2026 JOINT POLICY

SB 2402

2026 JOINT STANDING COMMITTEE MINUTES

Policy Committee
Pioneer Room, State Capitol

SB 2402
1/21/2026

Relating to the prescriptive authority of pharmacists and therapeutic substitution; relating to the scope of practice of pharmacists, relating to approved laboratory tests; and to provide an effective date.

2:29 p.m. Co-Chairman Lee called the hearing to order.

Members Present: Co-Chairman Senator Lee, Boschee, Clemens, Cory, Gerhardt, Hogan, Kessel, Myrdal, Powers, Roers, Rummel, Van Oosting, Walen, Weston, Co-Chairman Ruby, Beltz, Davis, Dobervich, Dressler, Frelich, Heinert, Jonas, Klemin, Novak, Porter, Rohr, Vollmer, Weisz

Discussion Topics:

- Ability to substitute
- Insurance coverage
- Drug Shortage
- Biological Products
- Urinary Tract Infection risks

2:29 p.m. Krista Fremming, Interim Director with the Medical Services Division, testified in favor and submitted testimony #45441.

2:31 p.m. Senator Roers introduced amendment #25.1386.01002 and submitted testimony #45471.

2:43 p.m. Mark Hardy, Executive Director of ND Board of Pharmacy, testified in favor and submitted testimony #45443.

2:58 p.m. Mike Schwab, Executive VP of North Dakota Pharmacist Association, testified in favor and submitted testimony #45454.

3:07 p.m. Marvin Nelson testified in favor and submitted testimony #45412.

3:13 p.m. Sandra DePountis, Executive Director of the North Dakota Board of Medicine, testified in opposition and submitted testimony #45402.

3:26 p.m. Courtney Koebele, North Dakota Medical Association, testified in opposition and submitted testimony #45444.

3:27 p.m. Dr. Erica Hofland testified in opposition and submitted testimony #45403.

3:33 p.m. Dr. Joan Connell testified in opposition and submitted testimony #45461.

3:39 p.m. Melissa Howard, General Counsel for the North Dakota Hospital Association, testified in opposition.

3:41 p.m. Senator Roers moved amendment LC#25.1386.01002 and further amend page 12 line 28 adding "under this section".

3:41 p.m. Seconded by Representative Beltz.

Voice vote passed.

3:46 p.m. Senator Roers moved Do Pass as amended.

3:46 p.m. Representative Frelich seconded the motion.

Senators	
Senator Judy Lee	Y
Senator Joshua Boschee	Y
Senator David Clemens	Y
Senator Claire Cory	Y
Senator Justin Gerhardt	Y
Senator Kathy Hogan	Y
Senator Greg Kessel	Y
Senator Janne Myrdal	Y
Senator Michelle Powers	Y
Senator Kristin Roers	Y
Senator Dean Rummel	Y
Senator Desiree Van Oosting	Y
Senator Chuck Walen	Y
Senator Kenton Weston	Y

Motion passed 14-0-0.

Representatives	
Representative Matt Ruby	Y
Representative Mike Beltz	Y
Representative Jayme Davis	Y
Representative Gretchen Dobervich	Y
Representative Ty Dressler	Y
Representative Kathy Frelich	Y
Representative Pat Heinert	Y
Representative Jim Jonas	Y
Representative Lawrence Klemin	Y
Representative Anna Novak	Y
Representative Todd Porter	Y
Representative Karen Rohr	Y
Representative Dan Vollmer	Y
Representative Robin Weisz	Y

Motion passed 14-0-0.

3:47 p.m. Senator Roers will carry the bill.

3:47 p.m. Representative Rohr will carry the bill.

Additional written testimony:

Jane Winston submitted testimony in opposition #45404.

Alicia Plemmons, Director for Knee Regulator Research Center at West Virginia University, submitted testimony in neutral #45401.

3:48 p.m. Co-Chairman Lee closed the meeting.

Andrew Ficek, Committee Clerk

Adopted by the Joint Policy Committee

January 21, 2026

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

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SENATE BILL NO. 2402

Introduced by

Legislative Management

(Joint Policy Committee)

A BILL for an Act to create and enact two new sections to chapter 43-15 and a new subsection to section 43-48-03 of the North Dakota Century Code, relating to the prescriptive authority of pharmacists and therapeutic substitution; to amend and reenact subsection 1 of section 26.1-36.11-01 and section 43-15-01 of the North Dakota Century Code, relating to the scope of practice of pharmacists; to repeal section 43-15-25.3 of the North Dakota Century Code, relating to approved laboratory tests; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-36.11-01 of the North Dakota Century Code is amended and reenacted as follows:

1. a. "Comprehensive medication management" means medication management pursuant to a standard of care that ensures each enrollee's medications, both prescription and nonprescription, are individually assessed to determine each medication is appropriate for the enrollee, effective for the medical condition, and safe, given the comorbidities and other medications being taken and able to be taken by the enrollee as intended. Services provided in comprehensive medication management are, as follows:
   (1) Performing or obtaining necessary assessments of the enrollee's health status;
   (2) Formulating a medication treatment plan;

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(3) Monitoring and evaluating the enrollee's response to therapy, including safety and effectiveness;

(4) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) Providing verbal or written, or both, counseling, education, and training designed to enhance enrollee understanding and appropriate use of the enrollee's medications;

(6) Providing information, support services, and resources designed to enhance enrollee adherence with the enrollee's therapeutic regimens;

(7) Coordinating and integrating medication therapy management services within the broader health care management services being provided to the enrollee;

(8) Initiating or modifying drug therapy under a collaborative agreement with a practitioner in accordance with section 43-15-31.4;

(9) Prescribing medications pursuant to protocols approved by the state board of pharmacy in accordance with subsection 24 of section 43-15-10;

(10) Administering medications in accordance with requirements in section 43-15-31.5; and

(11) Ordering, performing, and interpreting laboratory tests authorized ~~by section 43-15-25.3~~under chapter 43-15 and North Dakota Administrative Code section 61-04-10-06.

b. This subsection may not be construed to expand or modify pharmacist scope of practice.

SECTION 2. AMENDMENT. Section 43-15-01 of the North Dakota Century Code is amended and reenacted as follows:

43-15-01. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Administration" means the direct application of a drug to the body of a patient. The term includes:

   a. The emergency maintenance of a drug delivery device used in home infusion therapy by a qualified home pharmacist if nursing service is not available;

b. Immunization and vaccination by injection of an individual who is at least three years of age upon an order by a practitioner authorized to prescribe such a drug or by written protocol with a physician or nurse practitioner and subsequently reported as a childhood immunization and other information if required to the state's immunization information system pursuant to section 23-01-05.3;

c. Provision of other drugs to an individual who is at least three years of age upon the order of a practitioner authorized to prescribe such a drug; and

d. Provision of drugs to an individual receiving emergency services in a health care facility upon an order or by established written protocol.

2. "Automated dispensing system" means a mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, counting, labeling, and dispensing of medications and which collects, controls, and monitors all transaction information.

3. "Board" means the state board of pharmacy.

4. "Compounding" means the preparation, mixing, assembling, packaging, or labeling of a drug or device:

a. As the result of a practitioner's prescription drug order or initiative based on the practitioner, patient, and pharmacist relationship in the course of professional practice; or

b. For the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale or dispensing.

Compounding also includes the preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns.

5. "Confidential information" means individually identifiable health information maintained by the pharmacist in the patient's records or which is communicated to the patient as part of a patient counseling.

6. "Deliver" or "delivery" means the actual, constructive, or attempted transfer of a drug or device from one person to another, whether or not for a consideration.

7. "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component part or

accessory, which is required under federal or North Dakota law to be prescribed by a practitioner and dispensed by a pharmacist.

8. "Dispense" or "dispensing" means the preparation and delivery of a prescription drug, pursuant to a lawful order of a practitioner or a nurse licensed under chapter 43-12.1 who is authorized by the practitioner to orally transmit the order that has been reduced to writing in the patient's record, in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the prescription drug.

9. "Distribute" means the delivery of a drug other than by dispensing or administering.

