ALASKA BOARD OF PHARMACY MEETING AGENDA

AUGUST 21, 2025

Discussion of the following topics may require executive session. Only authorized members will be permitted to remain in the Board/Zoom room during executive session.

Meeting Details

Meeting Name: **Alaska Board of Pharmacy Quarterly Meeting**

Meeting Start Time: **9:00 AM**

Meeting Start Date: **August 21, 2025**

Meeting End Time: **5:00 PM**

Meeting End Date: **August 21, 2025**

Meeting Locations: **Teleconference via Zoom™**

Meeting Registration Link:
https://us02web.zoom.us/meeting/register/X8h7dPSATBu4sCprTGCCVA

Passcode: 274910
Meeting ID: 897 3358 8317

Links

Board of Pharmacy Homepage: pharmacy.alaska.gov

Prescription Drug Monitoring Program State page: pdmp.alaska.gov

Agenda

1. Roll Call/Call to Order **9:00 AM**

2. Ethics Disclosures **9:02 AM**

3. Consent Agenda Items **9:03 AM**

- **A. Review/Approve Meeting Agenda**
- **B. Review Lost or Stolen Controlled Substances/DEA 106s - CONFIDENTIAL**
- **C. Adverse Drug Events**

4. Division of Corporations, Business, and Professional Licensing Updates

- **A. Lisa Sherrell, Prescription Drug Monitoring Program (PDMP) Manager** **9:05 AM**
  - **i. PDMP Updates**
  - **ii. Long Lasting Injectables in other State PDMPs**
  - **iii. Update of Letter Addressing Telemedicine Regulations**
- **B. Investigations Review** **9:45 AM**
  - **i. Holly Handley, Investigator**
    - **a. Investigative Report**
    - **b. Case # 2025-000420 - EXECUTIVE SESSION**
  - **ii. Billy Homestead, Senior Investigator**
    - **a. Just Culture in the Investigative Process**
- **C. Michael Bowles, Executive Administrator of the Board of Pharmacy** **10:30 AM**
  - **i. Inspection Sheet Project**
  - **ii. DCCED Executive Ethics Act Training**

5. Public Comment Period **10:45 AM**

- **A. Public comments will be kept to 2 minutes per person and members of the public can only comment during one of the two periods.**

6. Industry Updates **11:00 AM**

- **A. Jennifer Adams, PharmD, EdD, FAPhA, FNAP - Associate Professor, L.S. Skaggs College of Pharmacy Idaho State University**
  - **i. ACPE Site Visit to UAA Campus**
- **B. Brandy Seignemartin, PharmD - Executive Director, Alaska Pharmacy Association (AKPhA)**
  - **i. AKPhA Updates**

7. Unfinished Board Business **11:30 AM**

A. ACPE Site Visit to UAA Campus Accreditation Report Discussion

B. Statutes

i. Current Legislative Matters

a. SB 147 - PHARMACIST PRESCRIPTION AUTHORITY

b. HB 195 - PHARMACIST PRESCRIPTION AUTHORITY

c. HB 225 - FLUORIDE SUPPLEMENTS, PUBLIC WATER SYSTEM

8. Adjourn for Lunch **12:00 PM**

9. Roll Call/Call to Order **12:30 PM**

10. Public Comment Period **12:45 PM**

A. Public comments will be kept to 2 minutes per person and members of the public can only comment during one of the two periods.

11. New Board Business **1:00 PM**

A. Ensuring Community Access Act (ECAPS)

B. Just Culture Survey Results

C. NABP Just Culture Decision Tree

D. Medical Spa Services Work Group Review - Sara Chambers, Boards and Regulations Advisor, Department of Commerce, Community and Economic Development

E. Board Letter Addressing "Neffy"

F. NABP Collaboration Addressing Workforce Well-Being

G. Medical Board Outreach and Collaboration

H. Long Lasting Injectables and PDMP 12 AAC 52.865/AS 17.30.200

I. Pharmacies Turning Off E-Prescribing During Closures

J. Regulations

i. Discussion on Regulations Review for Changes Related to Standard of Care Implementation

12. Tasks List Review and Update **4:15 PM**

13. Chair Final Comments **4:25 PM**

A. Next Quarterly Meeting – November 20, 2025

14. Adjourn

Alaska Board of Pharmacy

Agenda Item #1

Roll Call/Call to Order

Alaska Board of Pharmacy

Agenda Item #2

Ethics Disclosures

Alaska Board of Pharmacy

Agenda Item #3

Consent Agenda Items

Alaska Board of Pharmacy

Agenda Item #4

Division Updates

NABP
National Association of Boards of Pharmacy

1600 Feehanville Dr
Mount Prospect, IL 60056

1.847.391.4406
help@nabp.pharmacy

NASCSA
National Association of State Controlled Substances Authorities

June 10, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1833-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Docket CMS-1833-P – RIN 0935-AV45 – Request for Information (RFI) Regarding the Query of Prescription Drug Monitoring Program (PDMP) Measure within the FY2026 Hospital IPPS Proposed Rule

Submitted electronically via regulations.gov

Dear Administrator Dr. Mehmet Oz:

Thank you for the opportunity to comment on CMS's proposed rule: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes. The comments herein are made on behalf of the National Association of Boards of Pharmacy (NABP) **PMP InterConnect® Steering Committee** and the National Association of Controlled Substances Authorities (NASCSA) **PMP Committee**.

NABP is a 501(c)(3) nonprofit association that, for over 115 years, has protected public health by assisting its member boards of pharmacy and offering programs that promote safe pharmacy practices for the benefit of consumers. NABP PMP InterConnect® facilitates the transfer of prescription drug monitoring program (PDMP)[1] data across state lines. PMP InterConnect is governed by the PMP InterConnect Steering Committee, which is composed exclusively of representatives of the PDMPs that participate in the system. The Steering Committee serves as the governing and advisory body as it relates to the administration and function of PMP InterConnect. Currently, the PMP InterConnect Steering Committee is comprised of 53 PDMP Administrators from 53 states and territories.

The National Association of State Controlled Substances Authorities (NASCSA) was established in 1984 and is a 501 (C)(3) non-profit educational organization and is comprised of 53 state and territorial agencies, PDMPs, and others involved with controlled substances issues. NASCSA was established to provide a forum for the discussion and exchange of information and ideas, and to develop, implement, and monitor ongoing strategies to curtail the abuse, misuse, and diversion of controlled substances, including PDMPs. In 2015, recognizing the

[1]Use of the term prescription drug monitoring program (PDMP) versus prescription monitoring program (PMP) varies state to state. For consistency, utilizing "PDMP" throughout this document except when referring to PMP InterConnect®.

importance of PDMPs, NASCSA established a PDMP Committee comprised solely of state PDMP administrators that provides guidance and recommendations to the organization on policies, positions as well as content for our annual conference and webinars held throughout the year.

We are writing to provide information in response to CMS's PDMP RFI relating to the adoption of a performance-based (numerator/denominator) reporting requirement for the Query of PDMP measure. We appreciate the opportunity to work with CMS to achieve its goals of ensuring patients receive safe and effective care and that state-operated PDMPs are consulted in the prescribing and dispensing of controlled substances. However, we have operational questions and concerns with the updated measure as outlined in the RFI. **We urge CMS to carefully consider the operational, technological, and state law implications of any changes to the PDMP ecosystem.** As groups that represent the majority of the state PDMPs, we would be pleased to further assist in answering questions regarding PDMP infrastructure and data sharing in a way that would help CMS further its goals.

Please see our responses to the questions posed in the RFI, which outline our concerns and hesitations surrounding the suggested changes:

1. **Should CMS propose to adopt a performance-based (numerator/denominator) reporting requirement for the Query of PDMP measure? If so, how should the numerator and denominator be defined?**

   As PDMP Administrators that are not typically subject to the Medicare hospital IPPS rules, we are not familiar with the current performance-based reporting requirements for hospitals. However, we are intimately familiar with the data contained within PDMPs and how it is stored and shared, technologically and operationally in accordance with state and federal laws. Some requirements on hospitals for reporting regarding PDMP utilization may be more operationally feasible than others, and as representatives of nearly all the PDMPs across the country, we would be pleased to consult on this.

   Based on the background provided in the rule, we understand that the "Query of PDMP measure" initially finalized in the CY2019 IPPS rule was a performance-based measure, but it was changed to an attestation-based measure in CY2020 due to operational challenges stemming from inconsistent PDMP integration into electronic health records (EHRs). CMS contends that PDMP interoperability has now improved such that a performance-based measure should be possible.

   Whether or not CMS should adopt a performance-based reporting requirement for Query of PDMP hinges on both the intended outcome or goal of the requirement and the specifics of how the measure is calculated and which data is required to do so.

   If the goal of updating the performance measure is to encourage hospitals to integrate PDMPs into their EHRs, we agree with that premise, but see one main challenge with using the measure to achieve the goal:

   a) We agree that PDMP integration into EHRs has come a long way. While integrated PDMP queries in some states are approaching 95%, many states lack the funding and resources necessary to provide state-wide PDMP integration. In those states, the providers that aren't integrated are often small and lack resources and up-to-date technology. Thus, while we want to continue to encourage 100% integration, it is our experience that most providers who are able to integrate have, and additional support will be needed to encourage additional integration. We do not believe that this Query of PDMP measure would tip the scales for hospitals that otherwise have challenges with integration. Reducing reimbursements to hospitals and critical access hospitals for not achieving this benchmark

may negatively impact patient access to care.

If the goal of updating the measure is to encourage hospitals to require PDMP checks when clinicians prescribe controlled substances (CS), we see two clear challenges with implementing the measure:

a) Mandatory use laws vary by state: Presently, states have various forms of PDMP mandatory use laws when practitioners prescribe or dispense CS. Thus, a performance measure that compares the number of times a PDMP is checked against the number of CS prescriptions would vary widely across hospitals, especially from different states. In states with mandatory use laws in place, you would expect to see a higher number of PDMP checks than in states where it is not required. It is unclear how a national performance standard in the Medicare program could be met given the state variability. Additionally, the Drug Enforcement Administration issued a notice of proposed rulemaking for Special Registrations for Telemedicine and Limited State Telemedicine Registrations (Docket No. DEA-407) that specifies prescribers check the PDMP before prescribing a controlled substance through telehealth. It would be useful to align state and federal law from various sources such that prescribers have consistent rules to follow.

b) It is unclear how PDMP checks would be measured using EHR data: the suggested denominator of the measure, the number of controlled substance prescriptions electronically prescribed by a prescriber, may be readily available data in an EHR. However, the suggested numerator, or the number of times that a PDMP was checked, is not as readily available data. When a hospital or CAH has established integrated queries to the state PDMP, the CEHRT is likely able to identify when or if a prescriber or prescriber's delegate clicked to check the PDMP in the patient's chart. However, if the provider checks the PDMP through the state's PDMP platform, this check would not be identified in the CEHRT, and the hospital or CAH could be penalized even though the prescriber in fact checked the PDMP.

The PDMP ecosystem is working; In May 2025, the CDC reported that national overdose deaths are down by nearly 30 percent. We appreciate the attention that CMS has given to the importance of PDMPs and urge CMS to ensure that any changes made in attempts to improve the system do not unintentionally disrupt it. When considering a change to the PDMP ecosystem, we recommend that CMS proactively consult with state PDMP directors and administrators to discuss the issues you are attempting to remedy. We are available to discuss and answer questions in detail at your convenience.

2. What are the potential barriers for eligible hospitals and CAHs to meeting the PDMP's query as a performance-based measure?

For hospitals and critical access hospitals that do not have PDMP integration into their electronic health record, this measure would be extremely burdensome. Data contained within state PDMPs is highly confidential and may only be disclosed in accordance with state law. State PDMPs are prohibited from providing identifiable information to unauthorized entities including data showing whether a provider or group of providers checked the PDMP. This creates a challenge for eligible hospitals and CAHs to adjust and report on these performance metrics suggested in the RFI. Additional funding and human resources would be needed for these entities to make the necessary technological improvements to obtain integrated PDMP access.

3. How should CMS account for the varying levels of readiness and capacity for performance-based reporting, particularly for small and rural providers, including eligible hospitals and CAHs?

No response.

4. **Are there specific exclusions that we should consider for performance-based reporting?**

   If CMS decides to move forward with this performance-based reporting, we recommend that it considers excluding hospitals that do not have PDMP integration from the reporting requirements. As previously discussed, since these entities may lack the resources necessary to make the technological improvements necessary to integrate CEHRTs with the state PDMP and many states would be unable to disclose whether a provider checked the PDMP, obtaining a meaningful numerator would likely not be possible.

5. **What timeframe would allow for systems and process changes to account for a change of the Query of PDMP measure from an attestation measure to a performance-based measure while minimizing burden?**

   If the performance-based measure requires changes to the current PDMP ecosystem, such as proposed by the HTI-2 rule, we estimate it would take 10-15 years as state law changes would be required. Performance-based measures that simply require data available from the CEHRT would be much faster to adopt – for hospitals that have integrated their PDMPs.

6. **Would adoption and use of the Health IT Modules certified to the "Prescription Drug Monitoring Program (PDMP) Databases-Query, receive, validate, parse, and filter" certification criterion proposed by ONC in the HTI-2 proposed rule (89 FR 63547), if this criterion were to be finalized, help to mitigate previously identified burden associated with implementing and reporting on a performance-based "Query of PDMP" measure?**

   No, as indicated in our joint comments to the HTI-2 proposed rules, the certification criterion presents significant challenges for states and laws in place to maintain the confidentiality of PDMP data.

   To maintain state law mandated control of PDMP data including the ability to grant and audit access roles, PDMP data is typically displayed to a health care professional in a nondigestible image format (PDF or weblink) rather than a raw or discrete data format. In other words, PDMP data is intentionally human-readable, but not machine-readable.

   Unlike other health data sources, the PDMP is not a first-hand source. The PDMP staff have no direct ability to verify the accuracy of the information with the dispensing pharmacist, prescribing provider, or the patient. As such, PDMP data is often amended or corrected. Once incorrect or incomplete data is ingested by a health IT system, the PDMP would have no ability to correct it. Therefore, various conflicting copies of the patient's controlled substance history would exist in the health IT ecosystem. To further this, if PDMP data were subpoenaed from the patient's medical record and used in a civil/criminal case, there could be significant problems if the information ingested contained errors.

   In an EHR integration scenario, the system does not currently receive raw or discrete data. Instead, the ability to query a PDMP or multiple state PDMPs is accessible through EHR applications, and for the providers, the process is seamless. Requiring PDMPs to share discrete data either with health care systems via their EHR or with other health IT systems would be a fundamental change to the current process. Once discrete data is shared, PDMPs no longer have any control over how it is used and can therefore not control or audit who accesses it. This would result in a direct violation of state law.

