioration. A patient with suicidal ideation may be on a specific antidepressant because others in the class increased their suicide risk. This is documented in psychiatric notes, not pharmacy records.
- High risk of treatment failure.
- Long-term consequences and risk of acute crisis (suicidal ideation, psychotic break).

Chemotherapy Agents (oral chemo, targeted therapies, hormonal cancer treatments)

- Inappropriate substitution results in tumor progression, treatment failure, or fatal toxicity from bone marrow suppression and organ failure.
- Dose-limiting toxicities can be fatal (bone marrow suppression, organ failure).
- Complex drug interactions.
- Selection based on tumor genetics, staging, and prior treatment response which the pharmacist does not have access too.

Controlled Substances

- Federal and state regulations require specific prescriber authorization for good reason – these are our most dangerous medications.
- High concerns with the prescribing of Schedule II Controlled substances. Opioid tolerance is highly individual; substitution without knowing prior adverse reactions or addiction history that is documented in pain management agreements creates immediate death risk. Pain management-controlled substances require complex informed consent requirements, risk of abuse and diversion, patient specific tolerance and efficacy, addiction history considerations documented in pain management agreements, overdose risk, respiratory depression, or severe withdrawal.

Immunosuppressants (transplant medications, disease-modifying antirheumatic)

- Organ rejection in transplant patients can occur within days of substitution. Rejection may be irreversible, leading to organ loss and death. There are no rescue options once rejection begins.

- Require specialized monitoring.
- Selection based on HLA typing and prior rejection episodes.
- Some, but not all, are biological agents under N.D.C.C. § 19-02.1-14.3.

Anticonvulsants/Antiepileptic drugs (phenytoin, carbamazepine, valproate, lamotrigine)

- Breakthrough seizure risk with even minor substitutions can cause death, traumatic injury, permanent brain damage, or status epilepticus.
- Specific medications based on seizure type, prior treatment response, lab results, etc. that the pharmacist cannot see.
- Some, but not all, included in the narrow therapeutic index.

Anticoagulation therapy (warfarin, direct oral anticoagulants, antiplatelet agents)

- Substitution errors can cause major bleeding risk and fatal bleeding (intracranial hemorrhage, GI bleeding) or fatal stroke.
- Selection is based on renal function and prior bleeding episodes that the pharmacist cannot see.
- Some, but not all, included in the narrow therapeutic index.

Antiarrhythmics

- Inappropriate substitutions can trigger fatal arrhythmias, ventricular fibrillation, etc.
- Dose and drug selection is based on ejection fraction, specific rhythm disorders, comorbidities, and electrolyte states that is not visible to the pharmacist.
- Complex titrations protocols.
- Would normally do an EKG before making substitutions.
- Some, but not all, included in the narrow therapeutic index.

Beta Blockers

- Highly patient specific selection based on comorbidities (asthmatic patients cannot tolerate non-selective beta blockers), heart rate goals, and whether it's prescribed for hypertension, heart failure, arrhythmia, or post-MI protection.
- Wrong substitutions can cause bradycardia, heart block, or worsening heart failure.
- Pregnancy safety varies as some beta blockers cause fetal grown restriction.
- Some, but not all, included in the narrow therapeutic index.