

*****REVISED*** MEETING NOTICE**

**Missouri Board of Pharmacy
CONFERENCE CALL**

**Missouri Division of Professional Registration
3605 Missouri Boulevard
Jefferson City, MO 65109**

**August 26, 2020
3:30 p.m. (*Amended Time*)**

Notice is hereby given that the Missouri Board of Pharmacy will be meeting at **3:30 p.m.** on August 26, 2020 via conference call. A tentative agenda is attached. If any member of the public wishes to attend the meeting, s/he may join the WebEx meeting by:

1) Joining online at:

<https://stateofmo.webex.com/stateofmo/j.php?MTID=mfe1d2298dd75fa7aa34df0f157cb002c>

Access Code: **133 944 6674**

Password: **ehW3qqHGt42**

2) Calling:

Phone #: 650-479-3207

Access Code: **133 944 6674**

Password: **ehW3qqHGt42**

****Public participants may be required to provide a name and e-mail address when joining the WebEx meeting online. **NEW: A password may also be required when joining the meeting (provided above).** WebEx will provide a conference call phone number to access the audio portion of the call after you join. Telephone charges may apply as assessed by your service provider. ****

Except to the extent disclosure is otherwise required by law, the Missouri Board of Pharmacy is authorized to close meetings, records and votes pursuant to Section 610.021(1) and (14) and section 324.001.8 and .9, RSMo. If the meeting is closed, the appropriate section will be announced to the public with the motion and vote recorded in open session minutes.

Notification of special needs as addressed by the Americans with Disabilities Act should be forwarded to the Missouri Board of Pharmacy, P O Box 625, 3605 Missouri Blvd., Jefferson City, Missouri 65102, or by calling (573) 751-0091 to ensure available accommodations. The text telephone for the hearing impaired is (800) 735-2966.

***** REVISED*** MEETING NOTICE**
Missouri Board of Pharmacy
CONFERENCE CALL

Missouri Division of Professional Registration
3605 Missouri Boulevard
Jefferson City, MO 65109

August 26, 2020
3:30 p.m. (amended time)
(New items identified in red.)

OPEN SESSION AGENDA

- #1. Call to Order: James Gray, RPh, President
- #2. Roll Call
- #3. Approval of Minutes
 - a. April 22, 2020
- #4. 2020 Legislative Implementation
 - a. HB 1682- Class R Remote Dispensing Rule Discussion Draft
- #5. HHS Guidance on Pharmacist Immunizations of Pediatric Vaccines
 - a. HHS Pharmacist Immunization Announcement (8/19/20)
 - b. HHS Third Amendment to PREP Declaration Against COVID-19
 - c. Board COVID-19 Guidance (4-13-20)
- #6. General Office Updates
 - a. Office Updates
 - b. COVID-19 Updates
- #6. Future Meeting Dates/Topics
- #7. Adjournment

Except to the extent disclosure is otherwise required by law, the Missouri Board of Pharmacy may go into closed session pursuant to Section 610.021(1) and (14) and section 324.001.8 and .9, RSMo. If the meeting is closed, the appropriate section will be announced to the public with the motion and vote recorded in open session minutes.

- #3. Approval of Minutes
 - b. April 22, 2020

OPEN SESSION MINUTES

Missouri Board of Pharmacy CONFERENCE CALL

Missouri Division of Professional Registration 3605
Missouri Boulevard
Jefferson City, MO 65109

April 22, 2020

8:00 a.m.

The Missouri Board of Pharmacy met in open session via conference call during the times and dates stated in the following minutes. Each item in the minutes is listed in the order discussed.