10. "Drug" or "drugs" means:

    a. Articles recognized as drugs in the official United States pharmacopeia, official national formulary, official homeopathic pharmacopeia, other drug compendium, or any supplement to any of them;

    b. Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animal;

    c. Articles other than food intended to affect the structure or any function of the body of man or other animals; and

    d. Articles intended for use as a component of any articles specified in subdivision a, b, or c.

11. "Drug regimen review" includes the following activities:

    a. Evaluation of the prescription drug orders and patient records for:

        (1) Known allergies;

        (2) Rational therapy-contraindications;

        (3) Reasonable dose and route of administration; and

        (4) Reasonable directions for use.

    b. Evaluation of the prescription drug orders and patient records for duplication of therapy.

    c. Evaluation of the prescription drug orders and patient records for interactions:

        (1) Drug-drug;

        (2) Drug-food;

        (3) Drug-disease; and

(4) Adverse drug reactions.

d. Evaluation of the prescription drug orders and patient records for proper utilization, including overutilization or underutilization, and optimum therapeutic outcomes.

12. "Emergency pharmacy practice" means in the event a pharmacist receives a request for a prescription refill and the pharmacist is unable to obtain refill authorization from the prescriber, the pharmacist may dispense and bill using a pharmacist national provider identifier a one-time emergency refill of up to a thirty-day supply of the prescribed medication, provided that:

a. The prescription is not for a controlled substance listed in schedule II;

b. The pharmaceutical is essential to the maintenance of life or to the continuation of therapy;

c. In the pharmacist's professional judgment, the interruption of therapy might reasonably produce undesirable health consequences or may cause physical or mental discomfort;

d. The pharmacist properly records the dispensing; and

e. The dispensing pharmacist notifies the prescriber of the emergency dispensing within a reasonable time after the one-time emergency refill dispensing.

13. "Labeling" means the process of preparing and affixing of a label to any drug container exclusive, however, of the labeling by a manufacturer, packer, or distributor of a nonprescription drug or commercially packaged legend drug or device. Any label shall include all information required by federal and North Dakota law or regulation.

14. "Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a device or a drug, either directly or indirectly by extraction from substances of natural origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis and includes any packaging or repackaging of the substances or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a drug by an individual for the individual's own use or the preparation, compounding, packaging, or labeling of a drug:

a. By a pharmacist or practitioner as an incident to dispensing or administering of a drug in the course of the person's professional practice; or

b. By a practitioner or by the practitioner's authorization under supervision for the purpose of or as an incident to research, teaching, or chemical analysis and not for sale.

15. "Manufacturer" means a person engaged in the manufacture of drugs in facilities located within North Dakota.

16. "Medicine" means a drug or combination of drugs, used in treating disease in man or other animals.

17. "Nonprescription drugs" means medicines or drugs which may be sold without a prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements of the statutes and regulations of this state and the federal government.

18. "Original package" means the original carton, case, can, box, vial, bottle, or other receptacle, put up by the manufacturer or wholesaler or distributor, with label attached, making one complete package of the drug article.

19. "Patient-pharmacist relationship" means the required relationship between a patient and a pharmacist as defined under the rules of the board which authorizes the pharmacist to independently prescribe drugs, drug categories, and devices as limited by this chapter.

20. "Person" means an individual, corporation, limited liability company, partnership, association, or any other legal entity.

~~20.~~21. "Pharmaceutical care" is the provision of drug therapy and other pharmaceutical patient care services intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process as defined in the rules of the board.

~~21.~~22. "Pharmacist" means a person to whom the board has issued a license to practice the profession of pharmacy whose license has not expired or been suspended.

~~22.~~23. "Pharmacy" or "drugstore" means every store or shop where drugs, medicines, or chemicals are dispensed, displayed for sale, or sold, at retail for medicinal purposes, or where prescriptions are compounded, and which is duly registered by the board.

~~23.~~24. "Pharmacy technician" means a person registered by the board who is employed by a pharmacy to assist licensed pharmacists in the practice of pharmacy by performing specific tasks delegated by and under the immediate personal supervision and control of a licensed pharmacist, as permitted by the board.

~~24.~~25. "Practice of pharmacy" means ~~the~~:

a. The interpretation, evaluation, and monitoring of prescription orders and patient drug therapy; ~~the~~

b. The compounding, dispensing, and labeling of drugs and devices except labeling by a manufacturer, packer, or distributor of nonprescription drugs and commercially packaged legend drugs and devices; ~~the~~

c. The participation in drug selection, drug monitoring, drug administration, drug regimen review, the provision of these acts or services necessary as a primary health care provider of pharmaceutical care, and drug utilization evaluations; ~~the~~

d. The proper and safe storage of drugs and devices and the maintenance of proper records for this storage; ~~the~~

e. The responsibility for advising, consulting, and educating if necessary or if regulated, patients, the public, and other health care providers on the rational, safe, and cost-effective use of drugs including therapeutic values, content, hazards, and appropriate use of drugs and devices; ~~the~~

f. The participation in interpreting and applying pharmacokinetic data and other pertinent laboratory data to design safe and effective drug dosage regimens; ~~if~~

g. If appropriate and ~~if~~ regulated, the participation in scientific or clinical drug research ~~either scientific or clinical~~ as an investigator or in collaboration with other investigators for the purposes of studying the effects of drugs on animals or human subjects, with other drugs or chemicals, and with drug delivery devices; ~~emergency~~

h. Emergency pharmacy practice; ~~prescriptive~~

i. Prescriptive practices as limited under this chapter; ~~the~~

j. The ordering of laboratory tests;

k. The performance of laboratory tests to provide pharmaceutical care services which are waived under the Federal Clinical Laboratory Improvement Act of 1988

[Pub. L. 100-578, section 2; 102 Stat. 2903; 42 U.S.C. 263a et seq.], as amended; and ~~the~~

l. The offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of pharmacy.

~~25.~~26. "Practitioner" means an individual licensed, registered, or otherwise authorized by the jurisdiction in which the individual is practicing to prescribe drugs in the course of professional practice.

~~26.~~27. "Prescription" means any order for drugs or medical supplies, if such order is written or signed or transmitted by word of mouth, telephone, telegram, or other means of communication by a duly licensed physician, optometrist, dentist, veterinarian, or other practitioner, licensed by law to prescribe and administer such drugs or medical supplies intended to be filled, compounded, or dispensed by a pharmacist or any order for drugs or medical supplies transmitted orally by a nurse licensed under chapter 43-12.1 as written and signed by such a duly licensed physician, optometrist, dentist, veterinarian, or other practitioner.

~~27.~~28. "Prescription drug or legend drug" means a drug which, under federal law is required, prior to being dispensed or delivered, to be labeled with one of the following:

a. "Caution: Federal law prohibits dispensing without prescription";

b. "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian"; or

c. Rx only;

or a drug which is required by any applicable federal or North Dakota law or rule to be dispensed on prescription only or is restricted to use by practitioners only.

~~28.~~29. "Public health issues" include immunizations, tobacco cessation, and other issues deemed appropriate by the board.

~~29.~~30. "Radiopharmaceutical service" means, but is not limited to, the compounding, dispensing, labeling, and delivery of radiopharmaceuticals; the participation in radiopharmaceutical selection and radiopharmaceutical utilization reviews; the proper and safe storage and distribution of radiopharmaceuticals; the maintenance of radiopharmaceutical quality assurance; the responsibility for advising, where necessary or where regulated, of therapeutic values, hazards, and use of

radiopharmaceuticals; and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of radiopharmaceuticals.

~~30.~~31. "Wholesaler" means a person with facilities located in this state who buys for resale and distribution to persons other than consumers.

SECTION 3. A new section to chapter 43-15 of the North Dakota Century Code is created and enacted as follows:

Prescriptive authority.