In some states, it is a criminal offense to access PDMP data inappropriately. There would be no way for state regulators to track and enforce inappropriate access if discrete data were integrated into an EHR where an entire health system of clinicians, administrators, and business associates has access to the data. Further, states currently govern how and when PDMP data can be used in civil litigation and by state and federal investigators. Integrating raw or discrete PDMP data into the EHR or other health IT system would render it impossible to follow those laws. In cases where PDMPs obtain data from other sources to enhance the utility, PDMPs enter into agreements with those data sources that the data will not be further shared. Again, this would be impossible to prevent if discrete PDMP data were required to be provided to health IT systems. In that case, some states may have to disconnect from their other data sources causing prescribers to have less information to make a clinical decision.

As noted above, states have mandatory use laws which require certain clinicians to check the PDMP before prescribing or dispensing a controlled substance or opioid. PDMP Administrators can monitor adherence to said laws by checking whether providers checked the PDMP. If discrete data were shared with EHRs, it could be displayed in a different format or location, making it impossible for PDMP Administrators and the state health professional licensing boards responsible for regulating and enforcing PDMP mandatory use laws and rules to determine whether a licensee appropriately accessed PDMP data.

7. How would the adoption and use of Health IT modules certified to the proposed "Prescription Drug Monitoring Program (PDMP) Databases-Query, receive, validate, parse, and filter" certification criterion, if it were finalized, impact the numerator and denominator of a potential performance-based PDMP measure?

We do not believe the adoption and use of the proposed certification requirements would improve the capability of implementing a better performance-based PDMP measure. It's difficult to ascertain clinical outcomes measures based solely on whether a prescriber queries the PDMP. Many states vary in the information that is collected by the PDMP and presented in reports. These variables could contribute to differing outcomes. Clearly, state PDMPs and their appropriate use and maintenance of data confidentiality have positively impacted the nation's opioid epidemic. However, a provider that checks the PDMP does not necessarily correspond with a positive patient intervention. It depends on what the provider does with the information that's made available that makes the PDMP check meaningful. Therefore, providing incentives or disincentives for checking the PDMP is arbitrary.

Additionally, adoption of the HTI-2 rules may have a negative effect on PDMP use and its capabilities. As previously mentioned, some states have over 90% of their PDMP queries coming from an integrated source. Changing integration requirements would require everything to be rebuilt, adding significant costs to states, hospitals, CAHs, pharmacies, and providers.

8. What are other measure concepts we should consider that would allow us to focus on outcomes related to overdose prevention?

States have leveraged their PDMPs in response to the opioid epidemic and have enhanced offerings to providers and dispensers beyond providing patient dispensation reports. Disruption to the current PDMP ecosystem places all these advancements at risk of being unnecessarily dismantled.

- Prescriber Reports
    - 34 states issue prescriber reports to equip providers with insights into their controlled prescribing habits as compared to their peers and practice specialty.
- Clinical Alerts

    - 32 states have implemented clinical alerts which are delivered to prescribers within the PDMP platform when certain criteria are met to ensure prescribers are made aware of concerning patient behaviors.
- Data Analytics
    - 26 states have enabled providers' access to advanced PDMP analytics to assist with clinical decision-making at the point of care.
- Mandatory Use Reports
    - 13 states utilize mandatory use reports to ensure providers are in compliance with mandatory use laws.
- Internal PDMP Communications
    - 11 states have elected to participate in a communications module that facilitates provider messaging, including attachments, which can aid in the treatment of shared patients.
- Medical Marijuana
    - 10 states incorporate medical marijuana dispensary data into the PDMP.
- Prescriber Outliers
    - 4 states utilize detailed analysis of PDMP data to identify whose prescribing habits have negative repercussions on patient care.
- Overdose Notifications
    - A new feature, a confirmed diagnosis of an overdose is reported to the PDMP. Providers involved in that patient's care are notified of the overdose.
- Noncompliance Notifications
    - Prescribers are notified when their patients are non-compliant with medications for opioid use disorder.

As a specific example for clinical alerts and data analytics, in 2021, the South Carolina PDMP began ingesting naloxone administration data for both fatal and non-fatal opioid overdoses from healthcare facilities and first responders across the state. This information is presented in the PDMP to healthcare providers across the state to assist in clinical decision making resulting in safer prescribing and dispensing practices. The naloxone administration data is displayed as a clinical alert in the patient's PDMP report. Additionally, the administration of naloxone is calculated into the patient's unintentional overdose risk score to alert providers that the patient may need additional safety measures for certain controlled substances, including the co-prescribing of naloxone.

This work, along with other policy and regulatory changes, has had a dramatic impact on opioid overdoses from prescription opioids. It's important to note that while opioid deaths have decreased overall, illicitly obtained opioids rather than prescription opioids are the main drivers fueling the opioid epidemic.

9. Should we explore measures relating to monitoring data from PDMPs that could assess multiple opioid prescriptions, opioid prescriptions from multiple prescribers, combined opioid and benzodiazepine prescriptions, or very high standardized dosage of opioids prescribed?

As previously noted, many state PDMPs are already providing clinical alerts that inform providers when their patients meet certain criteria, including those identified in this question. If CMS explores measures related to overlapping opioid prescriptions from multiple providers, very high dosages of opioids, and concomitant prescribing of an opioid and a benzodiazepine, it will be vitally important to exclude certain chronic conditions, or the patient populations may be indiscriminately hurt if providers are pressured by performance criteria to reduce appropriate prescribing practices.

10. What measure concepts related to the use of PDMPs are likely to involve the lowest effort and provide the highest value to the health care community?

We believe that measurement and enforcement of PDMP use is best left to the states that operate them. While there are consistencies in policy between the states for PDMP operation and use, each state has its own unique idiosyncrasies that must be contemplated.

11. What challenges exist, if any, around expanding the Query of PDMP measure to include all Schedule II drugs?

Except for methadone that is administered or dispensed from opioid treatment programs and active-duty military facility dispensations, all state PDMPs collect dispensation information for all schedule II-controlled substances that are dispensed from outpatient pharmacies that are intended to treat non-institutionalized patients. Expanding the current measure to include all schedule-II controlled substances would not be inherently challenging. However, it's important to note that many states' mandatory use laws only require PDMP use when prescribing opioids.

12. What are the potential benefits versus risks of expanding the Query of PDMP measure to include all Schedule II drugs?

In recent years, PDMP dispensing data for schedule II stimulant prescriptions has shown a marked rise in the prescribing of these substances. Prescribers would likely benefit from checking the PDMP prior to prescribing any schedule II prescription to assist them with making informed decisions about prescribing stimulants.

Some states require dispensations to be reported for substances that are scheduled by the state, not the federal government. It's possible that a state may have discrepancies between its scheduling of a substance and how it's scheduled by the federal government. This disconnect may be concerning when attempting to expand this measure to additional classes or schedules of drugs.

13. Would expanding the Query of PDMP measure to Schedule II non-opioid drugs create barriers for patients appropriately prescribed Schedule II non-opioid drugs (for example, central nervous stimulants appropriately prescribed for ADHD)?

In addition to utilizing their professional judgement to determine when it's appropriate to check the PDMP, prescribers and pharmacists, at the very least, must check the PDMP in accordance with their state laws and regulations. Many states have requirements for prescribers and pharmacists to check the PDMP when prescribing or dispensing non-opioid controlled substances, including schedule II stimulants. Because of this, we do not anticipate any patient barriers to access if the Query of PDMP measure is expanded. However, as already noted, we do not support modifying how the reporting for the measure is conducted.

14. How should CMS account for varying levels of readiness and capacity for eligible hospitals and CAHs to meet an expanded scope of the measure, particularly for small and rural providers, including eligible hospitals and CAHs?

Consulting the PDMP when a prescriber or a pharmacist prescribes or dispenses an opioid or other controlled substance is generally a standard operating procedure. It's clear that as states provide resources to hospitals, prescribers, and pharmacies to integrate PDMP data into clinical workflow, the number of

queries made to the PDMP increase dramatically.

Should CMS decide to adopt its performance-based (numerator/denominator) reporting requirement, it's important to consider the readiness of hospitals and CAHs capability to obtain and provide these data points. We suggest that CMS delay reporting on this incentive for any eligible practitioner, hospital, or CAH unless and until those entities obtain integrated access to the state's PDMP into their clinical workflows. CMS should work with state PDMPs to determine whether the state supports state-wide integration of its PDMP and identify and alleviate barriers to providers, hospitals, and CAHS, to integration implementation.

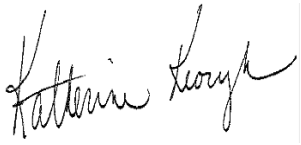
15. What exclusions should be considered, if any?

As discussed, we do not believe it is necessary for CMS to incorporate an additional reporting burden on eligible providers and entities to track and monitor PDMP use by prescribers issuing prescriptions for controlled substances. PDMPs are authorized by state legislatures and operated by state departments or boards. Likewise, the required use of the PDMP in certain scenarios is also best left up to the state legislatures and regulatory bodies that oversee the professionals who are obligated to use the program in their respective states.

The NABP PMP InterConnect Steering Committee and the NASCSA PMP Committee thank CMS for the opportunity to respond to this RFI. We encourage CMS to proactively reach out to NABP or NASCSA to discuss any real or perceived issues related to PDMPs, their use, enforcement, and data sharing between the states. NABP and NASCSA understand the important role that state PDMPs play in ensuring that public health is protected, and we remain committed to assisting our members in carrying out their public health duties.

Sincerely,

Alexandra Blasi
Chair, PMP InterConnect Steering Committee
Executive Secretary, Kansas Board of Pharmacy



Kathy Keough
Executive Director, National Association of State Controlled Substance Authorities

THE STATE of ALASKA

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING

550 West Seventh Avenue, Suite 1500
Anchorage, AK 99501-3567
Main: 907.269.8160
Fax: 907.269.8156

MEMORANDUM

DATE: August 04, 2025

TO: Board of Pharmacy

THRU: Erika Prieksat, Chief Investigator BH

FROM: Holly Handley, Investigator

RE: Investigative Report for the August 21, 2025 Meeting

The following information was compiled as an investigative report to the Board for the period of May 09, 2025 thru August 04, 2025; this report includes cases, complaints, and intake matters handled since the last report.

Matters opened by the Paralegals in Anchorage and Juneau, regarding continuing education audits and license action resulting from those matters are covered in this report.

OPEN - 68

Case Number	Violation Type	Case Status	Status Date
OUT OF STATE PHARMACY			
2023-000147	Violation of licensing regulation	Investigation	01/19/2024
PHARMACIST			
2025-000501	Violation of License Regulation	Intake	06/09/2025
2025-000694	License Application Review/Referral	Intake	07/25/2025
2025-000697	Violation of Profession Statute or Regulation	Intake	07/26/2025
2025-000006	Continuing education	Complaint	01/08/2025
2025-000019	License Application Problem	Complaint	06/04/2025
2025-000102	Unprofessional conduct	Complaint	07/22/2025
2025-000398	PDMP Violation: Failure to Register	Complaint	05/13/2025

2025-000475	Violation of Profession Statute or Regulation	Complaint	06/30/2025
2025-000497	Violation of Profession Statute or Regulation	Complaint	07/02/2025
2025-000598	License Application Review/Referral	Complaint	07/16/2025
2025-000675	PDMP Violation: Failure to Register	Complaint	07/22/2025
2025-000706	PDMP Violation: Failure to Register	Complaint	08/01/2025
2024-001175	License Application Review/Referral	Investigation	07/03/2025

PHARMACIST IN CHARGE

2025-000096	Violation of License Regulation	Complaint	06/06/2025
2025-000535	PDMP Violation: Failure to Register	Complaint	07/14/2025
2025-000647	PDMP Violation: Failure to Register	Complaint	07/16/2025

PHARMACY

2024-000802	Unlicensed practice or activity	Intake	09/03/2024
2024-000804	Unlicensed practice or activity	Intake	09/04/2024
2024-000813	License Application Review/Referral	Intake	09/05/2024
2024-000821	Unlicensed practice or activity	Intake	09/06/2024
2024-000822	Unlicensed practice or activity	Intake	09/06/2024
2024-000823	Unlicensed practice or activity	Intake	09/06/2024
2025-000208	Action in another state	Intake	03/14/2025
2025-000477	Violation of License Regulation	Intake	06/03/2025
2025-000571	Violation of License Regulation	Intake	06/23/2025
2025-000599	Violation of License Regulation	Intake	07/01/2025
2025-000640	Violation of License Regulation	Intake	07/09/2025
2025-000692	Action in another state	Intake	07/24/2025
2025-000707	Violation of Profession Statute or Regulation	Intake	07/31/2025
2024-001104	Violation of License Regulation	Complaint	02/28/2025
2025-000136	Continuing education	Complaint	05/19/2025
2025-000463	License Application Review/Referral	Complaint	06/16/2025
2025-000498	Violation of Profession Statute or Regulation	Complaint	06/23/2025
2025-000604	License Application Review/Referral	Complaint	08/01/2025
2025-000620	Violation of License Regulation	Complaint	07/30/2025

2024-000757	Violation of License Regulation	Investigation	07/23/2025
2025-000420	Unlicensed practice or activity	Investigation	07/07/2025
2024-000831	Compliance Inspection	Closed-Division Inspection	

PHARMACY TECHNICIAN

2024-001218	Continuing education	Intake	12/18/2024
2025-000682	Violation of Profession Statute or Regulation	Intake	04/02/2025
2025-000471	Violation of Profession Statute or Regulation	Complaint	06/16/2025
2025-000151	Unprofessional conduct	Investigation	04/01/2025
2025-000192	License Application Review/Referral	Investigation	06/17/2025
2025-000399	Violation of License Regulation	Investigation	07/14/2025

PODIATRIST

2025-000543	License Application Review/Referral	Complaint	07/02/2025

WHOLESALE DRUG DISTRIBUTOR

2025-000057	License Application Review/Referral	Intake	01/27/2025
2025-000097	Violation of License Regulation	Intake	02/10/2025
2025-000203	Violation of License Regulation	Intake	03/12/2025
2025-000567	Violation of License Regulation	Intake	06/24/2025
2025-000628	Unlicensed practice or activity	Intake	07/07/2025
2025-000629	Unlicensed practice or activity	Intake	07/07/2025
2025-000631	Unlicensed practice or activity	Intake	07/07/2025
2025-000667	Violation of License Regulation	Intake	07/21/2025
2025-000704	License Application Review/Referral	Intake	07/29/2025
2024-000984	License Application Review/Referral	Complaint	06/25/2025
2024-001054	Violation of License Regulation	Complaint	04/08/2025
2024-001162	Violation of License Regulation	Complaint	04/02/2025
2024-001172	Violation of License Regulation	Complaint	04/08/2025
2025-000061	Violation of License Regulation	Complaint	05/30/2025
2025-000207	Violation of License Regulation	Complaint	06/13/2025