Board Members Present

Douglas R. Lang, R.Ph., President
James Gray, PharmD., Vice-President
Colby Grove, PharmD., Member
Christina Lindsay, PharmD., Member
Pamela Marshall, R.Ph., Member
Christian Tadrus, PharmD., Member
Anita Parran, Public Member

Staff Present

Kimberly Grinston, Executive Director
Jennifer Boehm, Administrative Coordinator
Tom Glenski, R.Ph, Chief Inspector
Katie DeBold, PharmD., Inspector
Lisa Everett, R.Ph, Inspector
Andi Miller, PharmD, Inspector
Bennie Dean, R.Ph, Inspector
Scott Spencer, R.Ph, Inspector
Elaina Wolzak, R.Ph, Inspector

Others Present

Daryl Hylton, Legal Counsel

President Douglas Lang called the meeting to order at approximately 8:00 a.m. on April 22, 2020, and roll call was taken.

#3. COVID-19 Updates

- a. FDA Temporary Policy for Compounding of Certain Drugs for Hospitalized Patients by Pharmacy Compounders not Registered as Outsourcing Facilities

Missouri Board of Pharmacy
Open Minutes
April 22, 2020
Page 1 of 4

During the COVID-19 Public Health Emergency

Office Updates

DISCUSSION: Kimberly Grinston stated the Governor's Office approved the extension of technician renewals to July 31, 2020, without a grace period. Ms. Grinston advised the office is working with IT to extend online renewals accordingly and will notify technicians of the extension.

FDA Temporary Policy for Compounding:

DISCUSSION: Kimberly Grinston reported the FDA issued additional guidance for 503A compounding pharmacies that would allow 503A pharmacies to compound for hospital use without a patient-specific prescription. Ms. Grinston stated the office has already received inquiries on the new FDA guidance and asked if the Board would like to request a COVID-19 waiver from the Governor's Office.

- Tom Glenski stated Missouri hospitals are experiencing a shortage of drugs and the FDA's guidance would increase availability for hospitals. However, Mr. Glenski noted the guidance would allow the pharmacy to perform limited sterility testing if a reduced beyond use date (BUD) is assigned.
- Katie DeBold agreed with Mr. Glenski and stated her main concern is with the guidance document's different requirements for sterility testing and noted the Board's rule requires sterility testing for all Risk Level 3 preparations regardless of BUD. Tom Glenski suggested allowing pharmacies to compound in compliance with FDA guidance with the exception that pharmacies must still conduct sterility testing as required by the Board's rule.
- James Gray noted the FDA guidance only applies to the specific medication listed in the guidance; Christian Tadrus asked if sterility testing would be a significant barrier for hospitals/pharmacies compounding these products. James Gray replied patients may be acutely ill and need medication quickly.
- Douglas Lang suggested requesting a waiver from the Governor's Office, provided compounders follow FDA guidance. Tom Glenski noted a blanket waiver would allow pharmacies who are currently complying with the Board's testing requirements to forego future sterility testing under the FDA's guidance.
- Mr. Glenski questioned if a compounding pharmacy has to be licensed in Missouri to follow the FDA's guidance; Kimberly Grinston suggested non-resident pharmacies would be required to comply with the laws of their home state. Katie DeBold noted Board notification is required if a pharmacy will be compounding under the FDA's guidance.

Additional Board discussion held; **A motion was made by James Gray, seconded by Christian Tadrus, to request a waiver to allow Missouri licensed pharmacies not registered as outsourcers to compound medication for hospitals without a patient-specific prescription, in accordance with the FDA's guidance. Motion passed 6:0:0**

by roll call vote as follows:

**Colby Grove – Yes
Pamela Marshall – Yes**

**James Gray- Yes
Anita Parran – Yes**

**Christina Lindsay- Yes
Christian Tadrus- Yes**

DISCUSSION: Douglas Lang asked if the office has received calls regarding the state of emergency expiring and suggested the licensing boards may need to communicate with the Governor's Office that licensees may need a transition period to convert business operations back to normal once the state of emergency ends. Kimberly Grinston stated the boards have not discussed this topic in depth but noted the Governor could keep the State of Emergency and approved waivers active even though the state stay-at-home order is lifted. Ms. Grinston stated the division and department are communicating with the Governor daily and she will communicate the Board's transition concerns.