1. A pharmacist whose practice is physically located within this state, acting in good faith and exercising reasonable care, may independently prescribe drugs, drug categories, and devices as provided in this section if each of the following requirements are met:
   a. A pharmacist may prescribe drugs or devices only for conditions for which the pharmacist is educationally prepared and competence has been achieved and maintained.
   b. A pharmacist may issue a prescription only for a legitimate medical purpose arising from a patient-pharmacist relationship.
   c. A pharmacist shall obtain adequate information about the patient's health status to make appropriate decisions based on the applicable standard of care.
   d. For each drug or drug category a pharmacist intends to prescribe, the pharmacist shall maintain a patient assessment protocol based on current clinical guidelines, when available, or evidence-based research findings that specify the following:
      (1) Patient inclusion and exclusion criteria; and
      (2) Explicit medical referral criteria.
   e. A pharmacist shall revise the patient assessment protocol when necessary to ensure continued compliance with clinical guidelines or evidence-based research findings. The pharmacist's patient assessment protocol, and any related forms, must be made available to the board upon request.
   f. A pharmacist shall consult with and refer to other health care professionals as appropriate, including in situations where the pharmacist's knowledge or experience is limited.

g. A pharmacist shall develop and implement an appropriate follow-up care plan, including any monitoring parameters, in accordance with clinical guidelines. The plan may include follow-up care with the patient and communication with the patient's primary care provider.

h. A pharmacist shall inquire about the identity of the patient's primary care provider or provider of record. If a primary care provider or provider of record is identified, the pharmacist shall provide notification to the primary care provider or provider of record within three business days following the prescription of a drug. The notification must include the results of any test that required the prescription and, upon the provider's request, any relevant documentation required under subdivision i.

i. A pharmacist shall maintain documentation adequate to justify the care provided, including information collected as part of the patient assessment, the prescription record, any notification provided under this section, and the follow-up care plan.

2. A pharmacist may prescribe any drug approved by the federal food and drug administration which is indicated for the following conditions:

a. Lice;

b. Cold sores;

c. Motion sickness, including the prevention of motion sickness; and

d. Hypoglycemia~~; and~~

~~e. Uncomplicated urinary tract infections.~~

3. A pharmacist may prescribe any of the following devices approved by the federal food and drug administration:

a. Inhalation spacer;

b. Nebulizer;

c. ~~Diabetes~~Disposable diabetes blood sugar testing supplies~~; and~~

d. Pen needles; and

e. Auto-injectors containing drugs for patients with a documented history of allergies or anaphylaxis.

4. A pharmacist may prescribe any drug approved by the federal food and drug administration which is indicated for the following conditions, provided the

symptomatic patient first tests positive to a test that is waived under the Federal Clinical Laboratory Improvement Act of 1988 [Pub. L. 100-578, section 2; 102 Stat. 2903; 42 U.S.C. 263a et seq.], as amended:

a. Influenza;

b. Group A streptococcal pharyngitis; and

c. Severe acute respiratory syndrome coronavirus 2 identified as SARS-CoV-2.

5. If a patient tested positive for influenza, a pharmacist may prescribe an antiviral drug to an individual who has been exposed to the infected patient and for whom the clinical guidelines recommend chemoprophylaxis.

6. A pharmacist may prescribe any drug approved by the federal food and drug administration for the purpose of closing a gap in clinical guidelines as follows:

a. ~~Statins for a patient who has been diagnosed with diabetes~~Postexposure prophylaxis for nonoccupational exposure to human immunodeficiency virus infection; and

b. Short-acting beta agonists for a patient with asthma who has had a prior prescription for a short-acting beta agonist and who has a current prescription for a long-term asthma control drug.

7. A pharmacist who successfully completes an accredited continuing pharmacy education or continuing medical education course on travel medicine may prescribe any noncontrolled drug recommended for individuals traveling outside the United States which is specifically listed in the federal centers for disease control and prevention health information for international travel publication. The pharmacist only may prescribe drugs that are indicated for the patient's intended destination for travel.

8. If an emergency situation exists which in the professional judgment of the pharmacist threatens the health or safety of the patient, a pharmacist may prescribe the following drugs approved by the federal food and drug administration in the minimum quantity necessary until the patient is able to be seen by a provider:

a. Diphenhydramine;

b. Epinephrine; and

c. Short-acting beta agonists.

9. A pharmacist may prescribe antimicrobial prophylaxis for the prevention of lyme disease in accordance with the federal centers for disease control and prevention guidelines.

SECTION 4. A new section to chapter 43-15 of the North Dakota Century Code is created and enacted as follows:

Therapeutic substitution.

1. A pharmacist whose practice is physically located within this state may substitute a drug for a therapeutically equivalent drug, except for antidepressants, antipsychotics, chemotherapy agents, schedule II controlled substances, biological products, and narrow therapeutic index drugs, as limited by this section. Therapeutic equivalence may be established by clinical publications comparing dosages of drugs in a therapeutic class.
2. A pharmacist may not substitute a drug for a therapeutically equivalent drug if:
   a. The prescriber indicates no substitution is to be made; or
   b. The board has determined a therapeutically equivalent drug should not be substituted and notified pharmacists of that determination.
3. Before dispensing a therapeutically equivalent drug, a pharmacist shall:
   a. Verbally discuss the suggested substitution with the patient, including informing the patient that the therapeutically equivalent drug does not contain the identical active ingredient present in the prescribed drug and any differences in dosage and frequency between the prescribed drug and the therapeutically equivalent drug; ~~and~~
   b. Inform the patient of the patient's right to refuse the substitution; and
   c. Determine whether the substitution would provide a cost benefit to the patient or provide access if the prescribed drug is not available.
4. The pharmacist shall send notice of the substitution to the prescriber by electronic communication within twenty-four hours of dispensing the drug to the patient.
5. The prescribing provider is not liable for a substitution made by a pharmacist under this section.

SECTION 5. A new subsection to section 43-48-03 of the North Dakota Century Code is created and enacted as follows:

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Pharmacists duly and currently licensed to practice pharmacy.

SECTION 6. REPEAL. Section 43-15-25.3 of the North Dakota Century Code is repealed.

SECTION 7. EFFECTIVE DATE. This Act becomes effective upon its filing with the secretary of state.

REPORT OF STANDING COMMITTEE
SB 2402

Joint Policy Committee (Sen. Lee, Co-Chairman) recommends **AMENDMENTS (25.1386.01003)** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). SB 2402 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

REPORT OF STANDING COMMITTEE
SB 2402

Joint Policy Committee (Rep. M. Ruby, Co-Chairman) recommends **AMENDMENTS (25.1386.01003)** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT OR EXCUSED AND NOT VOTING). SB 2402 was placed on the Sixth order on the calendar.

WestVirginiaUniversity.
JOHN CHAMBERS COLLEGE OF
BUSINESS AND ECONOMICS

January 20th, 2026
Joint Policy Committee

Dear Chairman Lee, Chairman Ruby, and all distinguished members of the Joint Policy Committee:

I appreciate the opportunity to comment on SB 2402, increasing prescriptive authority for pharmacists in North Dakota. I am an assistant professor and director for the Knee Regulatory Research Center at West Virginia University. This comment is not submitted on behalf of any party or interest group.

Every county in North Dakota has at least one facility or areas that is designated as a primary care health professional shortage areas, where there is significant reduced access to physicians when residents need routine and preventative care.[1] North Dakota take an important step towards increasing access to healthcare services for residents by maximizing the number of locations and providers where residents are able to obtain necessary prescriptive medications for routine and minor conditions.

Our team of researchers published a peer-review study on the effectiveness of this policy in other states.[1] Idaho was the first to pass similar expansive prescriptive authority changes for pharmacists in 2018. Focusing on patients with diabetes or asthma, this change allowed individuals to obtain insulin pen needles and rescue inhalers without having to seek out emergency room treatment or waiting days, or weeks, for scheduled visits with a specialist.[2] This has increased access to medication that helps prevent potentially life-threatening health emergencies if individuals do not receive timely preventative medicines. Working with the Challey Institute at North Dakota State University,[2] we provide data-backed insight into different ways that North Dakota could unlock the potential of non-physician healthcare providers, and this was one of our top identified areas of improvement for the state.

Prescriptive authority expansions for pharmacists may have similar effects on increasing the number of locations where North Dakota residents are able to receive medications that are crucial for promoting preventative health care and improving patient well-being. This does not replace specialized and primary care, as patients are often required to have previous or existing prescriptions, but allows pharmacists to be an important part of the patient-focused care team. Access to medications is pivotal for bettering health outcomes for rural and marginalized communities that may not have ready and timely access to their physician or specialist.

