COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN PHARMACY

MINUTES OF THE PHARMACY ADVISORY COMMITTEE
239 Causeway Street, Fourth Floor ~ Room 417A
Boston, Massachusetts 02114

Friday, June 26, 2015

Advisory Committee Members Present
Monica Bharel, MD, MPH, DPH Commissioner, Chair
Sylvia B. Bartel, RPh (Expert in USP<797>)
Caryn D. Belisle, RPh, MBA (Expert in USP<71>)
Karen B. Byers, MS, RBP, CBSP (Expert in Microbiology)
Anthony M. Cundell, PhD (Expert in USP<71>).
David H. Farb, PhD (Expert in Clinical Pharmacology) type
Rory K.Geyer, PhD (Expert in cGMP)
Eric Kastango, RPh, MBA, FASHP (Expert in USP<797>)
Antoinette Lavino, RPh, BCOP (Expert in USP<797>) – arrived at 1:22 pm
Michael C. Thomas (Expert in Clinical Pharmacology) – via remote participation, called at 1:09 pm
John Walczyk, RPh, PharmD (Expert in USP<795>)
Keith B. Thomasset, BS, PharmD, MBA, BCPS (Pharmacoeconomics)

Advisory Committee Members Not Present
Judith Barr, MEd, ScD, FASHAP (Expert in Pharmacoeconomics)
Michael J. Gonyeau, RPh, PharmD, Med, BCPS, FNAP, FCCP (Expert in Clinical Pharmacology)
Francis McAteer (Expert in Microbiology)

Support Staff
Deborah Allwes, RN, BS, BSN, MPH, Director, Bureau of Health Care Quality and Safety
James Lavery, JD, Director, Divisions of Health Professions Licensure
David Sencabaugh, RPh, Executive Director, Board of Pharmacy
Heather Engman, JD, MPH, Board of Pharmacy Counsel
William E. Frisch, Jr., RPh, Director of Pharmacy Compliance
Kelly Ann Barnes, JD, RPh Director of Pharmacy Quality Assurance
David Dunn, RPh, Assistant Associate Executive Director, Board of Pharmacy
Colleen K. Collins, PharmD, RPh, Pharmacy Contract Investigator
Janet Sullivan, Program Coordinator

Board of Pharmacy Members
Michael J. Godek, RPh

TOPIC:

1. **WELCOME and CALL TO ORDER** **1:07pm**
   DISCUSSION: At 1:07 pm, DPH Commissioner and Advisory Committee Chair, M. BHAREL, MD, MPH called the first meeting of Pharmacy Advisory Committee to order. She stated that this is a public meeting and was being recorded. She asked if anyone in the audience was recording the meeting; no one indicated that they were recording the meeting. She thanked the members for

coming to the meeting and for their service and hard work.
Members of the Advisory Committee and others introduced themselves.
NOTE: A quorum was present.

TOPIC:

2. REMOTE PARTICIPATION PURSUANT TO THE OPEN MEETING LAW 1:08pm

DISCUSSION: Board Counsel, H. ENGMAN, JD, MPH discussed remote participation pursuant to the open meeting law. The open meeting law allows for remote participation, which allows committee members to call in. Permissible reasons include illness, disability, emergency, military service and geographic distance. The important thing to note is that the Advisory Committee would still need a quorum physically present. Members must all be able to hear each other and votes must be taken by role call. The Sub-Committee has allowed this in the past and it worked well. She advised that the Committee consider allowing remote participation.
ACTION: Motion by E. KASTANGO seconded by D.FARB and voted unanimously to allow remote participation pursuant to the Open Meeting Law.
A. LAVINO was not present for the vote.
M. THOMAS joined the meeting remotely.

TOPIC:

3. APPROVAL OF AGENDA 1:10pm

DISCUSSION: M. BHAREL asked if there were any changes to the agenda.
ACTION: Motion by J. WALCZYK seconded by S. BARTEL and voted unanimously by roll call to approve the agenda with the no changes.
D. FARB-yes, K. BYERS-yes, E. KASTANGO-yes, S. BARTEL-yes, J. WALCZYK-yes, A. CUNDELL-yes, K. BELISLE-yes, R. GEYER-yes, M. THOMAS- yes, K. THOMASSET-yes
A. LAVINO was not present for the vote.