#4. Final Orders of Rulemaking

a. 20 CSR 2220-2.710 (Pharmacy Technician and Intern Supervision)

- i. Public Comments**
- ii. Draft Final Order**
- iii. Filed Rule**

DISCUSSION: Kimberly Grinston reported the Board received two additional comments on the proposed rule from the Missouri Pharmacy Association and a licensed pharmacist. Ms. Grinston stated the comments essentially expressed concerns that the rule would either confuse licensees or improperly remove the requirement in 20 CSR 2220-2.010 that a pharmacist must be present whenever medication is compounded, prepared or dispensed. Ms. Grinston stated the Board was aware of the differences with 20 CSR 2220-2.710 when the rule was initially approved and voted to review 20 CSR 2220-2.010 at a later date.

Christina Lindsay left the meeting at 8:29 a.m.

- James Gray agreed with the Board's previous vote and noted the Board intentionally chose to address technician supervision for non-dispensing activities before addressing the more complex question of supervision for dispensing activities. Christian Tadrus suggested staff document the Board's rationale and advise licensees of the rule history.

A motion was made by Pamela Marshall, seconded by James Gray, to accept the responses to the final order of rulemaking for 20 CSR 2220-2.710, as provided in the agenda. Motion passed 4:0:0:2 by roll call vote as follows:

**Colby Grove – Yes
Pamela Marshall – Yes
technical issues)**

**James Gray- Yes
Anita Parran – Yes**

**Christina Lindsay- Absent
Christian Tadrus- Absent (due to**

Douglas Lang reported Board members have been receiving phishing e-mails and cautioned Board members and staff to look closely before opening e-mails and clicking links. Kimberly Grinston noted all Board communication would come from a @pr.mo.gov e-mail address.

MOTION TO ADJOURN (8:38 A.M.)

A motion was made by Pamela Marshall, seconded by Colby Grove to adjourn the April 22, 2020, conference call. Board consensus to adjourn the April 22, 2020, meeting at 8:38 a.m.

THE MEETING WAS ADJOURNED AT 8:38 A.M.

KIMBERLY GRINSTON
EXECUTIVE DIRECTOR

- #4. 2020 Legislative Implementation
 - b. HB 1682- Class R Remote Dispensing Rule Discussion Draft

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**Title 20—DEPARTMENT OF
COMMERCE AND INSURANCE
Division 2220—State Board of Pharmacy
Chapter 2- General Rules**

PROPOSED RULE

20 CSR 2220-2.680 Class R- Remote Dispensing Site Pharmacy

Purpose: This rule defines licensing requirements and compliance standards for Class-R Remote Dispensing Site pharmacies.

(1) Definitions.

- (A) “Community Mental Health Center”– A community mental health center as defined by 42 CFR § 410.2, § 205.975, RSMo, or the Missouri Department of Mental Health.
- (B) “Federally qualified health center”– A federally qualified health center as defined by 42 U.S.C. § 1396d(l)(2)(B), as amended.
- (C) “Intern Pharmacist”– An individual who holds a current and active Missouri intern pharmacist license and has completed employer approved training in the activities to be performed at the Class R pharmacy and has an initial and annual documented assessment of competency.
- (D) “Outpatient Clinic”– A facility where healthcare services are provided by a licensed healthcare provider on the facility’s premises to patients who are not hospitalized or admitted to the healthcare for an overnight stay.
- (E) “Qualified Pharmacy Technician”– A currently registered Missouri pharmacy technician who:
1. Holds an active pharmacy technician certification issued by a certification entity accredited by the National Commission for Certifying Agencies, and
 2. Has completed employer approved training in the activities to be performed at the Class R pharmacy and has an initial and annual documented assessment of competency; and
 3. Has assisted in the practice of pharmacy as a registered pharmacy technician in the state of Missouri for a minimum of 1 year.
- (F) “Remote Dispensing Site Pharmacy”– Any location in this state where the practice of pharmacy occurs that is staffed by one or more qualified pharmacy technicians or intern pharmacists whose activities are supervised by a pharmacist at a supervising pharmacy that is under common ownership through a continuous real-time audio and video link. A remote dispensing site pharmacy does not include a dispensing prescriber’s office or an automated device.
- (G) “Retail Pharmacy”– A pharmacy licensed by the Board that is open to, and offers pharmacy services to, the general public.
- (H) “Rural Health Clinic”– A rural health clinic as defined by the federal Rural Health Clinic Services Act, PL. 95-210, as amended [as defined by 42 U.S.C. § 1395(x)(aa).]