Best regards,

[1] https://doi.org/10.1111/coep.12647
[2] https://www.ndsu.edu/sites/default/files/fileadmin/challeyinstitute/Research_Briefs/Rural_Health_Care_Access.pdf

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2026 SPECIAL SESSION
JANUARY 21, 2026

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.

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Joint Policy Committee
SB 2402
January 21, 2026

Chair Lee, Chair Ruby, and members of the Joint Policy Committee, I am Dr. Erica Hofland, an Obstetrician and Gynecologist in Dickinson. Thank you for the opportunity to provide testimony regarding Senate Bill 2402. I am asking this committee to accept and implement the amendments set forth by the North Dakota Board of Medicine to Senate Bill 2402.

For the last 11 years, I have been a practicing Obstetrician and Gynecologist in Dickinson and have provided care to women throughout southwest North Dakota. While I appreciate that the goal of SB 2402 is to expand access to care, this bill in its current form could have unintended and harmful consequences for subsections of the population. I especially have this concern regarding pregnant persons.

When treating urinary tract infections, pregnant patients are managed differently. Several commonly used antibiotics are avoided in pregnancy due to concerns for fetal harm. Some antibiotics may be used at certain gestational ages but not at others. The medications are selected for the stage of fetal development, proximity to delivery, etc. Further, a clear urine culture and sensitivity history is needed for pregnant women, given the lower threshold to start a pregnant woman on daily prophylaxis if concerns for recurrent infection. Daily prophylaxis is sometimes needed to prevent concerns for more serious pyelonephritis, possible sepsis, and associated risks of preterm delivery. The ability to start this therapy is hindered by a lack of culture data.

When it comes to using statins during pregnancy, fetal harm can occur. I have received many seemingly automated insurance and pharmacy letters recommending starting a patient with Type 2 diabetes on a statin. What is not understood by these generated reports is that my patients are at varying stages of

pregnancy. Statin use is discouraged, except for a select few patients. Those patients who are kept on their medication or started on a statin are typically only done so after extensive counseling and with a multidisciplinary team panel. Therefore, I feel strongly that the prescriptive authority noted in this bill should be removed.

It is also my stance that therapeutic substitution be limited to drug classes as listed by the Board of Medicine. Not all drugs in the same class have the same amount of safety data and history when it comes to pregnancy. While attempts are made by providers to use the “best” medication possible for a fetus, there are also times, paradoxically, that a patient may be continued on a medication that is considered more dangerous than others. An example of this would be a patient with a history of seizure disorder that is only well controlled on a medication that is considered teratogenic. While the medication may increase the risk of fetal harm, this may be outweighed by a patient having uncontrolled seizures and the effect this would have on a developing pregnancy. Nuances in prescribing occur daily and medications should not be substituted without provider input.

The above scenarios are just a few examples of oversights with SB 2402. The amendments provided by the Board of Medicine help limit potential patient safety issues while still allowing the state to pursue funding programs with the Federal Government. I strongly encourage this Committee to adopt the amendments proposed by the Board of Medicine. I would be happy to answer any additional questions.

Sincerely,

Dr. Erica Hofland

I am a family physician and geriatrician with over forty years of clinical experience. I'm testifying today to express my concern about expanding pharmacists' prescribing privileges. This may seem like an easy solution to increase access to care in rural areas, however it can put patient safety at risk. I ask that you accept the amendments to the bill proposed by the ND Medical Board. This includes requiring that pharmacists share documentation of their prescribing with the patient's physician.

I also recommend that pharmacists not prescribe for urinary tract infections (UTI). Evaluation and treatment of urinary tract symptoms can be complex and is beyond the realm of a pharmacist's training. An example is treating an elderly nursing home patient who has dementia. Nursing home staff may request an antibiotic for possible UTI as a cause of the patient's increased confusion. UTI is rarely the cause, and unnecessary antibiotic use often leads to side effects such as chronic diarrhea. I foresee nursing home staff who are challenged by a dementia patient's behavior contacting the pharmacist for UTI treatment and causing unintended harm to the patient.

I am also very concerned about the ability of pharmacists to maintain patient confidentiality when prescribing in the pharmacy setting. The bill amendment that allows pharmacists to order post exposure prophylaxis (preventative treatment) for nonoccupational exposure to human immunodeficiency virus (HIV) is a good example. Ordering treatment in this situation involves asking sensitive questions about a patients' sexual orientation and practices. I can't imagine a busy pharmacist in one of our communities being able to safeguard a patient's privacy while discussing these issues and subsequently transmitting that information electronically to the patient's physician.

Thank you for your consideration. Please contact me if I can provide any additional information about my concerns.

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Testimony in favor of SB2402, Joint Policy Committee 1/21/2026 by Marvin Nelson

I am in favor of this bill. It seems to me we do a lot to have pharmacists be the experts in many aspects of medications, but then we often turn to other sources to make the decisions.

With many and by retirement age most people on many prescriptions, drug interactions are almost a certainty. Having meds reviewed is a good thing even though interactions can't always be avoided or might even be desired but hopefully we can have fewer meds treating symptoms of other meds.

And it seems today that much of people's knowledge on drugs comes from commercials, certainly not an unbiased source.

A personal example. I was on a steroid inhaler for my reactive lungs. Went in for a refill, the pharmacy benefit manager didn't like early fills, and the pharmacist says, they won't cover it. The PBM had changed their formulary which meant I needed to contact my internist for a new prescription on a Friday Afternoon. Which was the new inhaler, why the one on the formulary. It never worked as well for me, but in any case could just have well been the pharmacist instead of bothering the doctor. The prescribing decisions are actually being made by the PBMs, especially on expensive drugs.

One more example of PBMs with the diabetes class of drugss called SGLT2, there are three name brand ones available. Two cost about $500 a month, one costs about $50, the PBMs have only the expensive ones on their formulary so they can get massive kickbacks from the drug companies and make more money. The reasonably priced effective drug is never on a formulary at least by the major PBMs.

I don't think this bill actually goes far enough, I believe insulins should all be available over the counter like in Canada.

As things currently sit, we put companies with the goal of maximizing profits basically in control of what is prescribed. This control gives them great power which they use to extract even more. I am in favor of almost anything that reduces their control. Our local professionals are a much better choice.

Testimony
Senate Bill No. 2402
Joint Policy Committee
Senator Judy Lee and Representative Matthew Ruby, Co-Chairman
January 21, 2026

Chairman Lee and Chairman Ruby, and members of the Joint Policy Committee, I am Krista Fremming, Interim Director of Medical Services with the Department of Health and Human Services. I appear before you in support of Senate Bill No. 2402, which was introduced as part of North Dakota's Rural Health Transformation Program, relating to the prescriptive authority or pharmacists and therapeutic substitution.

In many North Dakota communities, a pharmacy is the only locally accessible health care institution. Expanding pharmacists' scope of practice to include prescriptive authority and therapeutic substitution will increase access to timely care across the state, especially in rural communities where patients must travel great distances for basic health services.

This legislation will allow pharmacists to prescribe medications for clearly identified common conditions, provide emergency prescriptions when necessary, and substitute therapeutically equivalent drugs when appropriate. The expanded scope maintains patient safety through clear protocols and standards of care.

This bill was incorporated into North Dakota's Rural Health Transformation Program application submitted to the Centers for Medicare and Medicaid Services (CMS) and the

state was awarded points and funding based on the intention to pass this legislation. The Rural Health Transformation Committee indicated support for the bill and following through on this commitment now is essential to maintaining an estimated $3.9 million for the 5-year Rural Health Transformation Program and continuing on the trajectory to make North Dakota the healthiest state in the nation.

Expanding pharmacists' scope of practice is a practical solution to address provider shortages and improve health outcomes for North Dakotans. I urge the committee to support Senate Bill No. 2402 and help us take this important step toward a stronger, more accessible health care system.

This concludes my testimony. I would be happy to try to answer any questions the committee may have.