2025-000273	License Application Review/Referral	Complaint	04/24/2025
2025-000371	Violation of License Regulation	Complaint	07/10/2025
2025-000390	Violation of License Regulation	Complaint	05/15/2025
2025-000474	Violation of License Regulation	Complaint	06/30/2025
2025-000570	Violation of License Regulation	Complaint	07/16/2025
2025-000605	License Application Review/Referral	Complaint	07/29/2025
2025-000630	Unlicensed practice or activity	Complaint	07/31/2025

Closed - 51

Case #	Violation Type	Case Status	Closed	Closure
PHARMACIST				
2025-000326	Violation of License Regulation	Closed-Intake	05/22/2025	Incomplete Complaint
2025-000372	Violation of Profession Statute or Regulation	Closed-Intake	06/16/2025	Review Complete
2025-000374	Violation of License Regulation	Closed-Intake	06/11/2025	Review Complete
2025-000438	Violation of License Regulation	Closed-Intake	06/23/2025	Incomplete Complaint
2025-000462	Violation of License Regulation	Closed-Intake	07/30/2025	Incomplete Complaint
2025-000562	Violation of License Regulation	Closed-Intake	07/24/2025	Incomplete Complaint
2025-000569	Violation of License Regulation	Closed-Intake	07/24/2025	Incomplete Complaint
2025-000247	License Application Problem	Closed-Complaint	06/02/2025	Application Withdrawn
2025-000256	Violation of License Regulation	Closed-Complaint	07/07/2025	No Action - No Violation
2025-000271	PDMP Violation: Failure to Register	Closed-Complaint	07/14/2025	No Action - No Violation
2025-000295	PDMP Violation: Failure to Register	Closed-Complaint	07/28/2025	No Action - No Violation
2025-000423	PDMP Violation: Failure to Register	Closed-Complaint	06/23/2025	No Action - No Violation
2025-000425	PDMP Violation: Failure to Register	Closed-Complaint	07/23/2025	No Action - No Violation
2025-000426	PDMP Violation: Failure to Register	Closed-Complaint	07/18/2025	No Action - No Violation
2025-000427	PDMP Violation: Failure to Register	Closed-Complaint	07/18/2025	No Action - No Violation

2025-000610	PDMP Violation: Failure to Register	Closed-Complaint	07/14/2025	No Action - No Violation
2025-000612	PDMP Violation: Failure to Register	Closed-Complaint	07/24/2025	No Action - No Violation
2024-001014	Violation of License Regulation	Closed-Investigation	07/01/2025	Advisement Letter
2025-000417	Criminal action - conviction	Closed-Investigation	07/14/2025	Advisement Letter
2025-000432	PDMP Violation: Failure to Register	Closed-Investigation	06/23/2025	Advisement Letter
2025-000442	Violation of License Regulation	Closed-Investigation	07/23/2025	Advisement Letter

PHARMACIST IN CHARGE

2025-000219	PDMP Violation: Failure to Register	Closed-Investigation	06/23/2025	Advisement Letter

PHARMACIST INTERN

2025-000230	Violation of License Regulation	Closed-Complaint	06/10/2025	Other (See Abstract)

PHARMACY

2025-000280	Violation of License Regulation	Closed-Intake	05/16/2025	Incomplete Complaint
2025-000325	Violation of License Regulation	Closed-Intake	05/22/2025	Incomplete Complaint
2025-000346	Violation of License Regulation	Closed-Intake	05/29/2025	Incomplete Complaint
2025-000362	Violation of License Regulation	Closed-Intake	06/16/2025	No Action - Lack of Jurisdiction
2025-000373	Violation of License Regulation	Closed-Intake	06/16/2025	Review Complete
2025-000397	Violation of License Regulation	Closed-Intake	06/23/2025	Incomplete Complaint
2025-000518	PDMP Violation: Failure to Report	Closed-Intake	06/26/2025	Compliance
2025-000578	Compliance Inspection	Closed-Intake	06/25/2025	Compliance
2025-000581	Compliance Inspection	Closed-Intake	06/25/2025	Compliance
2025-000700	Compliance Inspection	Closed-Intake	07/30/2025	Compliance
2025-000701	Compliance Inspection	Closed-Intake	07/30/2025	Compliance
2025-000702	Compliance Inspection	Closed-Intake	07/30/2025	Compliance
2025-000703	Compliance Inspection	Closed-Intake	07/31/2025	Compliance
2025-000157	Violation of License Regulation	Closed-Complaint	05/27/2025	No Action - No Violation

2025-000166	Violation of License Regulation	Closed-Complaint	06/02/2025	No Action - No Violation
2024-000769	Unlicensed practice or activity	Closed-Investigation	05/28/2025	Advisement Letter
2025-000198	Violation of License Regulation	Closed-Investigation	05/27/2025	Advisement Letter
2025-000388	Violation of License Regulation	Closed-Investigation	07/07/2025	Advisement Letter
2025-000385	Compliance Inspection	Closed-Division Inspection	05/09/2025	Compliance
2025-000386	Compliance Inspection	Closed-Division Inspection	05/09/2025	Compliance
2025-000387	Compliance Inspection	Closed-Division Inspection	05/09/2025	Compliance

PHARMACY TECHNICIAN

2025-000060	License Application Review/Referral	Closed-Intake	05/27/2025	Review Complete
2025-000418	Violation of License Regulation	Closed-Intake	06/23/2025	Incomplete Complaint

WHOLESALE DRUG DISTRIBUTOR

2024-000596	Violation of licensing regulation	Closed-Complaint	05/27/2025	Advisement Letter
2025-000389	Violation of License Regulation	Closed-Complaint	07/28/2025	No Action - No Violation
2024-000624	Violation of License Regulation	Closed-Investigation	05/28/2025	Advisement Letter
2024-000625	Violation of License Regulation	Closed-Investigation	05/28/2025	Advisement Letter
2025-000081	License Application Review/Referral	Closed-Investigation	06/18/2025	Advisement Letter

END OF REPORT

Alaska Board of Pharmacy

Agenda Item #5

Public Comment Period

Alaska Board of Pharmacy

Agenda Item #6

Industry Updates

Industry Update
Alaska Pharmacy Association

Brandy Seignemartin, PharmD
Executive Director

Brittany Keener, PharmD, MPH, BCPS, FAKPhA
President

RFK Jr., Senator Sullivan, & Senator Murkowski Visit Pharmacies

Tanana Chiefs Conference Rural Pharmacy Services

During visit Dan Nelson recognized with Federal Immunization Champion Award sponsored by Association of Immunization Managers (AIM) and Centers for Disease Control and Prevention (CDC)

One Big Beautiful Bill

- **PBM Transparency in Managed Medicaid**
  - **No direct impact on AK**
  - **Bans spread pricing**
  - **Limits PBM payment to administrative fee**
  - **Requires pharmacy payment of NADAC plus professional dispensing fee**
- **Medicaid cuts**
- **Orphan Cures Act**

New PBM Reform Package Introduced

Bipartisan Coalition Led by Rep. Buddy Carter

The PBM Reform Act will:

Ban “spread pricing” in Medicaid and move to a transparent system that ensures pharmacies are fairly and adequately reimbursed for serving Medicaid beneficiaries.

Establish new requirements for PBMs under Medicare Part D, including a policy to delink PBM compensation from the cost of medications and increase transparency.

Promote transparency for both employers and patients in their prescription drug plans, with semi-annual reporting on drug spending, rebates, and formulary determinations.

Require Centers for Medicare and Medicaid Services (CMS) to define and enforce "reasonable and relevant" contract terms in Medicare Part D pharmacy contracts and enforce oversight on reported violations.

Original Co-Sponsors include: Debbie Dingell (D-MI), Greg Murphy (R-NC), Deborah Ross (D-NC), Jodey Arrington (R-TX), Diana Harshbarger (R-TN), Vicente Gonzalez (D-TX), Rick Allen (R-GA), Raja Krishnamoorthi (D-IL), John Rose (R-TN), Derek Tran (D-CA), and Nicole Malliotakis (R-NY).

Idaho Pharmacist Confirmation Hearing for HHS Assistant Secretary for Family Support

Alex Adams, PharmD

nominated by President Trump on March 24

7/31 Hearing

- Dr. Adams was the architect of Idaho's original expanded scope of practice legislation for pharmacists—the exact model that SB 147 mirrors. Our bill is identical to the original Idaho statute that successfully modernized pharmacy practice under a standard of care framework.

Alaska Board of Pharmacy

Agenda Item #7

Unfinished Board Business

CS FOR SENATE BILL NO. 147(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered: 5/12/25
Referred:

Sponsor(s): SENATOR GIESSEL BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to the prescription and administration of drugs and devices by pharmacists; relating to reciprocity for pharmacists; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.80.030(b) is amended to read:

(b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy, including independent monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) license and regulate the qualifications of entities and individuals engaged in the manufacture or distribution of drugs and related devices;

(11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200;

(12) establish standards for the independent prescribing and administration of vaccines and related emergency medications under AS 08.80.168, including the completion of an immunization training program approved by the board and an epinephrine auto-injector training program under AS 17.22.020(b);

(13) establish standards for the independent prescribing and dispensing by a pharmacist of an opioid overdose drug under AS 17.20.085, including the completion of an opioid overdose training program approved by the board;

(14) require that a licensed pharmacist who **prescribes, administers, or** dispenses a **schedule IA, IIA, IIIA, IVA, or VA controlled substance under state law or** schedule II, III, [OR] IV**, or V** controlled substance under federal law to a person in the state register with the controlled substance prescription database under

AS 17.30.200(n);

(15) establish the qualifications and duties of the executive administrator and delegate authority to the executive administrator that is necessary to conduct board business;

(16) license and inspect the facilities of pharmacies, manufacturers, wholesale drug distributors, third-party logistics providers, and outsourcing facilities located outside the state under AS 08.80.159;

(17) license Internet-based pharmacies providing services to residents in the state;

(18) adopt regulations pertaining to retired pharmacist status.

*** Sec. 2.** AS 08.80.110 is amended to read:

Sec. 08.80.110. Qualifications for licensure by examination. An applicant for licensure as a pharmacist shall

(1) be fluent in the reading, writing, and speaking of the English language;

(2) be a graduate of a college in a degree program approved by the board;

(3) pass an examination or examinations given by the board or acceptable to the board under the score transfer process administered by the National Association of Boards of Pharmacy;

(4) have completed internship training or another program that has been approved by the board or demonstrated to the board's satisfaction that the applicant has experience in the practice of pharmacy that meets or exceeds the minimum internship requirements of the board**; and**

(5) receive education in pain management and opioid use and addiction, unless the applicant has demonstrated to the satisfaction of the board that the applicant does not currently hold a valid federal Drug Enforcement Administration registration number; an applicant may include past professional experience or professional education as proof of professional competence.

*** Sec. 3.** AS 08.80.145 is amended to read:

Sec. 08.80.145. Reciprocity; license transfer. If another jurisdiction allows

licensure in that jurisdiction of a pharmacist licensed in this state under conditions similar to those in this section, the board may license as a pharmacist in this state a person licensed as a pharmacist in the other jurisdiction if the person

(1) submits a written application to the board on a form required by the board;

(2) is at least 18 years of age;

(3) possesses at the time of the request for licensure as a pharmacist in this state the qualifications necessary to be eligible for licensure in this state;

(4) has engaged in the practice of pharmacy for at least one year immediately before applying for a license under this section;

(5) presents proof satisfactory to the board that the person is currently licensed as a pharmacist in the other jurisdiction and does not currently have a pharmacist license suspended, revoked, or otherwise restricted except for failure to apply for renewal or failure to obtain the required continuing education credits;

(6) has passed an examination approved by the board that tests the person's knowledge of Alaska laws relating to pharmacies and pharmacists and the regulations adopted under those laws; [AND]

(7) **meets the requirements of AS 08.80.110(5); and**

(8) pays all required fees.

*** Sec. 4.** AS 08.80.165 is amended to read:

Sec. 08.80.165. Continuing education requirements. The board shall establish requirements for continuing education in pharmacy that must be satisfied before a license issued under this chapter may be renewed. **The continuing education requirements must include at least two hours of education in pain management and opioid use and addiction in the two years preceding an application for renewal of a license. The board may exempt a licensee from the requirement to receive at least two hours of education in pain management and opioid use and addiction if the licensee demonstrates to the satisfaction of the board that**

(1) the licensee's practice does not include pain management and opioid prescription or administration; or

(2) the licensee does not currently hold a valid federal Drug

Enforcement Administration registration number.

*** Sec. 5.** AS 08.80.337(a) is amended to read:

(a) A pharmacist may, under a collaborative practice agreement with a written protocol approved by a practitioner **who is not a pharmacist**, provide patient care services.

*** Sec. 6.** AS 08.80.337(d) is amended to read:

(d) In this section, "patient care services" means medical care services**, including the prescription or administration of a drug or device to a patient, that are** given in exchange for compensation **and** 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**; "patient care services" does not include the prescription of an abortion-inducing drug to a patient**.

*** Sec. 7.** AS 08.80.337 is amended by adding a new subsection to read:

(e) A pharmacist prescribing or administering a drug or device under this section shall recognize the limits of the pharmacist's education, training, and experience and consult with and refer to other practitioners as appropriate.

*** Sec. 8.** AS 08.80.480(30) is amended to read:

(30) "practice of pharmacy" means the interpretation, evaluation, and dispensing of prescription drug orders in the patient's best interest; participation in drug and device selection, drug administration, drug regimen reviews, and drug or drug-related research; provision of patient counseling and the provision of those acts or services necessary to provide pharmaceutical care; the independent prescribing, dispensing, and administration of drugs in accordance with AS 08.80.168; **providing patient care services in accordance with AS 08.80.337;** the responsibility for compounding and labeling of drugs and devices except labeling by a manufacturer, repackager, or distributor of nonprescription drugs and commercially packaged legend drugs and devices; proper and safe storage of drugs and devices; and maintenance of proper records for them;

*** Sec. 9.** AS 08.80.480 is amended by adding a new paragraph to read:

(40) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140 and 11.71.160.