44 (I) “Supervising pharmacy”– A Missouri licensed pharmacy located in this state or
45 approved by the Board that oversees the dispensing activities of a Class R pharmacy.
46

47 (2) A Class R pharmacy permit is required for any Missouri location operating, or offering to
48 operate, as a remote dispensing site pharmacy in Missouri. Applications for a Class R permit
49 must be submitted on a form approved by the Board with the pharmacy permit fee, in accordance
50 with 20 CSR 2220-2.020.

51 (A) Class R pharmacy permits expire and must be renewed, as provided by Chapter 338,
52 RSMo and 20 CSR 2220-2 for pharmacy permits. Renewal applications must be submitted on a
53 form approved by the Board with the applicable renewal fee.

54 (B) Class R pharmacies must be located at least ten (10) miles away from an existing
55 retail pharmacy unless the Class R pharmacy is part of a community mental health center,
56 federally qualified health center, rural health clinic, or outpatient clinic setting. Requests to
57 waive the mileage requirement may be submitted to the board in writing along with
58 documentation supporting the request. The Board will consider the following factors when
59 determining whether to grant a waiver request:

- 60 1. The availability of pharmacy services in the proposed pharmacy area;
- 61 2. The nature of proposed Class R pharmacy services;
- 62 3. Benefits or risks to patient care;
- 63 4. The applicant’s and supervising pharmacy’s experience and compliance history;

64 and

- 65 5. Any other factor that may benefit or adversely impact patient safety.

66 (C) Class R pharmacies shall be authorized to provide Class A, Class B and Class C
67 pharmacy services with a Class R permit. Class R pharmacies must apply for and hold the
68 applicable pharmacy permit classification identified in § 338.220, for any additional pharmacy
69 services provided by the pharmacy (e.g., ~~Class D (Nonsterile compounding), Class E (Radio~~
70 ~~pharmaceutical), Class F (Renal dialysis), Class G (Medical gas), Class H (Sterile product~~
71 ~~compounding), Class I (Consultant services), Class K (Internet), Class L (Veterinary), Class M~~
72 ~~(Specialty Bleeding Disorder), Class N (Automated dispensing system – Health care facility),~~
73 ~~Class O (Automated dispensing system – Ambulatory Care), Class P (Practitioner office/clinic, or~~
74 ~~Class Q (Charitable pharmacy)). *The Bd. asked to list all potential classes in the rule; Staff*
75 *recommends simply referencing § 338.220 in the rule and listing the specific classes in the*
76 *Practice Guide. This would also avoid needing to amend the rule if § 338.220 changes in the*
77 *future.*] A Class J Shared services permit is not required for Class R pharmacies engaged in
78 shared pharmacy services with the supervising pharmacy, but is required for all other pharmacy
79 shared services arrangements as required by 20 CSR 2220-2.650.~~

80 (D) By the 10th day following each calendar quarter, Class R pharmacies must calculate the
81 average number of prescriptions dispensed by the pharmacy per day during the previous calendar
82 quarter, excluding immunizations given by protocol (e.g., January 10, April 10, July 10, October
83 10).