STATE OF NORTH DAKOTA
GOVERNOR KELLY ARMSTRONG

NORTH DAKOTA STATE BOARD OF PHARMACY
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Bill No 2402 – Practice Authorities for Pharmacists

Joint Policy Committee – 327B
1:00 PM - Wednesday – January 21st, 2026

Madam Chair Lee and Chairman Ruby, Members of the Joint Policy Committee, for the record I am Mark J. Hardy, PharmD, Executive Director of the North Dakota State Board of Pharmacy. I appreciate the opportunity to be here to speak to you today.

The Board of Pharmacy is fully supportive of pharmacists in our state practicing to the top of their education and expertise to serve the patients of our great state. Senate Bill 2402 will deliver on that, and it is why our Board is here in support of the legislation.

This bill is brought to you because of the Rural Health Transformation Grant "Grant" and the emphasis that the Grant conditions have for states to expand Pharmacist's practice authorities. Specifically, the Grant references a Cicero institute study to score states on the full practice authority for pharmacists in each state. As a backdrop to this, many states have enacted laws to allow more authorities for pharmacists to provide expanded models of care. Those policy solutions have been successful in utilizing the expertise and accessibility of pharmacists to provide options to the public for additional services that improve management of common illnesses and chronic diseases. Utilization of CLIA waived tests within pharmacies has continued to grow as patients desire the accessibility and affordability that is offered by having these simple but highly accurate tests conducted at pharmacies. The Federal Government has seen the impacts of these models in states with improved patient outcomes and lower costs. Thus, you see the emphasis to support these models by the current administration.

The Grant emphasizes that states enact policy changes that will enhance the pharmacist practice authorities to provide the state additional resources to impact rural health. Those policy changes included in this bill are:

1. allowing pharmacists to order laboratory tests and allowing pharmacists to perform all CLIA-waived laboratory tests
2. Extend further authorities of pharmacists to prescribe drugs and devices as well as allowing substitution of therapeutically equivalent drugs

The CLIA waived changes are set forward in Section 2 (page 7) and Section 5 (page 12). The last section creates a broad exemption for pharmacists to perform CLIA waived tests in the Clinical Laboratory Practice Act like nurses and physicians currently have.

In Section 3 (page 9) proposes a path of targeted prescriptive authorities for pharmacists in a similar manner to what the state of Idaho did in 2018 prior to moving to a full prescriptive

authority model for pharmacists. The drugs and devices proposed are fairly consistent to Idaho's approach and represents authorities commonly enacted by many other states. A pharmacist would need to meet the many requirements set forth in the section which includes maintaining a protocol for each drug category, maintaining documentation, and providing notification back to the primary care provider or provider of record. I would be happy to walk through the requirements and authorities in detail or I can discuss models of care I see impactful for any of the authorities if the committee wishes. The goal in this type of expansion is to look to utilize the extensive knowledge and expertise of pharmacists to diversify options for patients that lead to improved accessibility and efficiencies for an increasingly burdened healthcare system especially in a rural state like ours.

In Section 4 (page 11) proposes an allowance for pharmacies to perform therapeutic substitutions based on the therapeutic equivalence of medications. This section is modeled after the state of Arkansas's legislation from 2021. This equivalence would be mostly determined by clinical publications comparing dosages in distinct classes of medication. This is meant to empower pharmacists to better care for patients at the counter when the inevitable situations of insurance coverage or drug shortages may prevent patients from getting the therapies in which a practitioner originally prescribed. This authority would provide an option for pharmacists to ensure a patient's care is not delayed when there is a therapeutic alternative that would be able to be used. This preserves the authority of the practitioner to indicate "no substitution" and also requires the patient to consent to the substitution.

We have appreciated the dialogue with the Board of Medicine, Medical Association and Pharmacist Association as we have worked through the legislation. We are supportive of the amendments offered by Senator Roers to strike a compromise in many areas of the bill hopefully to assist in some of the concerns from our physician colleagues.

There have been claims made that utilizing pharmacists in these types of expansions may create substandard care models or that pharmacists lack the expertise, skills or information needed compared to the current models. Those arguments are not new and they ignore the extensive educational background, professional standards and oath that the pharmacist takes as they provide professional care each and every day. Pharmacists are there to serve their patients. Leveraging the accessibility of pharmacies and broad pharmacy network across our rural state, these authorities drafted from other states can be incorporated into the practice of pharmacy here and be safely regulated by our Board. We believe these models are safe, effective, proven and patient centered. We respectfully ask for the committee to adopt the amendments and move forward with this legislation. I would be more than happy to address any questions you may have.

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Joint Policy Committee
SB 2402
January 21, 2026

Chair Lee, Chair Ruby and Committee Members, I am Courtney Koebele, the Executive Director for the North Dakota Medical Association. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students.

NDMA shares the North Dakota Board of Medicine's concerns about SB 2402 in its current form and supports the Board's proposed amendments.

NDMA is in full support of the Rural Transformation Funding and wants North Dakota to receive the full extent of the funding. The concerns about clawback are understandable, but they do not apply to the amendments proposed today. North Dakota received a moderate score on the pharmacist expansion item, and the proposed amendments will not impact that score.

The bill, as proposed, expands the scope to allow pharmacists to independently test, prescribe, and substitute medications prescribed by a health care provider. NDMA has concerns about the broad reach of this language and potential patient safety risks. Here is why.

- Pharmacists without access to comprehensive patient records pose a significant safety risk. The prescriber loses the ability to screen for drug interactions, allergic reactions, and duplications. This could result in adverse events and lead to fragmented care, putting the patient's safety at risk.

- The original bill allows treatment of “uncomplicated urinary tract infections.” Dr. Erica Hofland submitted testimony on this issue, and the interested parties agree that this should be removed from the bill.

- Allowing a pharmacist to prescribe statins for closing gaps in clinical guidelines poses a considerable patient safety risk. As discussed by the Board of Medicine, there are reasons in the medical record why a patient would not be on a statin. Without this background, it would not be wise to allow a pharmacist to independently prescribe a statin.

- The bill allows therapeutic substitutions without limitations, provided that they are supported by clinical publications comparing dosages within therapeutic classes. Again, without access to the medical records, this is a concerning provision. The amendment proposes an exclusionary list of medications that shouldn’t be substituted without consulting the treating provider.

The Board’s amendments seek to clarify this and ensure that the primary care provider receives the information necessary to continue treating that patient.

NDMA stands in full support of the proposed amendments.

Thank you. I would be happy to answer any questions.

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Special Session January 2026
Joint Policy Committee – SB 2402
Joint Chairs, Senator Judy Lee and Rep. Matt Ruby

Madam Chair Lee, Chairman Ruby and members of the Policy Committee, for the record, my name is Mike Schwab, Executive Vice President of the North Dakota Pharmacists Association. We are here today in support of Senate Bill 2402 which expands prescriptive authority for pharmacists in North Dakota.

Why is this bill in front of all of you?

SB 2402 looks to address a specific area of the Rural Health Transformation Program (RHTP) effort dealing with the practice of pharmacy. CMS scored states in a variety of areas and the scope of practice for pharmacy happened to be one of those areas. In relationship to the ordering of labs and prescriptive authority for pharmacists, North Dakota was given a score of "zero" by CMS. The Rural Health Transformation Interim Committee and Legislative Management moved the bill you see in front of you in an effort to address the poor score North Dakota was given in this area. In addition, the North Dakota Department of Health and Human Services also included this bill effort in their funding application to CMS as well.

When the Rural Health Transformation Program was released by the federal government, the U.S. Secretary of the Department of Health and Human Services was quoted stating, "Rural Health Transformation can also be used to tackle workforce challenges head-on by allowing professionals like pharmacists to take on greater roles in delivering care…without such measures staffing shortages will continue to compromise access in too many rural communities." In addition, the CMS Administrator is urging states to utilize the Rural Health Transformation Program to allow pharmacists to prescribe and dispense medications to help alleviate travel for patients in underserved areas and reduce costs of care such as avoiding an ER visit for a strep test as an example.