TOPIC:

4. APPROVAL OF MINUTES FROM MARCH 27, 2015 1:13pm

DISCUSSION: M. BHAREL, asked if there were any changes to minutes from March 27, 2015.
ACTION: Motion by K. BELISLE seconded by E. KASTANGO and voted unanimously by roll call to approve the minutes with the no changes.
D. FARB-yes, K. BYERS-yes, E. KASTANGO-yes, S. BARTEL-yes, J. WALCZYK-yes, A. CUNDELL-yes, K. BELISLE-yes, R. GEYER-yes, M. THOMAS- yes, K. THOMASSET-abstain
A. LAVINO was not present for the vote.

TOPIC

5. RESPONSE TO ABNORMAL RESULTS:UPDATE ON PROGRESS OF ADVISORY COMMITTEE SUB-COMMITTEE ON ABNORMAL RESULTS AND DISCUSSION 1:14 pm

a. William E. Frisch, Jr., RPh, Director of Pharmacy Compliance
b. Kelly Ann Barnes, JD, RPh Director of Pharmacy Quality Assurance

M. BHAREL turned the meeting over to Director of Pharmacy Quality Assurance, K. BARNES and Director of Pharmacy Compliance, W. FRISCH for an update of Abnormal Results Sub-Committee.
K. BARNES presented the Abnormal Results Sub-Committee power point slides to the group, the group has:

- Met three times (May 1, 29 and June 26).
- Considered a definition of "State of Control."
- Considered defining successful remediation for above action level environmental monitoring (EM).
- Begun to develop guidance for appropriate response, remediation and notification requirements for pharmacies.
- Evaluated process flow diagrams.
- Reached consensus for ISO-5 above action EM (response, remediation, notification).
- Reached consensus for ISO-7 response, still working on remediation and notification requirements

Future considerations include: ISO-8, failed media fills, failed glove-fingertip, failed ISO certifications, failed HEPA leak test, Failed HVAC, failed smoke study.

WF: We will be able to take the actions and package them into a checklist that could be brought to the Board for adoption. We want the registrants to know the expectations, have the guidance and then it can be more self-directed.
JL: It will be the registrants themselves doing the work, as we do not have the capacity to walk them through it each time.
KAB: It is great to have the expertise of this group raise the bar for compounding so that the "Best Practice" is clear.
EC: Excited about this work in MA. <797> is the minimum standard and there is a lot of information that is not in there, and this work can be used as a template to include into future versions of USP <797>. Applauds the work of the Board to take on this task.
DF: Excited about the work for the citizens of MA and thinks it will expand throughout the nation.
MB: Any sense of your schedule/timeline?
KAB: The Sub-Committees will take some time.
MB: Thanked the Sub-Committee for their work.

TOPIC:

6. SHARED PHARMACY SERVICES: CENTRAL FILL, CENTRAL PROCESSING, REMOTE ORDER ENTRY/VERIFICATION OF PATIENT SPECIFIC PRESCRIPTIONS

1:17 pm

a. David Sencabaugh, RPh, Executive Director, Board of Pharmacy
b. Michael J. Godek, RPh, Board Member of the Board of Pharmacy

DISCUSSION:

Executive Director, Board of Pharmacy, D. SENCABAUGH, RPh, thanked the group for their attendance. He stated, "Section 24 of Chapter 159, the very same legislation that required putting together this terrific panel of experts, specifically mandates investigation into some emerging models of coordinated pharmacy services, by the Advisory Committee, in collaboration with DPH and the Board of Pharmacy. As your subcommittee continues to make progress with the work on just how to deal with Abnormal Results, it is now time to introduce the "emerging models" subject to you (the full committee), so that recommendations can be included in a written report, which is required to be filed with the clerks of the Senate and House of Representatives, then forwarded to the Joint Committees on Public Health and Healthcare Financing, by December 31st of this year. This is spelled out in the law. The intent

of the legislation is to investigate efficient, cost-effective and patient-centered healthcare in community settings, but with standards of practice that safeguard patient safety. Some of the potential positive impact of allowing central fill and/or central processing includes: improved patient outcomes, workload balance allows pharmacists to counsel, workload balance to reduce QRE's resulting from volume pressure/distractions, reduction in patient wait time, expanded immunization capabilities, enhanced patient safety, workload balance allows pharmacists to counsel, pharmacies that would be closed because of low volume can remain open and accessible thanks to taking advantage of workload opportunities, overhead costs are reduced by using fixed overhead versus adding additional staff, continuity of care."