*** Sec. 10.** AS 08.80.337(c) is repealed.

*** Sec. 11.** This Act takes effect January 1, 2026.

HOUSE BILL NO. 195

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES MINA, Gray

Introduced: 4/15/25
Referred: Health and Social Services, Labor and Commerce, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to the prescription and administration of drugs and devices by pharmacists; relating to reciprocity for pharmacists; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.80.030(b) is amended to read:

(b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy, including independent monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) license and regulate the qualifications of entities and individuals engaged in the manufacture or distribution of drugs and related devices;

(11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200;

(12) establish standards for the independent prescribing and administration of vaccines and related emergency medications under AS 08.80.168, including the completion of an immunization training program approved by the board and an epinephrine auto-injector training program under AS 17.22.020(b);

(13) establish standards for the independent prescribing and dispensing by a pharmacist of an opioid overdose drug under AS 17.20.085, including the completion of an opioid overdose training program approved by the board;

(14) require that a licensed pharmacist who **prescribes, administers, or** dispenses a **schedule IA, IIA, IIIA, IVA, or VA controlled substance under state law or** schedule II, III, [OR] IV**, or V** controlled substance under federal law to a person in the state register with the controlled substance prescription database under

AS 17.30.200(n);

(15) establish the qualifications and duties of the executive administrator and delegate authority to the executive administrator that is necessary to conduct board business;

(16) license and inspect the facilities of pharmacies, manufacturers, wholesale drug distributors, third-party logistics providers, and outsourcing facilities located outside the state under AS 08.80.159;

(17) license Internet-based pharmacies providing services to residents in the state;

(18) adopt regulations pertaining to retired pharmacist status.

*** Sec. 2.** AS 08.80.110 is amended to read:

Sec. 08.80.110. Qualifications for licensure by examination. An applicant for licensure as a pharmacist shall

(1) be fluent in the reading, writing, and speaking of the English language;

(2) be a graduate of a college in a degree program approved by the board;

(3) pass an examination or examinations given by the board or acceptable to the board under the score transfer process administered by the National Association of Boards of Pharmacy;

(4) have completed internship training or another program that has been approved by the board or demonstrated to the board's satisfaction that the applicant has experience in the practice of pharmacy that meets or exceeds the minimum internship requirements of the board**; and**

(5) receive education in pain management and opioid use and addiction, unless the applicant has demonstrated to the satisfaction of the board that the applicant does not currently hold a valid federal Drug Enforcement Administration registration number; an applicant may include past professional experience or professional education as proof of professional competence.

*** Sec. 3.** AS 08.80.145 is amended to read:

Sec. 08.80.145. Reciprocity; license transfer. If another jurisdiction allows

licensure in that jurisdiction of a pharmacist licensed in this state under conditions similar to those in this section, the board may license as a pharmacist in this state a person licensed as a pharmacist in the other jurisdiction if the person

(1) submits a written application to the board on a form required by the board;

(2) is at least 18 years of age;

(3) possesses at the time of the request for licensure as a pharmacist in this state the qualifications necessary to be eligible for licensure in this state;

(4) has engaged in the practice of pharmacy for at least one year immediately before applying for a license under this section;

(5) presents proof satisfactory to the board that the person is currently licensed as a pharmacist in the other jurisdiction and does not currently have a pharmacist license suspended, revoked, or otherwise restricted except for failure to apply for renewal or failure to obtain the required continuing education credits;

(6) has passed an examination approved by the board that tests the person's knowledge of Alaska laws relating to pharmacies and pharmacists and the regulations adopted under those laws; [AND]

(7) **meets the requirements of AS 08.80.110(5); and**

(8) pays all required fees.

*** Sec. 4.** AS 08.80.165 is amended to read:

Sec. 08.80.165. Continuing education requirements. The board shall establish requirements for continuing education in pharmacy that must be satisfied before a license issued under this chapter may be renewed. **The continuing education requirements must include at least two hours of education in pain management and opioid use and addiction in the two years preceding an application for renewal of a license. The board may exempt a licensee from the requirement to receive at least two hours of education in pain management and opioid use and addiction if the licensee demonstrates to the satisfaction of the board that**

(1) the licensee's practice does not include pain management and opioid prescription or administration; or

(2) the licensee does not currently hold a valid federal Drug

Enforcement Administration registration number.

*** Sec. 5.** AS 08.80.337(a) is amended to read:

(a) A pharmacist may, under a collaborative practice agreement with a written protocol approved by a practitioner **who is not a pharmacist**, provide patient care services.

*** Sec. 6.** AS 08.80.337(d) is amended to read:

(d) In this section, "patient care services" means medical care services**, including the prescription or administration of a drug or device to a patient, that are** given in exchange for compensation **and** 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.

*** Sec. 7.** AS 08.80.337 is amended by adding a new subsection to read:

(e) A pharmacist prescribing or administering a drug or device under this section shall recognize the limits of the pharmacist's education, training, and experience and consult with and refer to other practitioners as appropriate.

*** Sec. 8.** AS 08.80.480(30) is amended to read:

(30) "practice of pharmacy" means the interpretation, evaluation, and dispensing of prescription drug orders in the patient's best interest; participation in drug and device selection, drug administration, drug regimen reviews, and drug or drug-related research; provision of patient counseling and the provision of those acts or services necessary to provide pharmaceutical care; the independent prescribing, dispensing, and administration of drugs in accordance with AS 08.80.168; **providing patient care services in accordance with AS 08.80.337;** the responsibility for compounding and labeling of drugs and devices except labeling by a manufacturer, repackager, or distributor of nonprescription drugs and commercially packaged legend drugs and devices; proper and safe storage of drugs and devices; and maintenance of proper records for them;

*** Sec. 9.** AS 08.80.480 is amended by adding a new paragraph to read:

(40) "opioid" includes the opium and opiate substances and opium and opiate derivatives listed in AS 11.71.140 and 11.71.160.

*** Sec. 10.** AS 08.80.337(c) is repealed.

*** Sec. 11.** This Act takes effect January 1, 2026.

HOUSE BILL NO. 225

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE ALLARD

Introduced: 5/10/25
Referred: Health and Social Services, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

"An Act relating to prescription fluoride supplements; relating to the practice of pharmacy; and relating to fluoride in public water systems."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.80.030(b) is amended to read:

(b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy, including independent monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) license and regulate the qualifications of entities and individuals engaged in the manufacture or distribution of drugs and related devices;

(11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200;

(12) establish standards for the independent prescribing and administration of vaccines and related emergency medications under AS 08.80.168, including the completion of an immunization training program approved by the board and an epinephrine auto-injector training program under AS 17.22.020(b);

(13) establish standards for the independent prescribing and dispensing by a pharmacist of an opioid overdose drug under AS 17.20.085, including the completion of an opioid overdose training program approved by the board;

(14) require that a licensed pharmacist who dispenses a schedule II, III, or IV controlled substance under federal law to a person in the state register with the controlled substance prescription database under AS 17.30.200(n);

(15) establish the qualifications and duties of the executive administrator and delegate authority to the executive administrator that is necessary to

conduct board business;

(16) license and inspect the facilities of pharmacies, manufacturers, wholesale drug distributors, third-party logistics providers, and outsourcing facilities located outside the state under AS 08.80.159;

(17) license Internet-based pharmacies providing services to residents in the state;

(18) adopt regulations pertaining to retired pharmacist status**;**

(19) establish standards for review and approval of a standing order issued by the chief medical officer under AS 17.20.087.

*** Sec. 2.** AS 08.80 is amended by adding a new section to read:

Sec. 08.80.332. Fluoride supplements. (a) A pharmacist may dispense a fluoride supplement without a prescription drug order specific to a patient if the pharmacist is authorized to dispense the fluoride supplement under a standing order issued under AS 17.20.087.

(b) A pharmacist dispensing a fluoride supplement shall, at a minimum, provide patient counseling about

(1) appropriate administration and storage of the fluoride supplement;

(2) potential side effects and risks of the fluoride supplement; and

(3) when to seek emergency medical attention.

(c) In this section, "fluoride supplement" has the meaning given in AS 17.20.087(d).

*** Sec. 3.** AS 17.20 is amended by adding a new section to read:

Sec. 17.20.087. Fluoride supplements. (a) The chief medical officer of the department shall issue a standing order for the prescription of a fluoride supplement that allows a pharmacist to dispense the fluoride supplement without a prescription drug order specific to a patient.

(b) The standing order issued under this section must

(1) specify each pharmacist authorized to dispense a fluoride supplement under the order and the pharmacist's license number;

(2) establish a protocol to review, at least annually, the dispensing practices of each pharmacist authorized to dispense a fluoride supplement under the

order;

(3) require a pharmacist dispensing a fluoride supplement under the order to keep a record of each patient who receives a fluoride supplement under the order, including

(A) the name of the patient;

(B) the fluoride supplement received; and

(C) any other relevant information;

(4) require a pharmacist dispensing a fluoride supplement under the order to provide patient counseling as specified in AS 08.80.332; and

(5) be approved by the Board of Pharmacy.

(c) The chief medical officer of the department is not liable for civil damages as a result of an act or omission arising out of the dispensing of a fluoride supplement as authorized by a standing order issued under this section.

(d) In this section,

(1) "dispense" or "dispensing" has the meaning given in AS 08.80.480;

(2) "fluoride supplement" means a prescription drug containing fluoride that is intended to enhance oral health;

(3) "patient counseling" has the meaning given in AS 08.80.480;

(4) "pharmacist" has the meaning given in AS 08.80.480;

(5) "prescription drug" has the meaning given in AS 08.80.480;

(6) "prescription drug order" has the meaning given in AS 08.80.480.

*** Sec. 4.** AS 46.03 is amended by adding a new section to read:

Sec. 46.03.725. Fluoride in public water systems. A person may not add fluoride to a public water system.

*** Sec. 5.** AS 46.03.761(a) is amended to read:

(a) The department may assess an administrative penalty against an entity that violates or causes or permits to be violated a provision of AS 46.03.720(b) **or 46.03.725,** or a term or condition of a regulation, order, permit, approval, or certificate of the department issued or adopted under AS 46.03.720(b) **or 46.03.725**.

Alaska Board of Pharmacy

Agenda Item #8

Adjourn for Lunch

Alaska Board of Pharmacy

Agenda Item #9

Roll Call/Call to Order

Alaska Board of Pharmacy

Agenda Item #10

Public Comment Period

Alaska Board of Pharmacy

Agenda Item #11

New Board Business

I

119TH CONGRESS
1ST SESSION

H. R. 3164

To amend title XVIII of the Social Security Act to provide pharmacy payment of certain services.

IN THE HOUSE OF REPRESENTATIVES

MAY 1, 2025

Mr. SMITH of Nebraska (for himself, Mr. SCHNEIDER, Mrs. HARSHBARGER, and Ms. MATSUI) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend title XVIII of the Social Security Act to provide pharmacy payment of certain services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Ensuring Community Access to Pharmacist Services Act".

SEC. 2. COVERAGE OF PHARMACIST SERVICES UNDER MEDICARE PART B.

(a) COVERAGE.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) in subparagraph (JJ), by adding ''and'' at the end; and

(B) by adding at the end the following new subparagraph:

''(KK) pharmacist services (as defined in subsection (nnn));''; and

(2) by adding at the end the following new subsection:

''(nnn) PHARMACIST SERVICES.—

''(1) IN GENERAL.—The term 'pharmacist services' means such services furnished by a pharmacist, and such services and supplies furnished as an incident to the pharmacist's service, which the pharmacist is legally authorized to perform under State law as would otherwise be covered if furnished by a physician or as an incident to a physicians' service which—

''(A) in the case such State law requires such services to be furnished under the supervision of, or working in collaboration with, a physician or practitioner (as defined in section

1842(b)(18)(C)(i)), are so furnished under the supervision of, or working in collaboration with, such physician or practitioner in the manner and to the extent as so required by such State law; and

''(B) are—

''(i) for visits for the evaluation and management of individuals for testing or treatment for COVID–19, influenza, respiratory syncytial virus, or streptococcal pharyngitis; or

''(ii) testing or treatment services that address a public health need related to a public health emergency declared under section 319 of the Public Health Service Act (as determined by the Secretary).

''(2) COLLABORATION.—For purposes of this subsection, the term 'collaboration' means a process in which a pharmacist works with a physician or practitioner (as defined in section 1842(b)(18)(C)(i)), as applicable, to deliver health care services within the scope of the pharmacist's professional expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by

the law of the State in which the services are performed.''.

(b) PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and (HH)'' and inserting ''(HH)''; and

(2) by inserting before the semicolon at the end the following: ''and (II) with respect to pharmacist services (as defined in section 1861(nnn)), the amounts paid shall be equal to 80 percent of the lesser of (i) the actual charge for the services or (ii) 85 percent (or 100 percent, in the case of such services that address a public health need described in paragraph (2)(B) of such section) of the amount determined under the payment basis under section 1848 for such services.''.

(c) PROHIBITION ON BALANCE BILLING FOR PHARMACIST SERVICES.—Section 1842(b)(18) of the Social Security Act (42 U.S.C. 1395u(b)(18)) is amended—

(1) in subparagraph (A), by inserting ''or a pharmacist'' after ''a practitioner described in subparagraph (C)''; and

(2) in subparagraph (B)—

(A) in the first sentence, by inserting ", a pharmacist," after "a practitioner described in subparagraph (C)"; and

(B) in the third sentence—

(i) by inserting ", a pharmacist," after "a practitioner"; and

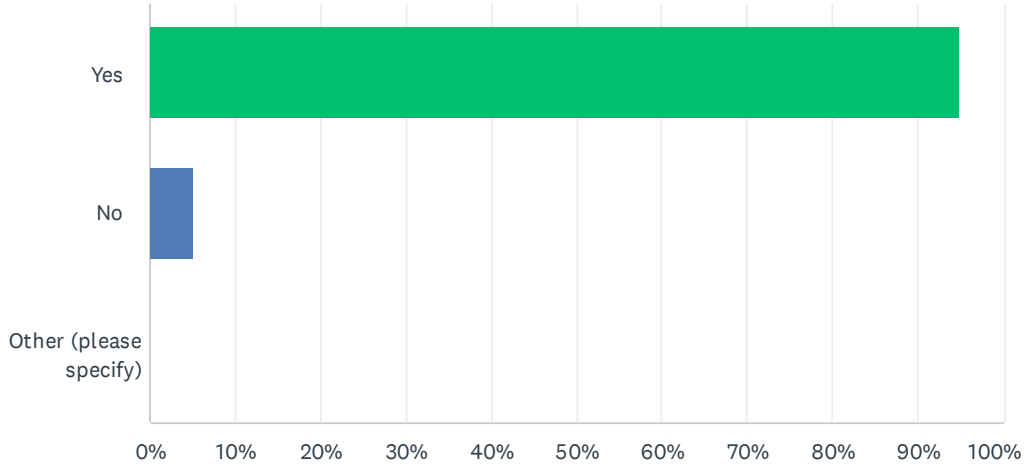
(ii) by inserting ", the pharmacist," after "the practitioner".