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The Rural Health Transformation Program aims to address some the challenges faced by rural communities, including limited access to healthcare services and workforce shortages. By allowing pharmacists to take on greater roles in delivering care, the program seeks to improve healthcare access and quality in rural areas. The program encourages states to commit to expanding pharmacists' scope of practice, which includes allowing more prescriptive authority. SB 2402 checks many boxes related to the intent of the Rural Health Transformation Program.

SB 2402 is modeled after legislation passed in Idaho back in 2018. The bill in front of you does not give pharmacists full prescriptive authority. Even though SB 2402 is limited, we feel it is a practical and thoughtful approach. This kind of an effort is not new and many states have gone even further than this bill outlines. Since 2018, Idaho has moved to full prescriptive authority for pharmacists. There are other states that allow full prescriptive authority like Idaho and have expanded prescriptive authority models for pharmacists such as Montana, Iowa, Colorado, Illinois, Oregon and West Virginia.

I think it is important to note that we are not aware of any major safety issues or negative outcomes being reported when states have implemented these types of expansions. In fact, we have seen extremely high patient satisfaction, reduced barriers to accessing care, reduced wait times for patients, reduction in patients seeking higher levels of care such as ER visits for basic treatments, reduced patient costs and reduced travel for patients. The 5 A's of Access hold true for these types of efforts – Affordability, Availability, Accessibility, Accommodation and Acceptability.

In most care models involving pharmacist test to treat services, a large portion of patients who access pharmacist-led services do not have a primary care provider and many accessed the pharmacy outside of normal clinic hours (evenings and weekends). These are patients who might otherwise have gone to an urgent care or ER, or delayed treatment. Studies also show patients have to take off work 4x more than if they accessed the same test and treat service at a pharmacy (strep for example).

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Peer-reviewed evidence consistently shows pharmacist-led test-and-treat services, when implemented with safeguards, are safe and yield health outcomes equivalent to physician-led care. In our rural state, we feel strongly that this kind of a model can fill gaps in care without sacrificing quality and safety as seen in studies. SB 2402 includes best practices for pharmacist-led independent prescribing involving a tightly defined scope, protocols based on clinical guidelines, use of objective tests, criteria for treating vs referring to other health care providers, documentation, follow-up care plans and communication with physicians and patients.

Project IMPACT 2025 showed and verified many of the positive findings mentioned above related to pharmacist-led test and treat services. In addition, Project IMPACT also stated 84% of patients did not have to take off work to access test and treat services when provided by a pharmacist.

We have spent a considerable amount of time working with the ND Board of Pharmacy, ND Board of Medicine, and the ND Medical Association with Senator Roers helping to facilitate common ground. While we are not happy with all the changes, we were willing participants in a true negotiation where neither side received everything they wanted. Let's face it, as healthcare providers in a small rural state, we all need to work together for the betterment of our patients, communities, colleagues, and our healthcare system. Whether we like it or not, community-based care models have been expanding, will continue to expand and there are plenty of reasons why pharmacists should be part of those models, especially as we look to transform healthcare in a rural state like ND.

We respectfully ask for your support of SB 2402. Thank you for your time and attention. I am happy to try and answer any questions.

Respectfully submitted,

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2026 SPECIAL SESSION
JANUARY 21, 2026

TESTIMONY OPPOSING SENATE BILL 2402

Chair Lee, Chair Ruby and Members of the Joint Policy Committee,

My name is Joan Connell. Every day I appreciate the knowledge and unique skill set that has resulted from my undergraduate education as a pharmacy major, followed by my experience working as a licensed pharmacist while attending medical school, and now working as a board-certified pediatrician. This currently affords me a unique perspective regarding this bill that would give prescriptive authority and therapeutic substitution privileges to licensed pharmacists.

I would like to share an experience that really shaped my job as a pharmacist as well as my formation as a physician. While working as a hospital pharmacist during medical school, I was processing some orders for blood thinning medication. I called the physician to "school" him and modify his orders based on what I had learned in pharmacy school. Post phone call, not only did his orders stand, but I was taught how my suggested prescription modification, which was based on the limited history that was available to me and no real capacity for physical exam, would have likely killed our patient.

I will never forget that experience. As I look through this bill, I wonder how pharmacists will discern the 1/3 of patients with a sore throat who carry Strep in the back of their throats but have a viral explanation for their symptoms versus those whose sore throats are caused by Strep. I then wonder who will attend to the phone calls, MyChart messages, and back and forth communications from the patients with viral illness who were treated for Strep throat by the pharmacist and now have a rash caused by the antibiotic reacting with the virus. I then wonder what the patient will do when they really do have a sore throat caused by Strep but are no longer allowed to take amoxicillin because "it caused a rash" when they were inappropriately prescribed that medication for their viral sore throat. This does not seem in line with what is best for our patient. The truth is, as in Strep throat, for quality health care, a provider must combine the patient's history with their physical exam to make an accurate diagnosis, which is necessary for appropriate treatment. My experience tells me that a 4-hour credit one semester class in pharmacy school that covers interviewing, physical exam, *and* pathophysiology of the human body is inadequate to get it right much of the time.

My mind then wanders to wondering what will happen with infants and children, who may exhibit different symptoms for a given illness compared with an adult, and have a completely different set of “normals” for physical exam- starting with the very basic vital signs in physical exam- heart rate, respiratory rate, blood pressure.

With that, I would like to oppose Senate Bill 2402, support the amendments brought by the Board of Medicine. I would also suggest that outcomes of this legislation be monitored regarding the obvious conflict of interest in doing what is best for the patient versus ordering tests and prescribing medications that increase the bottom line of the pharmacist owned pharmacies. Finally, I urge you as policy makers to assure that we, as a collective group of patient providers, First, Do No Harm.

25.1386.01002
Title.

Prepared by the Legislative Council staff for Senator Roers
January 20, 2026

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

SENATE BILL NO. 2402

Introduced by

Legislative Management

(Joint Policy Committee)

A BILL for an Act to create and enact two new sections to chapter 43-15 and a new subsection to section 43-48-03 of the North Dakota Century Code, relating to the prescriptive authority of pharmacists and therapeutic substitution; to amend and reenact subsection 1 of section 26.1-36.11-01 and section 43-15-01 of the North Dakota Century Code, relating to the scope of practice of pharmacists; to repeal section 43-15-25.3 of the North Dakota Century Code, relating to approved laboratory tests; and to provide an effective date.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26.1-36.11-01 of the North Dakota Century Code is amended and reenacted as follows:

1. a. "Comprehensive medication management" means medication management pursuant to a standard of care that ensures each enrollee's medications, both prescription and nonprescription, are individually assessed to determine each medication is appropriate for the enrollee, effective for the medical condition, and safe, given the comorbidities and other medications being taken and able to be taken by the enrollee as intended. Services provided in comprehensive medication management are, as follows:
   (1) Performing or obtaining necessary assessments of the enrollee's health status;
   (2) Formulating a medication treatment plan;

(3) Monitoring and evaluating the enrollee's response to therapy, including safety and effectiveness;

(4) Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

(5) Providing verbal or written, or both, counseling, education, and training designed to enhance enrollee understanding and appropriate use of the enrollee's medications;

(6) Providing information, support services, and resources designed to enhance enrollee adherence with the enrollee's therapeutic regimens;

(7) Coordinating and integrating medication therapy management services within the broader health care management services being provided to the enrollee;

(8) Initiating or modifying drug therapy under a collaborative agreement with a practitioner in accordance with section 43-15-31.4;

(9) Prescribing medications pursuant to protocols approved by the state board of pharmacy in accordance with subsection 24 of section 43-15-10;

(10) Administering medications in accordance with requirements in section 43-15-31.5; and

(11) Ordering, performing, and interpreting laboratory tests authorized ~~by section 43-15-25.3~~under chapter 43-15 and North Dakota Administrative Code section 61-04-10-06.

b. This subsection may not be construed to expand or modify pharmacist scope of practice.

SECTION 2. AMENDMENT. Section 43-15-01 of the North Dakota Century Code is amended and reenacted as follows:

43-15-01. Definitions.