D. SENCABAUGH continued and stated, "The "ask" today specifically concerns central fill and central processing. In your packet, we have included some articles on the topics, relevant NABP model language to consider, and sample regulations from other states. I trust this will be enough to get the conversation going. I also want to add that it is my hope that this is a topic that can be handled by the full Advisory Committee, without the need to create another Sub-Committee, which frankly would be tough to manage and schedule. At this time, I wish to introduce Board Member Michael Godek, who occupies one of the two chain seats on the Board, to formerly present the Board's request. Mike will get the discussion started by reviewing some questions that we believe need discussion and answering, then he will turn the talk over to you, the full Advisory Committee, to get on with the project.

M. GODEK indicated that at the last meeting on June 2nd the Board approved unanimously approved 15-03 to evaluate remote and shared pharmacy services to including, but not limited to central fill pharmacies, central fill processing pharmacies and looking for some response. Referred to questions on page 4 of the packet to consider:

- Should the service be disclosed to patients via an "opt in/opt out"?
- Should this be allowed for new or refill prescriptions?
- What would we want for licensee's accountability for filling/verification process?
- Licensing requirements for facilities?
- In-state only?
- Central fill much be licensed in MA, can we limit the number of states they are responsible for?
- Concerns regarding shipping controlled substances (CS)?
- Require PMP?
- Return to stock or return to central fill location?
- Common owner or not?
- Common computer systems?
- What considerations are there for maintenance of records requirements? (presriptions, invoices, CS) serialization of prescription numbers?
- Any regulations we need to fix? Would drafting regulations cause other issues?
- Re-dispensing issues or loopholes?
- One time transfer of CS, would this count as a transfer?

DS: We should formally ask the committee to approve this as a topic to discuss.
MB: The motion that we are looking at, is a motion to accept the "Emerging Models of Coordinating Pharmacy Services" as the next topic that we will discuss.
ACTION: Motion by D. FARB seconded by S. BARTEL and voted unanimously by roll call to accept the "Emerging Models of Coordinating Pharmacy Services" as the next topic to

discuss.
LAVINO-yes, D. FARB-yes, K. BYERS-yes, E. KASTANGO-yes, S. BARTEL-yes, J. WALCZYK-yes, A. CUNDELL-yes, K. BELISLE-yes, R. GEYER-yes, K. THOMASSET-yes, M. THOMAS- yes.
MB: We have now approved the Recommendation 15-03.

MB: Opened it up to the group for discussion.
SB: We use the terminology "prescription," but does this apply to orders in a hospital/institutional setting?
DS: At some point patient care is paramount. Currently there is no redispensing in the state, 44 states have regulations around some form of central fill/processing. Note, we need Health Care Quality to make this work appropriately. Board does not have jurisdiction over hospital pharmacies, except with regards to the sterile compounding with chapter 159.
JL: Should we walk through the questions?
MG: Yes, first, should the service be disclosed through an "opt in" versus "opt out. Should patients be notified?
CB: Difficult in a hospital environment due to logistics involved. Retail setting would be easier.
MG: Consider signage or auto-forms stating that this may be filled in another location.
CB: Or consider a patient in the ED that needs to be treated now, and it comes from a central location, how do we treat the patient now in the acute setting?
JL: Should there be exceptions?
MB: Falls under emergency consent.
SB: Are the relationships known? Typically it is an established relationship.
KT: From a central fill standpoint, the central fill may be one of the hospital systems and could be dispensing across the hospital systems.
EK: It might be interesting to silo the retail/community from hospital because there are different issues. In a small hospital part [of a larger system], they should be within their own system. My concern is that you should not allow interstate commerce. My recommendation is to take care of in-state needs and retail, then address issues of DPH in terms of allowing [hospital] compounding and centralizing and then we can look at other parts of that model.
KT: Segregation by license type, many hospitals will disepense to outpatients or their employees. 3 caveats: full acute care service, retail service and mixed.
SB: And an infusion based service.
EK: Do we also include compounding for offices (currently prohibited by MA Law)?
JL: We need to look at our own chapter 159 and if a clinic may have our purview. There are some issues that need to be flushed out. Seems that everyone agrees that we need to separate hospital and retail.
EK: Can you clarify the jurisdiction over hospital?
JL: Chapter 159 is the new compounding law that gave the Board jurisdiction over hospital clean rooms. The Board does not license other part of the hospital, that would come under Health Care Quality.
DF: In terms of informing patients, this would apply to hospitals?
JL: Yes.
DF: Seems that the patient would not need to know since there is one set of policies.
JL: Central fill raises different questions. This is more of a controlled environment.
DF: Why would a patient need to know where it comes from if there is one standard that needs to be enforced?