(d) APPLICATION.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2026.

○

Q1 Does your workplace encourage reporting errors and mistakes?

Answered: 58 Skipped: 1

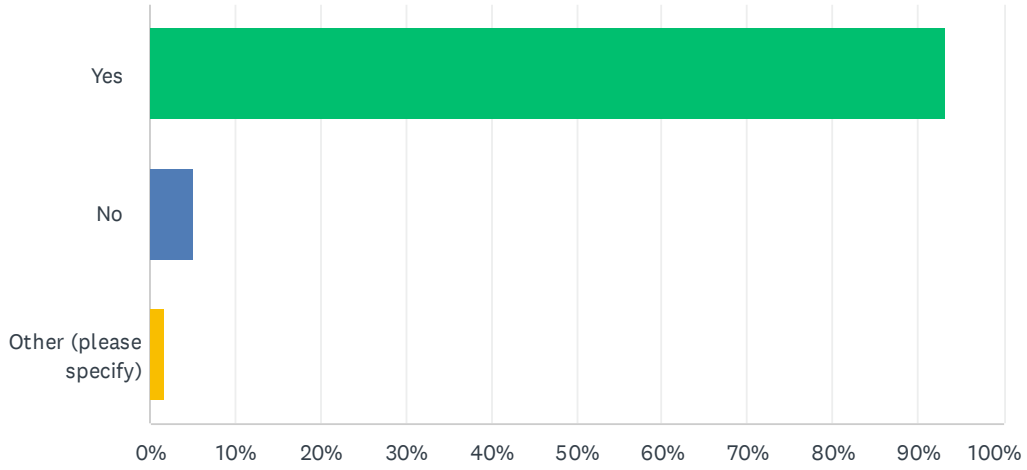


ANSWER CHOICES	RESPONSES	
Yes	94.83%	55
No	5.17%	3
Other (please specify)	0.00%	0
TOTAL		58

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q2 Is there a clear process to report errors and mistakes at your workplace?

Answered: 59 Skipped: 0

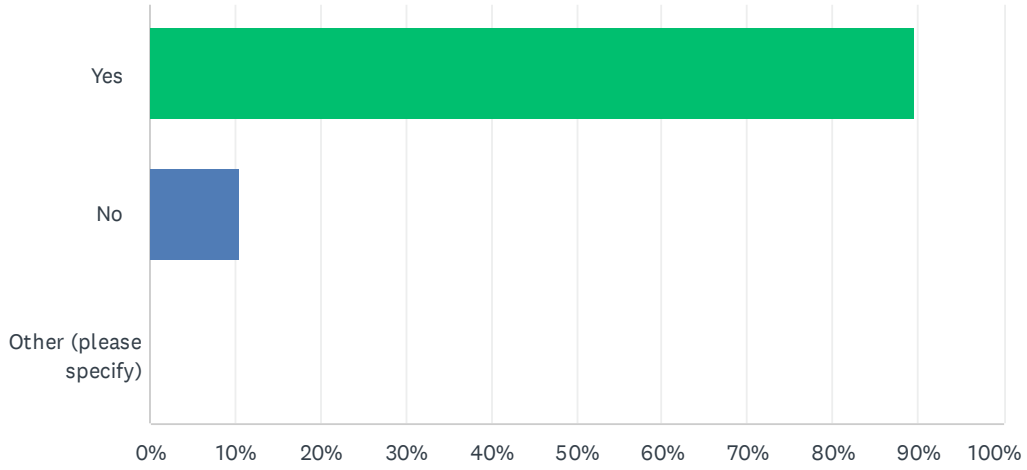


ANSWER CHOICES	RESPONSES	
Yes	93.22%	55
No	5.08%	3
Other (please specify)	1.69%	1
TOTAL		59

#	OTHER (PLEASE SPECIFY)	DATE
1	The is a process, leadership makes it unclear on when and how to use it.	8/4/2025 2:40 PM

Q3 Do you feel comfortable reporting errors and mistakes with no fear of repercussions?

Answered: 58 Skipped: 1

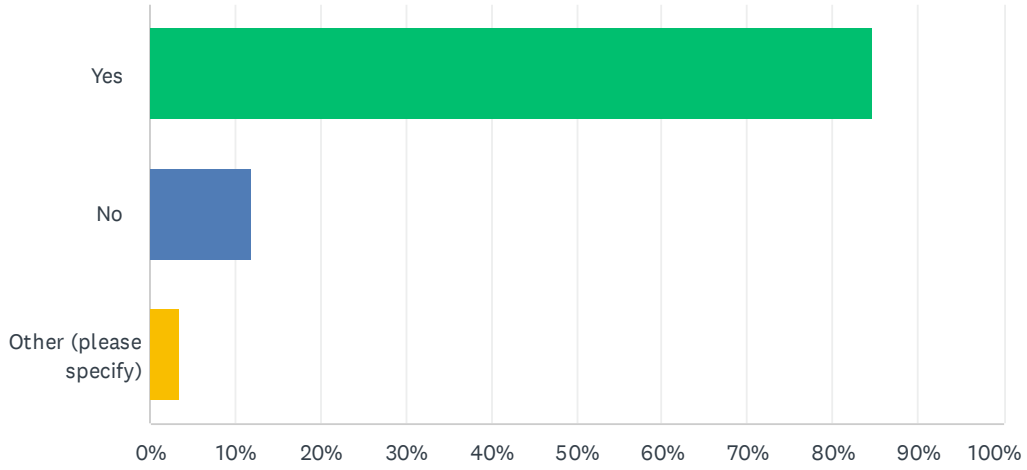


ANSWER CHOICES	RESPONSES	
Yes	89.66%	52
No	10.34%	6
Other (please specify)	0.00%	0
TOTAL		58

#	OTHER (PLEASE SPECIFY)	DATE
	There are no responses.	

Q4 Does your workplace perform a root cause and system weakness investigation rather than assign blame to individuals?

Answered: 59 Skipped: 0

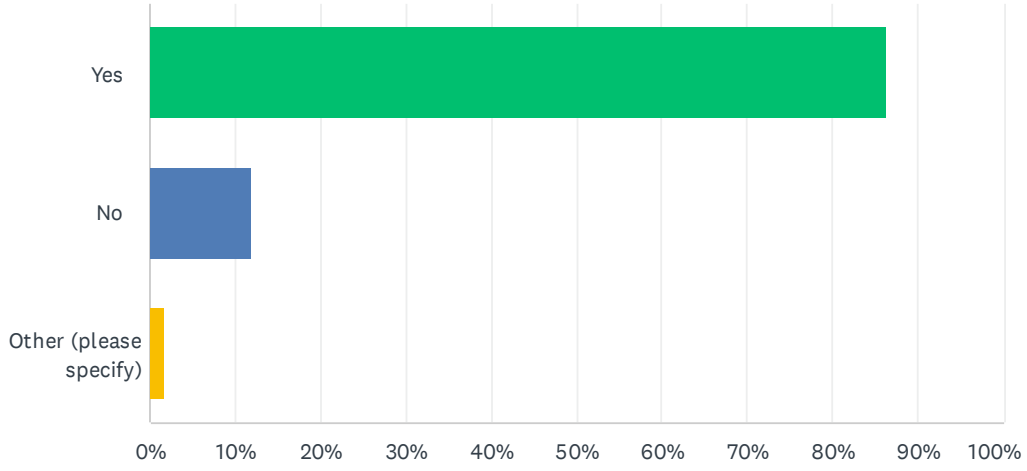


ANSWER CHOICES	RESPONSES	
Yes	84.75%	50
No	11.86%	7
Other (please specify)	3.39%	2
TOTAL		59

#	OTHER (PLEASE SPECIFY)	DATE
1	Depends on what type of problem or error was made.	8/4/2025 2:40 PM
2	They try to, but don't always do as good of a job at it as they probably want to or should	6/9/2025 4:24 PM

Q5 Are mistakes seen as a learning opportunity at your workplace?

Answered: 59 Skipped: 0

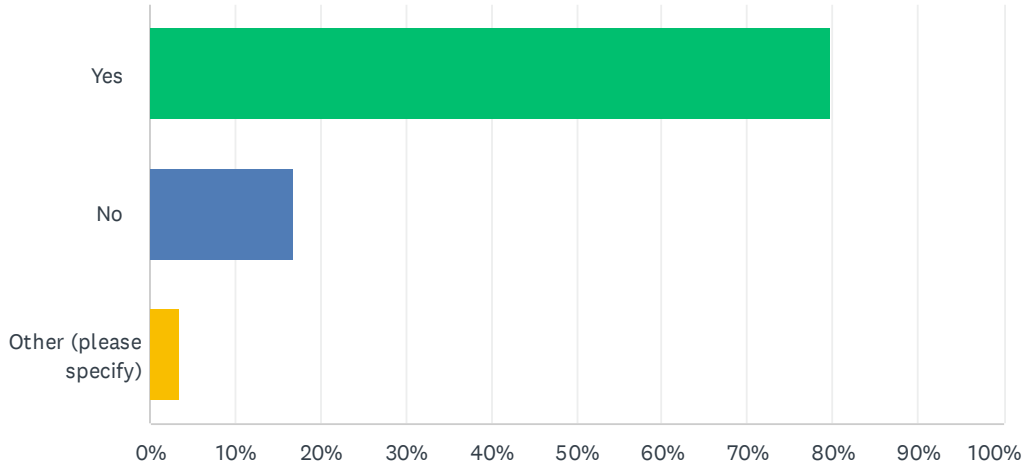


ANSWER CHOICES	RESPONSES	
Yes	86.44%	51
No	11.86%	7
Other (please specify)	1.69%	1
TOTAL		59

#	OTHER (PLEASE SPECIFY)	DATE
1	Nothing ever changes; they just steamroll ahead with whatever asinine ideas come into their ridiculous C-suite brains, regardless of how unsafe their ideas/practices are.	6/10/2025 9:24 AM

Q6 Are systems continually being analyzed and improved at your workplace?

Answered: 59 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	79.66%	47
No	16.95%	10
Other (please specify)	3.39%	2
TOTAL		59

#	OTHER (PLEASE SPECIFY)	DATE
1	It’s grossly under staffed and my work load is obscenely heavyI don’t even care if I make a mistake I just want to get out of of there at the end of my sentence.The board shouldn’t be cucks for the big business end of pharmacy! You should be more about better working conditions for the peon pharmacist	8/4/2025 8:39 PM
2	see above	6/10/2025 9:24 AM

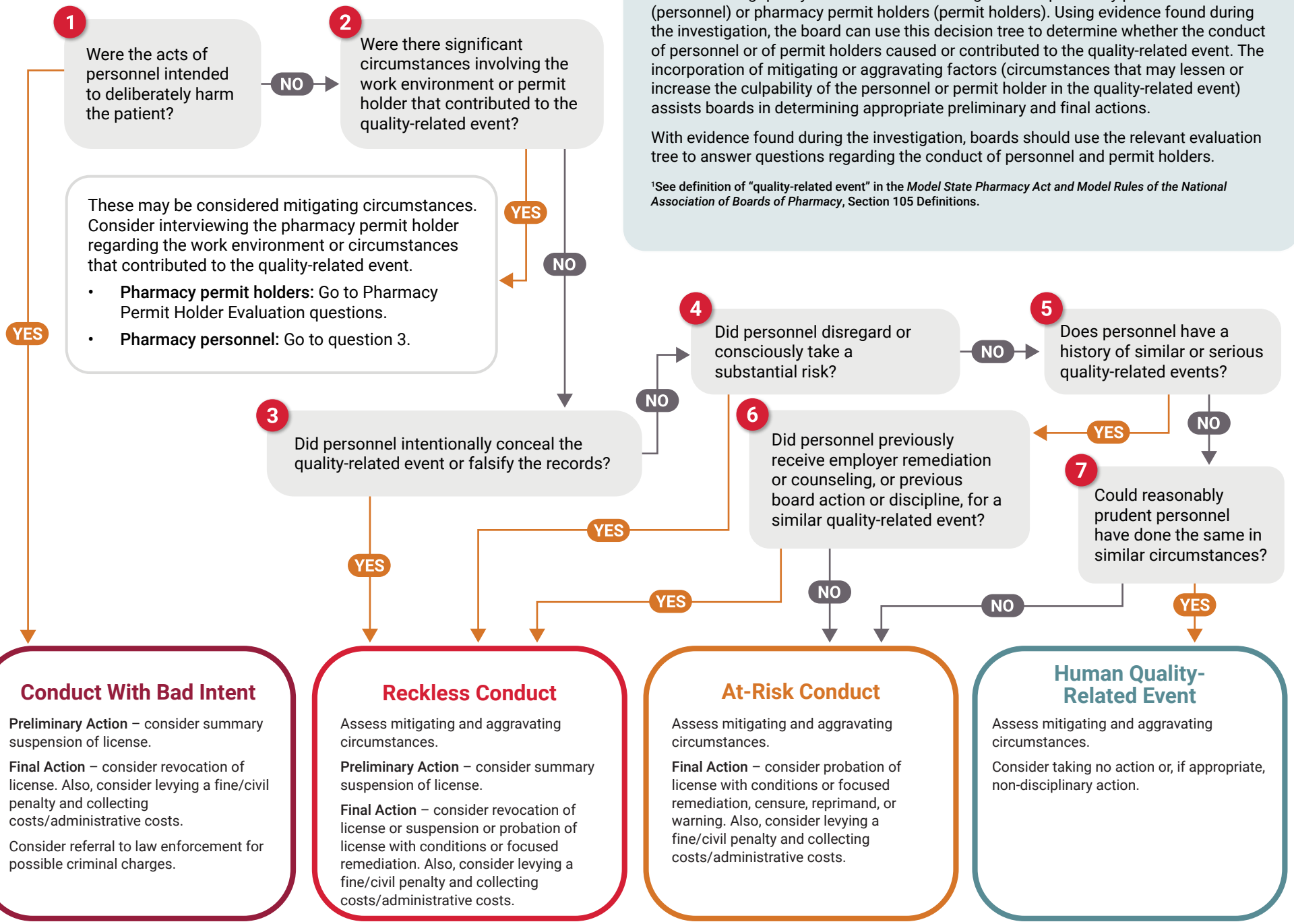
NABP
National Association of Boards of Pharmacy

Board of Pharmacy Action Decision Tree — Pharmacy Personnel Evaluation

The Board of Pharmacy Action Decision Tree is designed to assist boards of pharmacy with evaluating quality-related events[1] involving licensed pharmacy personnel (personnel) or pharmacy permit holders (permit holders). Using evidence found during the investigation, the board can use this decision tree to determine whether the conduct of personnel or of permit holders caused or contributed to the quality-related event. The incorporation of mitigating or aggravating factors (circumstances that may lessen or increase the culpability of the personnel or permit holder in the quality-related event) assists boards in determining appropriate preliminary and final actions.