In this chapter, unless the context or subject matter otherwise requires:

1. "Administration" means the direct application of a drug to the body of a patient. The term includes:

   a. The emergency maintenance of a drug delivery device used in home infusion therapy by a qualified home pharmacist if nursing service is not available;

b. Immunization and vaccination by injection of an individual who is at least three years of age upon an order by a practitioner authorized to prescribe such a drug or by written protocol with a physician or nurse practitioner and subsequently reported as a childhood immunization and other information if required to the state's immunization information system pursuant to section 23-01-05.3;

c. Provision of other drugs to an individual who is at least three years of age upon the order of a practitioner authorized to prescribe such a drug; and

d. Provision of drugs to an individual receiving emergency services in a health care facility upon an order or by established written protocol.

2. "Automated dispensing system" means a mechanical system that performs operations or activities, other than compounding or administration, relative to the storage, packaging, counting, labeling, and dispensing of medications and which collects, controls, and monitors all transaction information.

3. "Board" means the state board of pharmacy.

4. "Compounding" means the preparation, mixing, assembling, packaging, or labeling of a drug or device:

a. As the result of a practitioner's prescription drug order or initiative based on the practitioner, patient, and pharmacist relationship in the course of professional practice; or

b. For the purpose of, or as an incident to, research, teaching, or chemical analysis and not for sale or dispensing.

Compounding also includes the preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns.

5. "Confidential information" means individually identifiable health information maintained by the pharmacist in the patient's records or which is communicated to the patient as part of a patient counseling.

6. "Deliver" or "delivery" means the actual, constructive, or attempted transfer of a drug or device from one person to another, whether or not for a consideration.

7. "Device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component part or

accessory, which is required under federal or North Dakota law to be prescribed by a practitioner and dispensed by a pharmacist.

8. "Dispense" or "dispensing" means the preparation and delivery of a prescription drug, pursuant to a lawful order of a practitioner or a nurse licensed under chapter 43-12.1 who is authorized by the practitioner to orally transmit the order that has been reduced to writing in the patient's record, in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the prescription drug.

9. "Distribute" means the delivery of a drug other than by dispensing or administering.

10. "Drug" or "drugs" means:

    a. Articles recognized as drugs in the official United States pharmacopeia, official national formulary, official homeopathic pharmacopeia, other drug compendium, or any supplement to any of them;

    b. Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animal;

    c. Articles other than food intended to affect the structure or any function of the body of man or other animals; and

    d. Articles intended for use as a component of any articles specified in subdivision a, b, or c.

11. "Drug regimen review" includes the following activities:

    a. Evaluation of the prescription drug orders and patient records for:

        (1) Known allergies;

        (2) Rational therapy-contraindications;

        (3) Reasonable dose and route of administration; and

        (4) Reasonable directions for use.

    b. Evaluation of the prescription drug orders and patient records for duplication of therapy.

    c. Evaluation of the prescription drug orders and patient records for interactions:

        (1) Drug-drug;

        (2) Drug-food;

        (3) Drug-disease; and

(4) Adverse drug reactions.

d. Evaluation of the prescription drug orders and patient records for proper utilization, including overutilization or underutilization, and optimum therapeutic outcomes.

12. "Emergency pharmacy practice" means in the event a pharmacist receives a request for a prescription refill and the pharmacist is unable to obtain refill authorization from the prescriber, the pharmacist may dispense and bill using a pharmacist national provider identifier a one-time emergency refill of up to a thirty-day supply of the prescribed medication, provided that:

a. The prescription is not for a controlled substance listed in schedule II;

b. The pharmaceutical is essential to the maintenance of life or to the continuation of therapy;

c. In the pharmacist's professional judgment, the interruption of therapy might reasonably produce undesirable health consequences or may cause physical or mental discomfort;

d. The pharmacist properly records the dispensing; and

e. The dispensing pharmacist notifies the prescriber of the emergency dispensing within a reasonable time after the one-time emergency refill dispensing.

13. "Labeling" means the process of preparing and affixing of a label to any drug container exclusive, however, of the labeling by a manufacturer, packer, or distributor of a nonprescription drug or commercially packaged legend drug or device. Any label shall include all information required by federal and North Dakota law or regulation.

14. "Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of a device or a drug, either directly or indirectly by extraction from substances of natural origin or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis and includes any packaging or repackaging of the substances or labeling or relabeling of its container, except that this term does not include the preparation or compounding of a drug by an individual for the individual's own use or the preparation, compounding, packaging, or labeling of a drug:

a. By a pharmacist or practitioner as an incident to dispensing or administering of a drug in the course of the person's professional practice; or

b. By a practitioner or by the practitioner's authorization under supervision for the purpose of or as an incident to research, teaching, or chemical analysis and not for sale.

15. "Manufacturer" means a person engaged in the manufacture of drugs in facilities located within North Dakota.

16. "Medicine" means a drug or combination of drugs, used in treating disease in man or other animals.

17. "Nonprescription drugs" means medicines or drugs which may be sold without a prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements of the statutes and regulations of this state and the federal government.

18. "Original package" means the original carton, case, can, box, vial, bottle, or other receptacle, put up by the manufacturer or wholesaler or distributor, with label attached, making one complete package of the drug article.

19. "Patient-pharmacist relationship" means the required relationship between a patient and a pharmacist as defined under the rules of the board which authorizes the pharmacist to independently prescribe drugs, drug categories, and devices as limited by this chapter.

20. "Person" means an individual, corporation, limited liability company, partnership, association, or any other legal entity.

~~20.~~21. "Pharmaceutical care" is the provision of drug therapy and other pharmaceutical patient care services intended to achieve outcomes related to the cure or prevention of a disease, elimination or reduction of a patient's symptoms, or arresting or slowing of a disease process as defined in the rules of the board.

~~21.~~22. "Pharmacist" means a person to whom the board has issued a license to practice the profession of pharmacy whose license has not expired or been suspended.

~~22.~~23. "Pharmacy" or "drugstore" means every store or shop where drugs, medicines, or chemicals are dispensed, displayed for sale, or sold, at retail for medicinal purposes, or where prescriptions are compounded, and which is duly registered by the board.

~~23.~~24. "Pharmacy technician" means a person registered by the board who is employed by a pharmacy to assist licensed pharmacists in the practice of pharmacy by performing specific tasks delegated by and under the immediate personal supervision and control of a licensed pharmacist, as permitted by the board.

~~24.~~25. "Practice of pharmacy" means ~~the~~:

a. The interpretation, evaluation, and monitoring of prescription orders and patient drug therapy; ~~the~~

b. The compounding, dispensing, and labeling of drugs and devices except labeling by a manufacturer, packer, or distributor of nonprescription drugs and commercially packaged legend drugs and devices; ~~the~~

c. The participation in drug selection, drug monitoring, drug administration, drug regimen review, the provision of these acts or services necessary as a primary health care provider of pharmaceutical care, and drug utilization evaluations; ~~the~~

d. The proper and safe storage of drugs and devices and the maintenance of proper records for this storage; ~~the~~

e. The responsibility for advising, consulting, and educating if necessary or if regulated, patients, the public, and other health care providers on the rational, safe, and cost-effective use of drugs including therapeutic values, content, hazards, and appropriate use of drugs and devices; ~~the~~

f. The participation in interpreting and applying pharmacokinetic data and other pertinent laboratory data to design safe and effective drug dosage regimens; ~~if~~

g. If appropriate and ~~if~~ regulated, the participation in scientific or clinical drug research ~~either scientific or clinical~~ as an investigator or in collaboration with other investigators for the purposes of studying the effects of drugs on animals or human subjects, with other drugs or chemicals, and with drug delivery devices; ~~emergency~~

h. Emergency pharmacy practice; ~~prescriptive~~

i. Prescriptive practices as limited under this chapter; ~~the~~

j. The ordering of laboratory tests;

k. The performance of laboratory tests to provide pharmaceutical care services which are waived under the Federal Clinical Laboratory Improvement Act of 1988

[Pub. L. 100-578, section 2; 102 Stat. 2903; 42 U.S.C. 263a et seq.], as amended; and ~~the~~

l. The offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of pharmacy.