MB: That is the first question for the group, should patients be informed and how does it help or not help the patient? Most patients assume that it is not.
JL: Most people do not know what it means.
SB: Important for patients to know who they can call. Labeling is important; patient needs to know who to call if they have questions.
EK: Hospitals are different, they are a system.
CB: We cannot expect to put that information in a hospital setting. We need to be clear that we are talking about outpatient retail.
JW: How does that look in the retail setting?
DS: From the regulatory point of view there is the accountability factor. So, if something goes wrong, we would need to deal with that at the Board. Labeling will become very important. Many patients may object to the fact that someone else filled the prescription.
SB: This is different for retail versus hospital.
AC: My understanding is that the majority of patients sign consent forms without reading them, as they cannot cope with this level of detail.
MB: What would this statement say in lay person's term? The hospital is easier because of the oversight.
JW: Examples would be good if they do this in other states.
EK: Label will say "Johnson's Pharmacy" filled by "Eric's Pharmacy" so it is clear. Certainly challenging with real estate issues, is it primary or secondary labeling, accountability, processing, clinical, compound, dispense. Contracts can identify who is responsible (e.g. checking allergies). Key steps should be parsed out to identify responsibilities.
JL: Does NJ allow out of state central fill?
EK: They allow out of state but both parties must be licensed in both states.
SB: Initial, for a new prescription or refill?
EK: Both
SB: Do they have the same clinical systems?
EK: They have the ability to share it, which is key.
JL: Are both culpable, can you legally divide the responsibilities?
MG: There are checkpoints to break down the process of each step.
AL: There is some precedence in hospitals already (some enter the order/review the chart, some fill based on a label).
JL: We should separate the duties.
CB: We need to keep in mind what pharmacists are doing what acts. You have a clinical review and filling/dispensing, and it needs to be clearly defined.
KT: How much of these actions are completed automated, bar-coding, etc? That can help with some of our questions.
JL: Are any other committee members actively filling via this method?
EK: No, because it is against the law.
JL: Legislature knows it is important so we want to work through this as quick as possible. There is a report due on this. We are further ahead on this issue in comparison to the abnormal results issue. They have recommended a draft by December 31.
DS: Today is a good day to flush out the questions. We should talk about the difference between central fill and central processing. Central fill, closed door pharmacy, is that the prescription is brought in, scanned, goes to the central fill pharmacy, filled entirely at a remote pharmacy and sent overnight to the pharmacy. Central processing is where the data input and review of profile but then a label is filled at the store and they fill the prescription. They are 2 different concepts. In any case, I feel that all involved needs a MA license.

JL: Are you saying all of them should be licensed in MA?
DS: Yes, anyone that is handling it.
MB: Should the group focus on both?
DS: Both, they are both part of chapter 159.
JW: If you are filling the script, who is the one that adjudicates the claim? If you are selling the same product, how anticipatory are you making and it is considered manufacturing?
DF: Lawsuits always identify the chain pharmacy.
KT: Most of what you hear about is the retail pharmacies. Are compounding pharmacies allowed to do this because of the risk and should we focus on maintenance medications or refills? Central fill for a hospital is different for "batching" to serve as a central repository in a hospital for distribution.
JL: Should a compounding pharmacy be able to do this? That is definitely an issue.
EK: So we have community/hospital, process/filling, sterile/non-sterile. We have to granulate this down because there will be a different set of rules. You should prohibit a home infusion company offering that service to hospitals, because that mechanism exists with the 503Bs.
AL: If you excluded the hospital systems, would it be any different?
EK: If you want to build a super compounding location, they could distribute amongst their hospitals, then that should be permissible and would be my recommendation to the Board.
JL: Are we conflating distributing and dispensing?
EK: You have to differentiate that because that is the issue of MOU Memorandum of Understanding – this is where the FDA is working with the state Boards to identify at what point does a pharmacy cross the bounds in terms of 5% and 30%. There are 2 thresholds: 5% across state lines and 30% across state lines. The FDA is negotiating that they want the states to sign the MOU so if you have a pharmacy that ships at least 30% of their drugs (dispense/distribute) they want the Boards to handle the adverse drug reporting and other reporting. If the states don't agree, then the rule is 5% and allows the FDA to come in sooner.
DS: Let's look at community/retail. I am an advocate for it because of errors that we see at the Board. If you look at staffing and volume, anything that can offload to other pharmacies and second checked, I am for the concept if it can be done safely.
JL: In underserved areas, may have 1 pharmacist that can't keep up with demand, they can use this for these populations.
CB: Agrees, we need to have the foresight for the future of pharmacists and their role, decreasing overall costs, increasing technology (automation).
KT: Agrees with both DS and CB and add that DS stated "done safely." We need to understand the pressures of the community pharmacies, but we are also obligated to keep this in mind so we don't put the pressure on central fill pharmacies.
SB: Agrees. In retail pharmacies you are constantly interrupted and you may miss an error.
DS: What other regulations do we have to add to, in order to help us? In addition to errors, we see a lot of diversion. A concern of central fill is that the pharmacy may not have the relationship. Consider if you should be required to be used the PMP for central fill?
Consensus from group.
JL: So, let's start, we are on retail. Should we ask if it should be in-state or out-of-state?
DS: Should be in state because your licensee understands your laws. I suggest in-state.
Group agreed.
JL: Does anyone disagree?
Nobody disagreed.
CB: Does not disagree but wants group to consider, would we be inhibiting efficiency? What would be the bad points of not keeping it on the state level?