With evidence found during the investigation, boards should use the relevant evaluation tree to answer questions regarding the conduct of personnel and permit holders.

[1]See definition of "quality-related event" in the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy*, Section 105 Definitions.



NABP
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Board of Pharmacy Action Decision Tree — Pharmacy Permit Holder Evaluation

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With evidence found during the investigation, boards should use the relevant evaluation tree to answer questions regarding the conduct of personnel and permit holders.

[1]See definition of "quality-related event" in the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy*, Section 105 Definitions.

1 Were the acts of the permit holder intended to deliberately harm the patient?

- YES → **Conduct With Bad Intent**
- NO → **2**

2 Did the permit holder intentionally conceal the quality-related event or falsify the records?

- YES → **Reckless Conduct**
- NO → **3**

3 Did the permit holder disregard or consciously take a substantial risk?

- YES → **Reckless Conduct**
- NO → **4**

4 Does the permit holder have a history of similar or serious quality-related events?

- YES → **Reckless Conduct**
- NO → **5**

5 Is the permit holder in violation of state pharmacy laws or rules regarding working conditions?

- YES → **At-Risk Conduct**
- NO → **6**

6 Are prohibited performance metrics, quotas, and measured wait times used?

- YES → **At-Risk Conduct**
- NO → If policies and procedures of permit holders support safety and just culture, consider referring to the Pharmacy Personnel Evaluation to review actions of personnel.

Conduct With Bad Intent

Preliminary Action – consider summary suspension of permit/license.

Final Action – consider revocation of license. Also, consider levying a fine/civil penalty and collecting costs/administrative costs.

Consider referral to law enforcement for possible criminal charges.

Reckless Conduct

Assess mitigating and aggravating circumstances.

Preliminary Action – consider summary suspension of license.

Final Action – consider revocation of license or suspension or probation of license with conditions or focused remediation. Also, consider levying a fine/civil penalty and collecting costs/administrative costs.

At-Risk Conduct

Assess mitigating and aggravating circumstances.

Final Action – consider probation of license with conditions or focused remediation, censure, reprimand, or warning. Also, consider levying a fine/civil penalty and collecting costs/administrative costs.

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, and Economic Development

DIVISION OF CORPORATIONS, BUSINESS AND PROFESSIONAL LICENSING
Juneau Office

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550
Fax: 907.465.2974

Medical Spa Services Frequently Asked Questions
DRAFT 7-11-25

This document is intended to assist in interpretation of Alaska statutes and regulations regarding various medical spa services. This draft will be reviewed from time to time by the Medical Spa Services Work Group, then circulated to relevant professional licensing boards for final approval prior to publication. This work draft should not be relied upon as a final interpretation or alternative to the law. Certain regulations are included below; always review the entirety of statutes and regulations of the appropriate programs and seek attorney assistance when needed. Last Medical Spa Services Work Group review: June 11, 2025

MEDICAL DIRECTOR AND CLINIC OVERSIGHT

- **What is a medical spa?**
  A "medical spa" is not a term specifically recognized in Alaska law, though the services rendered and personnel performing them may be regulated by one or more professional licensing boards. For the purpose of this FAQ, a "medical spa" is a popular term of art describing a clinic where medical procedures and services may be delivered, albeit in a more casual or consumer-focused setting than a traditional clinic and potentially alongside nonmedical services. Medical spas themselves are not specifically regulated as a unique *entity* by the state, though licensees advertising or performing medical or esthetics services and procedures are. A medical facility regulated by the Department of Health that offers medical spa services may have additional requirements than those outlined in this FAQ.

  The term "medical spa services" is also not specifically defined in Alaska law. For the purpose of this analysis, examples of medical spa services include, but are not limited to, all aspects of oversight, diagnosis, prescription, administration, and follow-up care for elective cosmetic and wellness-related medical activities if performed outside a traditional medical setting. Some of the services reviewed by the Medical Spa Services Work Group are discussed below.

- **Who may serve as the "medical director"?**
  "Medical director" is not a term specifically found in Alaska law. Within this context, a medical director is considered anyone who has the legal authority to supervise or delegate medical or nursing activities: A physician or physician assistant licensed by the Alaska State Medical Board or an advanced practice registered nurse licensed by the Alaska Board of Nursing and operating within a population focus with a lifespan scope. An APRN may not practice outside of their designated population focus.

  A person serving as the medical director of a spa or clinic providing services requiring professional licensure takes on the responsibility of ensuring delegation is appropriate under state law and within their own scope of practice, including ensuring the appropriateness of any licensing, training, and education of persons to whom they are delegating.

  A registered nurse, licensed practical nurse, chiropractor, dentist, physical therapist, massage therapist, EMT, paramedic, or other licensed health care provider may not evaluate, diagnose, determine, or

delegate treatment for a patient in a general medical spa or IV hydration clinic setting. Refer to the individual scopes of practice for these licenses and certifications.

- **What services may a physician or physician assistant delegate, and what are those requirements?** 12 AAC 40.967(32) prohibits a Medical Board licensee from permitting patient care that includes administering a botulinum toxin or dermal filler, autotransplanting biological materials, or treating with chemical peels below the dermal layer, or hot lasers, by a person who is not an appropriate health care provider trained and licensed under AS 08 to perform the treatment.

  Otherwise, if a licensee with the ability to delegate determines the procedure can be delegated and the licensee and the person to whom they are delegating meet the qualifications--both of which as determined within reason by the licensee under statute or regulation--then the delegation is permissible.

  What procedures are *permissible and not permissible* to be delegated are spelled out at 12 AAC 40.920(e) and (f):

  (e) Routine medical duties that may be delegated to another person under the standards set out in this section means duties that

  (1) occur frequently in the daily care of a patient or group of patients;
  (2) do not require the person to whom the duty is delegated to exercise professional medical knowledge or judgment;
  (3) do not require the exercise of complex medical skills;
  (4) have a standard procedure and predictable results; and
  (5) present minimal potential risk to the patient.

  (f) Duties that require the exercise of professional medical knowledge or judgment or complex medical skills may not be delegated. Duties that may not be delegated include

  (1) the assessment of the patient's medical condition, and referral and follow-up;
  (2) formulation of the plan of medical care and evaluation of the patient's response to the care provided;
  (3) counseling of the patient and the patient's family or significant others regarding the patient's health;
  (4) transmitting verbal prescription orders, without written documentation, from the patient's health care provider;
  (5) duties related to pain management and opioid use and addiction;
  (6) the initiation, administration, and monitoring of intravenous therapy, including blood or blood products;
  (7) the initiation administration, and monitoring of procedural sedation;
  (8) assessing sterile wound or decubitus ulcer care;
  (9) managing and monitoring home dialysis therapy;
  (10) oral tracheal suction;
  (11) medication management for unstable medical conditions requiring ongoing assessment and adjustment of dosage or timing of administration;
  (12) placement and administration of nasogastric tubes and fluids;
  (13) initial assessment and management of newly-placed gastrostomy tubes and the patient's nutrition; and
  (14) the administration of injectable medications, unless

  (A) it is a single intramuscular, intradermal, or subcutaneous injection, not otherwise prohibited under 12 AAC 40.967(33); and
  (B) all other provisions of this section are met; and
  (C) the delegating physician, podiatrist, osteopath, or physician assistant is immediately available on site.

  The circumstances under which delegable procedures may be delegated, how the unlicensed practice must be supervised, and how a medical director makes those assessments are substantially addressed for medicine at 12 AAC 40.920(a) – (d):

(a) A physician, podiatrist, osteopath, or physician assistant licensed under AS 08.64 may delegate the performance of routine medical duties to an agent of the physician, podiatrist, osteopath, or physician assistant, if the following conditions are met:

(1) the duty to be delegated must be within the scope of practice of the delegating physician, podiatrist, osteopath, or physician assistant;

(2) a licensed physician, podiatrist, osteopath, or physician assistant must assess the patient's medical condition and needs to determine if a duty for that patient may be safely delegated;

(3) the patient's medical condition must be stable and predictable;

(4) the person to whom the duty is to be delegated has received the training needed to safely perform the delegated duty, and this training has been documented;

(5) the delegating physician, podiatrist, osteopath, or physician assistant determines that the person to whom a duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;

(6) performance of the delegated duty would not require the person to whom it is delegated to exercise professional medical judgment or have knowledge of complex medical skills;

(7) the delegating physician, podiatrist, osteopath, or physician assistant provides to the person, with a copy maintained on record, written instructions that include

(A) a clear description of the procedure to follow to perform each task in the delegated duty;

(B) the predicted outcomes of the delegated task;

(C) procedures for observing, reporting, and responding to side effects, complications, or unexpected outcomes in the patient; and

(D) the procedure to document the performance of the duty in the patient's record.

(b) A physician, podiatrist, osteopath, or physician assistant who has delegated a routine duty to another person shall provide appropriate direction and supervision of the person, including the evaluation of patient outcomes. Another physician, podiatrist, osteopath, or physician assistant may assume delegating responsibilities from the delegating physician, podiatrist, osteopath, or physician assistant if the substitute physician, podiatrist, osteopath, or physician assistant has assessed the patient, the skills of the person to whom the delegation was made, and the plan of care. Either the original or substitute delegating physician, podiatrist, osteopath, or physician assistant shall remain readily available for consultation by the person to whom the duty is delegated, either in person or by telecommunication.

(c) The delegation of a routine duty to another person under this section is specific to that person and for that patient, and does not authorize any other person to perform the delegated duty.

(d) The physician, podiatrist, osteopath, or physician assistant who delegated the routine duty to another person remains responsible for the quality of the medical care provided to the patient.

In every consideration of delegation, the delegating physician or physician assistant must decide what constitutes appropriate professional judgment as it pertains to their interpretation of these cited regulations. The AMA Code of Ethics adopted by reference by the Medical Board at 12 AAC 40.955 provides useful guidance as to what appropriate professional judgment looks like in a medical director who is licensed under AS 08.64.

- **What services may an advanced practice registered nurse delegate, and what are those requirements?**

If a licensee with the ability to delegate determines the procedure can be delegated and the licensee and the person to whom they are delegating meet the qualifications--both of which as determined within reason by the licensee under statute or regulation--then the delegation is permissible.

The board has formally adopted a regulation regarding scope of practice that generally refers to activities allowable by an APRN, in addition to other requirements pertaining to licensure in the APRN's population focus, prescriptive authority, etc.:

12 AAC 44.430. SCOPE OF PRACTICE. The board recognizes advanced and specialized acts of nursing practice as those described in the scope of practice statements published by national professional nursing associations recognized by the board for advanced practice registered nurses certified by the national certification bodies recognized by the board.

The procedures that are *permissible* to be delegated to unlicensed persons are fairly well spelled out in 12 AAC 44.955, .960, .965, .966, .970, .975.

The circumstances under which delegable procedures may be delegated, how the unlicensed practice must be supervised, and how an APRN makes those assessments are substantially addressed for nursing at 12 AAC 44.950 and .975.

12 AAC 44.950. Standards for delegation of nursing duties to other persons

(a) A nurse licensed under AS 08.68 may delegate the performance of nursing duties to other persons, including unlicensed assistive personnel, if the following conditions are met:

(1) the nursing duty to be delegated must be within the scope of practice of the delegating nurse;

(2) a registered nurse must assess the patient's medical condition and needs to determine if a nursing duty for that patient may be safely delegated to another person;

(3) the patient's medical condition must be stable and predictable;

(4) the person to whom the nursing duty is to be delegated has received the training needed to safely perform the delegated duty, and this training has been documented;

(5) the nurse determines that the person to whom a nursing duty is to be delegated is competent to perform the delegated duty correctly and safely and accepts the delegation of the duty and the accountability for carrying out the duty correctly;

(6) performance of the delegated nursing duty would not require the person to whom it was delegated to exercise professional nursing judgment or knowledge or complex nursing skills;

(7) the nurse provides to the person, with a copy maintained on record, written instructions that include

(A) a clear description of the procedure to follow to perform each task in the delegated duty;

(B) the predicted outcomes of the delegated nursing task;

(C) how the person is to observe and report side effects, complications, or unexpected outcomes in the patient, and the actions appropriate to respond to any of these; and

(D) the procedure to document the performance of the nursing duty in the patient's record.

(b) A nurse who has delegated a nursing duty to another person shall provide appropriate direction and supervision of the person, including the evaluation of patient outcomes. Another nurse may assume delegating responsibilities from the delegating nurse if the substitute nurse has assessed the patient, the skills of the person to whom the delegation was made, and the plan of care. Either the original delegating nurse or the substitute nurse shall remain readily available for consultation by the person, either in person or by telecommunication.

(c) The delegation of a nursing duty to another person under this section is specific to that person and for that patient, and does not authorize any other person to perform the delegated duty.

(d) The nurse who delegated the nursing duty to another person remains responsible for the quality of the nursing care provided to the patient.

12 AAC 44.955 Delegation of routine nursing duties

(a) Routine nursing duties may be delegated to another person under the standards set out in 12 AAC 44.950. Routine nursing duties are those that

(1) occur frequently in the daily care of a patient or group of patients;

(2) do not require the person to whom the duty is delegated to exercise professional nursing knowledge or judgment;

(3) do not require the exercise of complex nursing skills;

(4) have a standard procedure and predictable results; and

(5) present minimal potential risk to the patient.

(b) Routine nursing duties that may be delegated include

(1) monitoring bodily functions;

(2) taking and recording vital signs;

(3) transporting patients;

(4) non-invasive collection and testing of physical specimens;

(5) measuring and recording fluid and food intake and output; and

(6) personal care tasks such as bathing, oral hygiene, dressing, toileting, assisting with eating, hydrating, and skin care.

12 AAC 44.960 Delegation of specialized nursing duties

(a) Specialized nursing duties are those duties that do not require professional nursing education to correctly perform, but require more training and skill than routine nursing duties. Specialized nursing duties may be delegated to another person under the standards set out in 12 AAC 44.950.

(b) Specialized nursing tasks that may be delegated include

(1) changing simple, nonsterile dressings using aseptic technique when no wound debridement or packing is involved;

(2) assisting patients with self-medication;

(3) obtaining blood glucose levels;

(4) suctioning of the oral pharynx;

(5) providing tracheostomy care in established, stable patients;

(6) removal of internal or external urinary catheters;

(7) adding fluid to established gastrostomy tube feedings and changing established tube feeding bags; and

(8) placing electrodes and leads for electrocardiogram, cardiac monitoring, and telemetry.