~~25.~~26. "Practitioner" means an individual licensed, registered, or otherwise authorized by the jurisdiction in which the individual is practicing to prescribe drugs in the course of professional practice.

~~26.~~27. "Prescription" means any order for drugs or medical supplies, if such order is written or signed or transmitted by word of mouth, telephone, telegram, or other means of communication by a duly licensed physician, optometrist, dentist, veterinarian, or other practitioner, licensed by law to prescribe and administer such drugs or medical supplies intended to be filled, compounded, or dispensed by a pharmacist or any order for drugs or medical supplies transmitted orally by a nurse licensed under chapter 43-12.1 as written and signed by such a duly licensed physician, optometrist, dentist, veterinarian, or other practitioner.

~~27.~~28. "Prescription drug or legend drug" means a drug which, under federal law is required, prior to being dispensed or delivered, to be labeled with one of the following:

a. "Caution: Federal law prohibits dispensing without prescription";

b. "Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian"; or

c. Rx only;

or a drug which is required by any applicable federal or North Dakota law or rule to be dispensed on prescription only or is restricted to use by practitioners only.

~~28.~~29. "Public health issues" include immunizations, tobacco cessation, and other issues deemed appropriate by the board.

~~29.~~30. "Radiopharmaceutical service" means, but is not limited to, the compounding, dispensing, labeling, and delivery of radiopharmaceuticals; the participation in radiopharmaceutical selection and radiopharmaceutical utilization reviews; the proper and safe storage and distribution of radiopharmaceuticals; the maintenance of radiopharmaceutical quality assurance; the responsibility for advising, where necessary or where regulated, of therapeutic values, hazards, and use of

radiopharmaceuticals; and the offering or performing of those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of radiopharmaceuticals.

~~30.~~31. "Wholesaler" means a person with facilities located in this state who buys for resale and distribution to persons other than consumers.

SECTION 3. A new section to chapter 43-15 of the North Dakota Century Code is created and enacted as follows:

Prescriptive authority.

1. A pharmacist whose practice is physically located within this state, acting in good faith and exercising reasonable care, may independently prescribe drugs, drug categories, and devices as provided in this section if each of the following requirements are met:
   a. A pharmacist may prescribe drugs or devices only for conditions for which the pharmacist is educationally prepared and competence has been achieved and maintained.
   b. A pharmacist may issue a prescription only for a legitimate medical purpose arising from a patient-pharmacist relationship.
   c. A pharmacist shall obtain adequate information about the patient's health status to make appropriate decisions based on the applicable standard of care.
   d. For each drug or drug category a pharmacist intends to prescribe, the pharmacist shall maintain a patient assessment protocol based on current clinical guidelines, when available, or evidence-based research findings that specify the following:
      (1) Patient inclusion and exclusion criteria; and
      (2) Explicit medical referral criteria.
   e. A pharmacist shall revise the patient assessment protocol when necessary to ensure continued compliance with clinical guidelines or evidence-based research findings. The pharmacist's patient assessment protocol, and any related forms, must be made available to the board upon request.
   f. A pharmacist shall consult with and refer to other health care professionals as appropriate, including in situations where the pharmacist's knowledge or experience is limited.

g. A pharmacist shall develop and implement an appropriate follow-up care plan, including any monitoring parameters, in accordance with clinical guidelines. The plan may include follow-up care with the patient and communication with the patient's primary care provider.

h. A pharmacist shall inquire about the identity of the patient's primary care provider or provider of record. If a primary care provider or provider of record is identified, the pharmacist shall provide notification to the primary care provider or provider of record within three business days following the prescription of a drug. The notification must include the results of any test that required the prescription and, upon the provider's request, any relevant documentation required under subdivision i.

i. A pharmacist shall maintain documentation adequate to justify the care provided, including information collected as part of the patient assessment, the prescription record, any notification provided under this section, and the follow-up care plan.

2. A pharmacist may prescribe any drug approved by the federal food and drug administration which is indicated for the following conditions:

a. Lice;

b. Cold sores;

c. Motion sickness, including the prevention of motion sickness; and

d. Hypoglycemia~~; and~~

~~e. Uncomplicated urinary tract infections.~~

3. A pharmacist may prescribe any of the following devices approved by the federal food and drug administration:

a. Inhalation spacer;

b. Nebulizer;

c. ~~Diabetes~~Disposable diabetes blood sugar testing supplies~~; and~~

d. Pen needles; and

e. Auto-injectors containing drugs for patients with a documented history of allergies or anaphylaxis.

4. A pharmacist may prescribe any drug approved by the federal food and drug administration which is indicated for the following conditions, provided the

symptomatic patient first tests positive to a test that is waived under the Federal Clinical Laboratory Improvement Act of 1988 [Pub. L. 100-578, section 2; 102 Stat. 2903; 42 U.S.C. 263a et seq.], as amended:

a. Influenza;

b. Group A streptococcal pharyngitis; and

c. Severe acute respiratory syndrome coronavirus 2 identified as SARS-CoV-2.

5. If a patient tested positive for influenza, a pharmacist may prescribe an antiviral drug to an individual who has been exposed to the infected patient and for whom the clinical guidelines recommend chemoprophylaxis.

6. A pharmacist may prescribe any drug approved by the federal food and drug administration for the purpose of closing a gap in clinical guidelines as follows:

a. ~~Statins for a patient who has been diagnosed with diabetes~~Post-exposure prophylaxis for nonoccupational exposure to human immunodeficiency virus infection; and

b. Short-acting beta agonists for a patient with asthma who has had a prior prescription for a short-acting beta agonist and who has a current prescription for a long-term asthma control drug.

7. A pharmacist who successfully completes an accredited continuing pharmacy education or continuing medical education course on travel medicine may prescribe any noncontrolled drug recommended for individuals traveling outside the United States which is specifically listed in the federal centers for disease control and prevention health information for international travel publication. The pharmacist only may prescribe drugs that are indicated for the patient's intended destination for travel.

8. If an emergency situation exists which in the professional judgment of the pharmacist threatens the health or safety of the patient, a pharmacist may prescribe the following drugs approved by the federal food and drug administration in the minimum quantity necessary until the patient is able to be seen by a provider:

a. Diphenhydramine;

b. Epinephrine; and

c. Short-acting beta agonists.

9. A pharmacist may prescribe antimicrobial prophylaxis for the prevention of lyme disease in accordance with the federal centers for disease control and prevention guidelines.

SECTION 4. A new section to chapter 43-15 of the North Dakota Century Code is created and enacted as follows:

Therapeutic substitution.

1. A pharmacist whose practice is physically located within this state may substitute a drug for a therapeutically equivalent drug, except for antidepressants, antipsychotics, chemotherapy agents, schedule II controlled substances, biological products, and narrow therapeutic index drugs, as limited by this section. Therapeutic equivalence may be established by clinical publications comparing dosages of drugs in a therapeutic class.
2. A pharmacist may not substitute a drug for a therapeutically equivalent drug if:
   a. The prescriber indicates no substitution is to be made; or
   b. The board has determined a therapeutically equivalent drug should not be substituted and notified pharmacists of that determination.
3. Before dispensing a therapeutically equivalent drug, a pharmacist shall:
   a. Verbally discuss the suggested substitution with the patient, including informing the patient that the therapeutically equivalent drug does not contain the identical active ingredient present in the prescribed drug and any differences in dosage and frequency between the prescribed drug and the therapeutically equivalent drug; ~~and~~
   b. Inform the patient of the patient's right to refuse the substitution; and
   c. Determine whether the substitution would provide a cost benefit to the patient or provide access if the prescribed drug is not available.
4. The pharmacist shall send notice of the substitution to the prescriber by electronic communication within twenty-four hours of dispensing the drug to the patient.
5. The prescribing provider is not liable for a substitution made by a pharmacist.

SECTION 5. A new subsection to section 43-48-03 of the North Dakota Century Code is created and enacted as follows:

Pharmacists duly and currently licensed to practice pharmacy.

SECTION 6. REPEAL. Section 43-15-25.3 of the North Dakota Century Code is repealed.

SECTION 7. EFFECTIVE DATE. This Act becomes effective upon its filing with the secretary of state.