MG: Perhaps for a natural disaster, with Katrina, Louisiana relaxed the state laws so that patients could go across state lines.
MB: Then it is declared a public health emergency and laws could be relaxed.
JL: Also, we do not have jurisdiction out of state and cannot inspect those facilities. We could start with in-state. So we are going to keep it in-state.
Group agreed.
DS: One of the questions is if it is limited to common ownership or can we expand to someone with common computer systems? Is it considered OK with common computer systems?
KT: If 3-4 independent pharmacies, contracting with a central fill, who is liable or getting the revenue?
JW: On return to stock, where does it go?
DD: We do not have to limit ourselves to a common system as long as data can be converted and used. Services agreements would be worked out through the parties so it is of benefit to both.
DS: Once it is out of chain of custody, you run into issues.
DD: Currently 50/50 split if the RTS go back or stay with the pharmacy, no right or wrong answer.
JL: Is there a cost savings to consumer? Any studies done regarding cost savings to the consumer?
KT: From a hospital standpoint, if we use a 503B, the savings is forwarded to the hospital, we only get reimbursed based on our DRG anyway. A question for David, regarding return to stock, were the local sites disposing of the stock or returning to stock to re-dispense?
DD: Not clear on all, but assumed most is returned to stock. Jim, cost savings to pharmacy, reimbursements are low, benefits of reduction in inventory, that is the savings to the consumer.
DS: They would return to stock but it would not have a lot number, so in the event of a recall, you would need to assume the worst and dispose of it.
AL: In looking at McKesson, maybe they do keep track of lot number?
JL: For tracking, is that required?
KT: No lot number required at this time.
JW: You will still have overhead compounding costs.
MB: There must be a business model. Our focus is the safety piece.
DD: I believe there will be a day that it will be outcome based (more MTM, services) and stepping away from the product.
DF: How does this work with regards to the central processing fill process? Pharmacist role is to provide high level expertise to assist physician in dispensing the correct drug. How does the central process fill fit in?
KT: Overall, in the profession there is more focus on service, education, and compliance. We see it in the hospital, pharmacists are less likely doing the dispensing, but more likely on the floors, doing MTM, counseling, targeted drug therapy, etc and that is where we are seeing more of an impact. They are getting paid more for knowledge and not checking skills.
DF: Is that knowledge equitably distributed across the population (certain classes)? So, organizations that focus on one level of financial class. Is there anything like that we should consider or is that transparent?
KT: There is no standard practice level at this point. But the state can establish baseline competencies that would help, that patients should get from pharmacies.
JL: Is there agreement in that there should be common ownership, it sounds like it is not needed.
DS: If you can search the profile, do the DUR, then that what matters. As long as you can