(c) A nurse who delegates a nursing duty to another person under this section shall develop a nursing delegation plan that describes the frequency and methods of evaluation of the performance of the delegated duty by the other person. The delegating nurse shall evaluate a continuing delegation as appropriate, but must perform an evaluation on-site at least once every 90 days after the delegation was made. The delegating nurse shall keep a record of the evaluations conducted.

12 AAC 44.970. Nursing duties that may not be delegated.

Nursing duties that require the exercise of professional nursing knowledge or judgment or complex nursing skills may not be delegated. Nursing duties that may not be delegated include

(1) the comprehensive assessment of the patient by a registered nurse, and referral and follow-up;

(2) the focused assessment of the patient by a licensed practical nurse;

(3) formulation of the plan of nursing care and evaluation of the patient's response to the care provided;

(4) health education and health counseling of the patient and the patient's family or significant others in promoting the patient's health;

(5) receiving or transmitting verbal, telephone, or written orders from the patient's health care provider;

(6) the initiation, administration, and monitoring of intravenous therapy, including blood or blood products;

(7) providing and assessing sterile wound or decubitus ulcer care;

(8) managing and monitoring home dialysis therapy;

(9) oral tracheal suction;

(10) medication management for unstable medical conditions requiring ongoing assessment and adjustment of dosage or timing of administration;

(11) placement and administration of nasogastric tubes and fluids;

(12) initial assessment and management of newly-placed gastrostomy tubes and the patient's nutrition;

(13) except as provided in 12 AAC 44.966, the administration of injectable medications.

12 AAC 44.975. Exclusions

The provisions of 12 AAC 44.950 – 12 AAC 44.970 apply only to the delegation of nursing duties by a nurse licensed under AS 08.68; they do not apply when nursing duties have not been delegated, including when a person is acting
(1) within the scope of the person's own license;
(2) under other legal authority; or
(3) under the supervision of another licensed health care provider.

In every consideration of delegation, the delegating physician or physician assistant must decide what constitutes appropriate professional judgment as it pertains to their interpretation of these cited regulations. In addition to the statutes and regulations of the board, we can usually turn to the code of ethics adopted by the board in regulation as an additional standard. The Board of Nursing has not officially adopted a code of ethics in regulation; however, nurses informally lean on codes published by national nursing associations that generally echo the same principles.

Note that 12 AAC 44.770 spells out unprofessional conduct, including a list of examples. Nursing conduct that could adversely affect the health and welfare of the public constitutes unprofessional conduct under AS 08.68.270(7).

- **Does the medical director need to be onsite? When is telemedicine allowed?**
  The medical director must remain readily available for consultation by the person to whom the duty is delegated, either in person or by telecommunication. An initial consultation with a patient may happen via telecommunication. During medical procedures, a person with the appropriate level of licensure to perform the procedure and manage emergencies according to established facility protocols should always be onsite. Medical director should be immediately available (by phone or text) in case of complications.

- **Who can perform patient evaluations, diagnose conditions requiring treatment, and make treatment recommendations?**
  A physician, physician assistant, or advanced practice registered nurse may evaluate patients, perform diagnoses, and make recommendations for treatment. Registered nurses, licensed practical nurses, medical assistants, and other persons with appropriate training may be delegated certain functions relating to patient intake, such as performing an interview regarding symptoms and medical history and taking vital signs. This information helps inform the physician, physician assistant, or advanced practice registered nurse in performing their patient evaluation.

  Although medical spas may offer services that are not medically necessary, or they may consider themselves "wellness"—rather than medical—institutions, the medical cosmetic procedures and hydration services they provide fall under the delivery of medical or nursing services and are regulated by the State Medical Board and Board of Nursing.

- **Who can obtain, prescribe, administer, or dispense prescription medicines and products?**
  A licensee with prescriptive authority and who is practicing within their scope, such as a physician, physician assistant, or advanced practice registered nurse. Delegation requirements are spelled out in the statutes and regulations of each board. A dentist may do so within the practice of dentistry, which does not include most esthetics procedures.

  Standing orders are unique to each patient. They may not be generally given for a class or group of patients. Any changes to an individual's standing orders must include evaluation and written changes by the medical director or other provider in the practice who is an Alaska-licensed physician, physician assistant, or advanced practice registered nurse.

- **What are the requirements for medical recordkeeping, HIPAA, etc.?**

Medical spas and hydration clinics must adhere to all recordkeeping standards relevant to the practitioner's license, state and federal laws, and other standards that may apply to their individual situations, such as insurance requirements. Each facility should have a written protocol for recordkeeping.

- **What is the legal risk for a medical director?**
  The risk is the same as it would be for any practitioner within any other medical practice. If a licensee delegates authority to another person, they also assume the risk associated with actions by that individual. If the medical director is also the owner of the facility, additional liabilities regarding the workplace or public access may apply.

  Any facility where medical services are provided should have written emergency protocols, both to address general crises and those specific to the potential risks of the procedures performed. Providers should be trained on monitoring patients for adverse outcomes and how to respond in case of an emergency. The medical director should always be available onsite or by telecommunication.

EMTs AND PARAMEDICS

The State EMS Medical Director and State EMS Medical Direction Committee are solely responsible for the scope of practice and medical direction for EMS and Paramedics in the state. The scope of practice for these individuals is limited to procedures authorized in regulation or by the EMS Medical Director.

The activities of these personnel are contemplated within the context of basic or advanced life support (ALS) and only under the supervision of a sponsoring physician. There is currently no authorization for certified EMS personnel or Paramedics to practice advanced procedures outside of ALS activities, such as performing procedures authorized within their certification while employed at a medical spa. Doing so can constitute a breach of the EMS regulations, placing an ALS EMS clinician at professional risk.

ESTHETICS

1. **What services may an Alaska-licensed esthetician provide under their own license?**
   A person providing esthetics services must be licensed as an esthetician by the Alaska Board of Barbers and Hairdressers or be licensed in Alaska as a health care professional. Certain limited exceptions may apply; please refer to AS 08.13.160(d). Holding a "license" or "certification" by the manufacturer of an esthetics device does not in itself authorize the individual to legally use that device on another person. With limited exception, estheticians must practice in a shop licensed by the board.

   Per AS 08.13.220, "esthetics" means the use of the hands, appliances, cosmetic preparations, antiseptics, or lotions in massaging, cleansing, stimulating, or similar work on the scalp, face or neck, including skin care, make-up, and temporary removal of superfluous hair, for cosmetic purposes for a fee.

   12 AAC 09.990(b) clarifies the definition of "appliances":

   > (1) "appliances" in the field of esthetics means only those devices used to stimulate natural physiological processes intended to improve the health and appearance of a person's skin; a device
   >
   > (A) operates within the manufacturer's guidelines;
   > (B) does not directly ablate or destroy live tissue;
   > (C) does not involve an incision into skin beyond the epidermis; and
   > (D) is not defined as a Class III or Class IV laser device under 21 C.F.R. 1040.10, revised as of April 2, 2018, and adopted by reference;

2. **What esthetics services may an Alaska-licensed hairdresser provide under their own license?**
   A person licensed by the Alaska Board of Barbers and Hairdressers to practice hairdressing is considered to be licensed to practice manicuring, hair braiding, and limited esthetics under the same license. Per AS 08.13.220, "limited esthetics" means to perform for a fee for cosmetic purposes temporary removal of superfluous hair on the face or neck, including eyebrow arching by use of wax; or application of makeup or false eyelashes. With limited exception, hairdressers must practice in a shop licensed by the board.

3. **What are "advanced esthetics services" and who may provide them?**
The term "advanced esthetics services" is not defined under Alaska law. For the purposes of the Medical Spa Services Work Group and related boards, the term refers to any procedure or service that falls outside of the scope of an Alaska-licensed esthetician, above.

Licenses or certifications in other jurisdictions, by private companies, or by manufacturers of beauty or health care products do not qualify individuals to practice esthetics, nursing, or medicine in Alaska. Persons who do not hold an Alaska license and persons who are licensed and considering performing services outside of their scope should review whether the services or procedures—or the promotion of such services or procedures—qualifies as the practice of medicine under AS 08.64.380 or nursing under AS 08.68.850.

As noted above, the Medical Board has specifically opined that the treatment with chemical peels below the dermal layer or use of hot (ablative) lasers is the practice of medicine and can only be delegated by a physician to a health care provider appropriately trained and licensed to perform the procedure.

AS 08.64.380 (6) "practice of medicine" or "practice of osteopathy" means:

(A) for a fee, donation or other consideration, to diagnose, treat, operate on, prescribe for, or administer to, any human ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition; or to attempt to perform or represent that a person is authorized to perform any of the acts set out in this subparagraph;

(B) to use or publicly display a title in connection with a person's name including "doctor of medicine," "physician," "M.D.," or "doctor of osteopathic medicine" or "D.O." or a specialist designation including "surgeon," "dermatologist," or a similar title in such a manner as to show that the person is willing or qualified to diagnose or treat the sick or injured;

AS 08.68.850 (9) "practice of advanced practice registered nursing" includes, in addition to the practice of registered nursing, the performance of acts of medical diagnosis and the prescription and dispensing of medical, therapeutic, or corrective measures under regulations adopted by the board;

AS 08.68.850 (10) "practice of practical nursing" means the performance for compensation or personal profit of nursing functions that do not require the substantial specialized skill, judgment, and knowledge of a registered nurse;

AS 08.68.850 (11) "practice of registered nursing" means the performance for compensation or personal profit of acts of professional service that requires substantial specialized knowledge, judgment, and skill based on the principles of biological, physiological, behavioral, and sociological sciences in assessing and responding to the health needs of individuals, families, or communities through services that include

(A) assessment of problems, counseling, and teaching

(i) clients to maintain health or prevent illness; and

(ii) in the care of the ill, injured, or infirm;

(B) administration, supervision, delegation, and evaluation of nursing practice;

(C) teaching others the skills of nursing;

(D) execution of a medical regimen as prescribed by a person authorized by the state to practice medicine;

(E) performance of other acts that require education and training that are recognized by the nursing profession as properly performed by registered nurses;

(F) performance of acts of medical diagnosis and the prescription of medical therapeutic or corrective measures under regulations adopted by the board;

<u>IV HYDRATION</u>

1. **What are the general practice requirements for an IV hydration clinic?**
An IV hydration clinic in any form and in any location is considered a medical clinic and must follow all state and federal standards applicable to any other general health care facility.

2. **Who may evaluate, diagnose, and determine treatment for a patient?**
As noted above, a physician, physician assistant, or advanced practice registered nurse may evaluate patients, perform diagnoses, and make recommendations for treatment. A chiropractor, dentist, physical therapist, EMT, paramedic, or other licensed health care provider may not evaluate, diagnose, and determine treatment for a patient in a general medical spa setting. Refer to the individual scopes of practice for these licenses and certifications.

Registered nurses, licensed practical nurses, medical assistants, and other unlicensed persons with appropriate training may be delegated certain functions relating to patient intake, such as performing an interview regarding symptoms and medical history and taking vital signs. This information helps inform the physician, physician assistant, or advanced practice registered nurse who will personally assess the patient's condition and determine a treatment plan. This assessment may be performed in person or through telecommunication but may not be delegated.

Although medical spas may offer services that are not medically necessary or consider themselves "wellness"—rather than medical—institutions, the medical cosmetic procedures and hydration services they provide fall under the delivery of medical or nursing services and are regulated by the State Medical Board and Board of Nursing.

3. **Who may order, and administer substances delivered intravenously?**
Substances administered intravenously, including but not limited to saline and vitamins, require a prescription under federal law. A physician, physician assistant, or advanced practice registered nurse may order prescription medications if authorized under their Alaska license. A dentist may only order and administer prescription substances for use within the practice of dentistry. A chiropractor, physical therapist, massage therapist, or other licensed or certified health care provider without prescriptive authority may not order or administer prescription medication. Refer to the statutes and regulations for each license type for details about each scope of practice.

12 AAC 40.920(f) and (g) prevents a physician or physician assistant from delegating the initiation, administration, and monitoring of intravenous therapy, including blood or blood products. A person with the authority to perform these procedures under the scope of their own license is not restricted from doing so as long as these duties have not been delegated.

A medical director may delegate placing and starting an IV to a registered nurse or licensed practical nurse with an appropriate course of training on administering intravenous medication.

4. **What are the compounding requirements for IV hydration clinics?**
USP <797> governs sterile compounding within the United States. Conditions for sterile compounding are outlined in this federal guidance, including standards for sterile "immediate use" (mixing and using within four hours) and use of a clean room if prepared outside of the immediate use window.

A registered nurse may add an appropriate substance to an IV bag per the medical director order for a specific patient, following USP standards.

BOTOX, FILLERS, and OTHER COSMETIC INJECTABLES

1. **Who may evaluate, diagnose, and determine treatment for a patient?**
As noted above, a physician, physician assistant, or advanced practice registered nurse may evaluate patients, perform diagnoses, and make recommendations for treatment. A chiropractor, dentist, physical therapist, EMT, paramedic, or other licensed health care provider may not evaluate, diagnose, and determine treatment for a patient in a general medical spa setting. Refer to the individual scopes of practice for these licenses and certifications.

Registered nurses, licensed practical nurses, medical assistants, and other unlicensed persons with appropriate training may be delegated certain functions relating to patient intake, such as performing an interview regarding symptoms and medical history and taking vital signs. This information helps inform the physician, physician assistant, or advanced practice registered nurse who will personally assess the patient's condition and determine a treatment plan. This assessment may be performed in person or through telecommunication but may not be delegated.

2. Who may order and administer cosmetic injectables?

A physician, physician assistant, or advanced practice registered nurse may order prescription medications if authorized under their Alaska license. A dentists may order and administer Botox within the scope of practice of dentistry, such as to treat symptoms of TMJ. A dental hygienist is not allowed to administer Botox, fillers, or other cosmetic injectables.

12 AAC 40.967(32) prohibits a Medical Board licensee from permitting patient care that includes administering a botulinum toxin or dermal filler by a person who is not an appropriate health care provider trained and licensed under AS 08 to perform the treatment.

The Board of Nursing has issued an advisory opinion on cosmetic injectables; https://www.commerce.alaska.gov/web/Portals/5/pub/NUR_AO_Medical_Aesthetic_2024.pdf

An esthetician, chiropractor, physical therapist, massage therapist, or other licensed or certified health care provider without prescriptive authority may not order prescription medication. They may not administer prescription medication without proper delegation. Refer to the statutes and regulations for each license type for details about each scope of practice.

Medical Spa Services Work Group

Alaska Division of Corporations, Business and Professional Licensing
Minutes for Wednesday, June 11, 2025, at 4:00 PM AKDT
Held via Teams videoconfererence

Work group members present: April Erickson, Board of Nursing; Ramsey Bell for Ashley Schaber, Board of Pharmacy; Shannon Thompson, Board of Barbers and Hairdressers; John Lloyd, Board of Chiropractic Examiners; David Paulson, State Medical Board

Work group members excused: Kenley Michaud, Board of Dental Examiners

Staff present: Sara Chambers, facilitator; Sylvan Robb, Reid Bowman, Natalie Norberg, Patty Wolf
Members of affiliated boards present: Kevin McKinley and Mae Canady, Board of Barbers and Hairdressers
Public: Approximately half a dozen members of the public were present.

CALL TO ORDER
As facilitator, Ms. Chambers called the Work Group to order at 4:00 p.m. by calling the roll. She noted that a quorum was present and welcomed staff and members of the public who were present. She mentioned that Dr. Michaud could not attend the meeting due to a work commitment, which he had shared with the group when the meeting was scheduled.

She clarified the purpose of the Work Group:

- Identify “lifestyle enhancement” services that have a medical nexus and are currently performed or likely to be performed outside of a medical clinic or without appropriate supervision.
- Identify existing statutes and regulations that govern current requirements for training, licensure, and supervision of these procedures.
- Clarify how licensing boards could—jointly or in part—explain existing statutes and regulations that would help the public and licensees understand how these procedures should be safely administered according to the current laws of the state.
- Suggest changes in statute that would allow defensible and transparent pathways forward for appropriately trained and supervised individuals to provide these services without imposing undue economic or regulatory barriers.
- Carry forward Work Group updates and work products to the member boards for their subsequent review and action.

AGENDA OVERVIEW
Ms. Chambers outlined the meeting agenda, which included a review of an FAQ summarizing the group's work and a discussion on Botox, fillers, and cosmetic injectables. She emphasized the importance of staying on task and invited public comments.

REVIEW CORRESPONDENCE and PUBLIC COMMENT
No public comment or correspondence was received for review.

BOTOX AND COSMETIC INJECTABLES DISCUSSION
Ms. Chambers led a discussion on Botox, fillers, and cosmetic injectables, focusing on who can evaluate, diagnose, and administer these treatments. The group agreed that physicians, physician assistants, and APRNs are qualified to perform these tasks. Dr. Paulson raised a question about dentists' ability to use Botox for cosmetic procedures. Ms. Chambers clarified that the Board of Dental Examiners had explored this topic within the last year and determined dentists, but not dental hygienists, can use Botox within the scope of dentistry, such as for TMJ treatment, but not for general cosmetic purposes. Dr. Erickson supported this clarification.

Delegation and Certification: The group discussed the delegation of tasks to medical assistants and the certification requirements for administering injectables. Ms. Wolf provided information on a specific regulation (12 AAC 44.966) that allows APRNs to delegate injectable medication administration to certified medical assistants. However, upon discussion, it did not seem that the restriction to an "ambulatory care" setting was relevant to medical spas. There was also a question about whether this would be relevant to Botox placement since that is a different procedure than a typical injectable medication. Dr. Erickson will take this topic back to the Board of Nursing to see if additional definition or clarification would be helpful.

Dr. Paulson was interested in exploring licensure of medical assistants beyond the private certification currently addressed in Board of Nursing regulations. Ms. Chambers recounted the proposed legislation attempting to license medical assistants in or around 2018, which was defeated by the medical industry. Dr. Erickson mentioned that medical assistant training was a topic the Board of Nursing was already discussing.

DRAFT MEDICAL SPA SERVICES FREQUENTLY ASKED QUESTIONS REVIEW

The group walked through most of the areas of the draft FAQ Ms. Chambers had provided, stating that for the most part, they thought it was well-written and was ready for further review by each board.

Medical Director and Clinic Oversight: Ms. Chambers explained the roles and responsibilities of a medical director, emphasizing that they must have the legal authority to supervise or delegate medical or nursing activities. She clarified that "medical spa" and "medical director" are not legally defined in the state. The group discussed the qualifications and scope of practice for medical directors, with concerns raised by Dr. Paulson and Dr. Erickson regarding whether a physician assistant could serve as a medical director since they cannot practice independently. Ms. Chambers said she would note that concern for the Medical Board to discuss, particularly whether that service could be included in the collaborative agreement and, if so, what the legal impact would be to the supervising physician.

Chiropractic Scope of Practice: Dr. Lloyd raised concerns about the inclusion of laser and tattoo removal services in the FAQ, arguing that these services fall within the scope of chiropractic practice. The group discussed who would be "an appropriate health care provider trained and licensed under AS 08 to perform the treatment" per the Medical Board's regulation 12 AAC 40.967(32). There was also discussion about whether chiropractic statutes and regulations permitted or prohibited these practices. They agreed to seek clarification from the Medical Board on this issue. Dr. Lloyd also asked how other practices that are not specifically called out in statute or regulation are regulated, such as acoustical soundwave therapy for treatment of erectile dysfunction. He said he did not agree that use of lasers is restricted to those who hold a medical license; it is part of the practice of chiropractic since it addresses whole body wellness. Ms. Chambers said she would request clarification on that and reiterated that the current goal of this work group is to clarify what the existing statutes and regulations say about common medical spa practices; proposed changes to current statutes and regulations can be addressed in the near future.

EMS Professionals and Work in Medical Spas

Ms. Chambers mentioned that she worked with the State EMS Medical Director to clarify that EMS professionals and paramedics may not work within a medical spa setting. It is not covered within their license and puts their certification at risk.

Future Meetings

Ms. Chambers encouraged work group members to provide feedback and announced plans to schedule a follow-up meeting in mid-July, pending feedback from the Department of Law on the questions raised at this meeting. The goal would be to perfect a draft for each board to review at their upcoming August meetings.

ADJOURN

Having no further business to come before it, the work group adjourned the meeting at approximately 5:00 p.m.

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Commerce, Community, & Economic Development

Corporations, Business, & Professional Licensing
Board of Pharmacy

P.O. Box 110806
Juneau, Alaska 99811-0806
Main: 907.465.2550
Fax: 907.465.2974

July 23, 2025

Statement Regarding Epinephrine Administration

On August 9, 2024, the U.S. Food and Drug Administration approved *neffy* (epinephrine nasal spray) for the emergency treatment of allergic reactions (Type I), including those that are life-threatening (anaphylaxis), in adult and pediatric patients who weigh at least 30 kilograms (about 66 pounds).[1, 2]

Alaska Statute (AS) 08.80.030(b)(12), AS 08.80.168(e), and AS17.22.010 codified the availability of epinephrine for the treatment of emergencies, identifying auto-injector as a method of administrating epinephrine. This advisory seeks to make clear that the language in AS 08.80.030(b)(12), AS 08.80.168(e), and AS 17.22.010 regarding the administration of epinephrine, **applies to ALL available, FDA-approved, pre-dosed forms of epinephrine.**

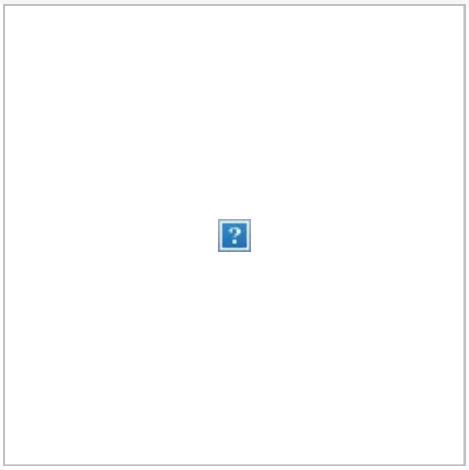
Sincerely,

Ashley Schaber, PharmD, MBA, BCPS
Chair, Alaska Board of Pharmacy

[1]Press Release, U.S. Food & Drug Admin., FDA Approves First Nasal Spray for Treatment of Anaphylaxis (Aug. 9, 2024), *available at* https://www.fda.gov/news-events/press-announcements/fda-approves-first-nasal-spray-treatment-anaphylaxis

[2] More information about *neffy*, including indications, dosing, and instructions for administration can be found on the product website: https://neffypro.com/

From: NABP
To: Bowles, Michael P (CED)
Subject: Pharmacy organizations collaborate to prioritize pharmacy workforce well-being and mental health
Date: Tuesday, July 8, 2025 9:22:05 AM



FOR IMMEDIATE RELEASE
July 8, 2025
Media Contact: media@nabp.pharmacy

Pharmacy organizations collaborate to prioritize pharmacy workforce well-being and mental health

MOUNT PROSPECT, IL – On June 22-23, 2025, the American Pharmacists Association (APhA), American Society of Health-System Pharmacists (ASHP), and National Association of Boards of Pharmacy (NABP) reaffirmed their commitment to strengthening the pharmacy workforce and prioritizing mental health and well-being during an invitation-only event, *"Implementing Solutions Summit 2.0: Building a Sustainable, Healthy, Pharmacy Workforce and Workplace."* The summit brought together over 80 pharmacy professionals from across all practice settings to share progress, explore challenges, and identify new strategies to improve workplace conditions for pharmacists and pharmacy personnel.

The summit, a follow-up to a convening held in 2023, was conducted in response to persistent reports of challenging workplace environments and the ongoing stigma surrounding mental health support. Leaders at the summit acknowledged the emotional toll that high-stress work environments can have on pharmacists and

pharmacy personnel and the need for safer, more supportive spaces where pharmacy professionals feel seen, valued, and able to ask for help without fear or stigma. The summit called for continued investment in mental health resources, peer support networks, and suicide awareness and prevention.

APhA, ASHP, and NABP remind all pharmacists and pharmacy personnel that if you are feeling alone and having thoughts of suicide–whether or not you are in crisis–or know someone who is, talk to someone you can trust by calling or texting “988,” the Suicide & Crisis Lifeline.

Tackling complex workforce and workplace challenges will require unified action across the profession. APhA, ASHP, and NABP are committed to working collaboratively and strategically to drive meaningful, lasting change. Summit proceedings will be shared by each participating organization in the fall. In the meantime, we encourage all members of the pharmacy profession to explore and utilize the resources currently available through each organization.

APhA – Well-Being and Resiliency

ASHP – Workforce Well-Being and Resilience

NABP – Mental Health Resources for Pharmacy Staff

About APhA

APhA is the only organization advancing the entire pharmacy profession. Our expert staff and strong volunteer leadership, including many experienced pharmacists, allow us to deliver vital leadership to help pharmacists, pharmaceutical scientists, student pharmacists, and pharmacy technicians find success and satisfaction in their work and advocate for changes that benefit them, their patients, and their communities. For more information, please visit pharmacist.com.

About ASHP

ASHP is the largest association of pharmacy professionals in the United States, representing 60,000 pharmacists, student pharmacists, and pharmacy technicians in all patient care settings, including hospitals, ambulatory clinics, and health-system community pharmacies. For over 80 years, ASHP has championed innovation in pharmacy practice, advanced education, and professional development, and served as a steadfast advocate for members and patients. In addition, ASHP is the accrediting body for pharmacy residency and technician training programs and provides comprehensive resources to support pharmacy professionals through every stage of their careers. For more information, visit ashp.org and ASHP’s consumer website, SafeMedication.com. Learn more about ASHP’s public awareness campaign at

yourpharmacist.org.

About NABP

NABP is the independent, international, and impartial 501(c)(3) nonprofit Association that assists its state member boards and jurisdictions for the purpose of protecting the public health. NABP was established in 1904 to assist the state boards of pharmacy in creating uniform education and licensure standards. Today, we help support patient and prescription drug safety through examinations that assess pharmacist competency, pharmacist licensure transfer and verification services, and various pharmacy accreditation and inspection programs.

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Alaska Board of Pharmacy

Agenda Item #12

Tasks List Review and Update

ALASKA BOARD OF PHARMACY
TASK LIST - ACTION ITEMS
(as of 08/07/2025)

	Incomplete Action Items from Previous Meetings
	Task created for Ramsey Bell to update all inspection forms for pharmacies and facilities.
	Task created for Ramsey Bell to review the self-inspection form for updated regulations and bring the pharmacy inspection form into alignment with the self-inspection form.
	Task created for all board members to review the statute and regulations to work on standard of care regulatory language changes. Ashley Schaber - vaccines Carla Hebert - medipak Sylvain Nouvion - security Julie McDonald - TBD Dylan Sanders- labeling
	Task created for Michael Bowles to meet with PDMP to coordinate meeting with healthcare related board chairs.
	Task for the board to track what other state boards are doing with AI. (Carla Hebert is spearheading)
	Task created for the board to follow up on pharmacies turning off e-prescribing during closures.
	Action Items from May 22, 2025 Meeting
	Task for the board to review the Ensuring Community Access Act (ECAPS) at the August meeting.
	Task for Michael Bowles to reach out to the Alaska Department of Health and request a representative provide a presentation to the board on harm reduction and Buprenorphine in EMS in Alaska.
	Task for Michael Bowles to add NABP Just Culture Decision Tree to August agenda.
	Task created for Michael Bowles to add the two new epinephrine auto-injector training programs to the board of pharmacy website.
	Task for the board to submit a letter to the legislature thanking him for the Red Cross training recommendation.
	Task for board members to review 12 AAC 52.865/AS 17.30.200 PDMP alongside long lasting injectables.
	Task for Lisa Sherrell to reach out to PDMP managers in other states to request information on how they address long lasting injectables in their PDMPs.
	Task for the board to add the ACPE accreditation report to the August meeting agenda.
	Task created for Michael Bowles to send the Industrial Hemp and Intoxicating Hemp Products FAQ for Professional Licensees document out via listserv.
	Task created for Michael Bowles to word smith and finalize strategic plan wording and place in OnBoard for final vote approval.
	Task created to add standard of care regulations changes to August agenda.
	Task created for Ashley Schaber to investigate legislative intent of HB 225 and provide the information at the August meeting.

	Task for Ashley Schaber to meet with legislators on abortion amendment SB 147/HB 195 as discussed during the Public Comment Period.
	Task for Michael Bowles to request Investigations to provide the board with an update on Just Culture in the investigative process.
	Task created for Michael to create and post the Just Culture survey and present the results to the board at the August meeting.
	Task for the board to submit letter of support for HB 131/SB 124.
	Task for the board to submit letter of support for HB 158/SB 145.

	Not Started
	In Process
	Complete

Alaska Board of Pharmacy

Agenda Item #13

Chair Final Comments

Alaska Board of Pharmacy

Agenda Item #14

Adjourn