establish it without common ownership.
EK: The 2 aspects, if there is not common ownership, is that there needs to be a contract filed with the state, both pharmacies should register with the state that they are engaged in the activity and in the contract, you identify the key aspects of the activities that are going to be performed by each organization and then you have an audit trail for each of the steps that occurred for 100% transparency.
DS: I see that in the regulation.
EK: You can survey existing regulations and see which would work best.
JL: We sent 4 states, and next time [the group should] pick out some things that do not appear to be best practice or missing, bring it back to the next meeting or send it to Janet. Janet will collect the input.
EC: We have not discussed outsourcing facilities or tele-pharmacy. Are outsourcing/manufacturers licensed by the Board?
HE: They are under the Drug Control Program (DCP) within DPH
EK: My suggestion is that for outsourcing facilities (some states are wrestling whether they should license the 503B), we should not take that on, keep that under the DCP.
JL: We should talk about tele-pharmacy.
DS: It is something we should address for patients in remote access areas? Being a small state, there are not that many areas without access, but there are some.
JL: Is there a reason to not have tele-pharmacy?
CB: Don't see why we would say no.
AL: Think about how people interpret what it means.
EK: There is a need, but, to AL's point, think about unintended consequences. Be careful of how it is worded and how it is downsized.
CB: Again, we want to think about the future. Recently saw it being utilized at Yale New Haven, they used tele-pharmacy in their sterile product device for rural areas in Conneticut (see photos, product, weight, etc).
JL: Would they have to keep the same technician ratios? I would think they would.
SB: Have also seen it during less busy parts of the days. Has seen it in CT.
SB to forward CONN regulations to JL.
DS: Would not want to see loss of oversight; want to see a re-deploying of staff. Recent site visit, pharmacist can watch the pharmacy, watch what is going on, look into the bottle.
DD: 247 CMR would need to be overhauled with this legislature.
MB: Any other questions for the Board?
MG: It appears we touched upon everything, is there anything else we missed?
JL: We did not look into new or refills, but we touched upon it.
SB: Based on NJ, it would need to be only refills. My opinion is that either is fine.
JL: Licensing, looked into that, keeping in state, everyone agreed that PMP to check is important, return to stock we talked about that …
KT: With all the work done with PMP we may want to consider discussing this further, there are some CS that you may not want to send to central fill or can't send to central fill, if someone is coming out of a procedure. We may want to discuss maintenance CS versus acute need CS.
EK: Are any new regulations going to have an impact on licensees? Technicians may take on a greater role. Do we need to look at training and competency? My biggest concern is that what we are backfilling roles that were traditionally done by more educated individuals.
JL: We may want to require certified technicians for the central fill spots.
AL: Will there be some verbiage that a pharmacy cannot force a patient to have to use the

services of a central fill?
DS: That was the reason for the first question, regarding "opt in" or "opt out."
AL: Filling CS, that might be an issue.

JL: We should take that into consideration.
MB: Any final thoughts?
None noted by the group.

TOPIC:

7. CLOSING REMARKS/ADJOURNMENT 2:58 pm

ACTION: Motion by J. WALCZYK seconded by, D.FARB and voted unanimously by roll call adjourn
A. LAVINO-yes, D. FARB-yes, K. BYERS-yes, E. KASTANGO-yes, S. BARTEL-yes, J. WALCZYK-yes, A. CUNDELL-yes, K. BELISLE-yes, R. GEYER-yes, K. THOMASSET-yes, M. THOMAS- yes.

LIST OF EXHIBITS USED DURING THE MEETING

1. Preliminary Agenda for the June 26, 2015 Pharmacy Advisory Committee Meeting
2. Pharmacy Advisory Committee Meeting Minutes, March 27, 2015 by Joseph M. Sceppa, RPh, MS, MBA.
3. Advisory Committee Update: Abnormal Results Sub-Committee by Kelly Ann Barnes, JD, Rh and William E. Frisch, Jr., RPh
4. Advisory Committee Recommendation Document 15-03, Emerging Models of Coordinated Pharmacy Services.
5. NABP Model Act 2013. Shared Services.
6. *States, NABP Create Model Regulations Addressing Shared Remote Pharmacy Services Across Jurisdictions*, NABP Newsletter, 2013.
7. *Best of Both Worlds; McKesson Begins Offering Central Fill Benefits to Independent Pharmacies*, Pharmacy Today, October, 2010, 56- 57.
8. *Central Fill Promises to Make Pharmacies More Efficient*, Chain Drug Review, July 19, 2010.
9. Rhode Island Section 22.0, *Central Fill Operations*, p. 62-63.
10. New Hampshire Chapter Ph 1200 *Central Prescription Processing*, Ph 1201.01 – 1203.
11. Pennsylvania § 27.203. *Centralized Prescription Processing*.
12. Oregon Processing Drug Outlets 855-041-3100. *General Requirements, Policies and Procedures, Records, Prescription or Drug Order Processing, Prohibited Practices.*

Respectfully submitted,

Colleen K. Collins, PharmD, RPh, Pharmacy Contract Investigator