- 84 1. If the average number of prescriptions or medication orders dispensed by the pharmacy
85 during the previous quarter exceeds 150 prescriptions/medication orders per day,

86 excluding immunizations given by protocol, the pharmacy must apply for a change of
87 classification to add a Class A, B, or C permit classification within ten (10) days of
88 discovery. Change of classification requests must be submitted on a form approved by
89 the Board with the applicable fee. Class R operations must cease once a Class A, B or C
90 permit is issued by the Board.

- 91 2. Class R operations may resume if the daily average number of prescriptions dispensed by
92 the pharmacy does not exceed 150 prescriptions/medications orders during a calendar
93 quarter (January 1 – March 31, April 1 – June 30, July 1- September 30, or October 1 –
94 December 31). The pharmacy’s Class A, B or C pharmacy classification must be
95 surrendered to the Board within five (5) days of resuming Class R operations.
96

97 (3) Supervising Pharmacies. Class R pharmacies must be under the supervision of a supervising
98 pharmacy, as required by § 338.215, RSMo. The supervising pharmacy must ensure the Class R
99 pharmacy is properly and safely operated in compliance with applicable state and federal law.
100 Effective policies and procedures must be in place to ensure appropriate oversight of a Class R
101 pharmacy at all times.

102 (A) The supervising pharmacy and Class R pharmacy must manually or electronically
103 maintain a current and accurate written policy and procedure manual that complies with §
104 338.215, RSMo.

105 (B) The supervising pharmacy and Class R pharmacy must share a common database or
106 have access to each other’s prescription record-keeping system. The common database or shared
107 system must allow real-time, online access to the patient’s complete profile for both the
108 supervising pharmacy and the Class R pharmacy.

109 (C) Supervising pharmacies must be located in Missouri and within fifty (50) miles of
110 the supervised Class R pharmacy site, unless otherwise approved by the Board. Requests to
111 waive the location and mileage requirements must be submitted to the board in writing along
112 with proof the Class R pharmacy will be sufficiently supported by the supervising pharmacy and
113 that necessary personnel or supplies can be delivered to the Class R pharmacy within a
114 reasonable period of time of an identifiable need. The Board will also consider the factors
115 identified in section (2)(B) of this rule when reviewing a waiver request.

116 (D) A Class R pharmacy must immediately cease operations if the supervising pharmacy
117 and Class R pharmacy are no longer under common ownership, the supervising pharmacy is no
118 longer eligible to supervise the Class R pharmacy, or the supervising pharmacy’s Missouri
119 pharmacy permit is not current and active. Class R operations may resume once the supervising
120 pharmacy’s permit returns to active or eligible status or common ownership is reestablished.
121

122 (4) Class R Standards of Operation. Except as otherwise authorized by law, Class R pharmacies
123 must comply with all laws and regulations applicable to the pharmacy services provided by the
124 Class R pharmacy, including, 20 CSR 2220-2.010.

125 (A) Class R pharmacies must be staffed by a current and active Missouri licensed
126 pharmacist at least eight (8) hours a month. At a minimum, the pharmacist-in-charge (PIC) of
127 the Class R pharmacy must visit the remote dispensing site weekly during the first month of

128 operation to verify compliance and monthly thereafter. The date of the monthly PIC compliance
129 visit must be documented in the pharmacy's records.

130 (B) Class R pharmacies must maintain a perpetual inventory for all controlled substances
131 that is reconciled twice per month. The PIC must review the reconciliation for
132 accuracy/discrepancies during the compliance visits required by subsection (4)(A).

133 (C) A prominent sign must be posted at the Class R pharmacy notifying patients that the
134 remote dispensing site is supervised by the supervising pharmacy along with the supervising
135 pharmacy's name, address and telephone number.

136 (D) Intern pharmacists and qualified pharmacy technicians activities must be supervised
137 by a Missouri-licensed pharmacist present at the Class R pharmacy or remotely supervised by a
138 Missouri-licensed pharmacist located at the supervising pharmacy using technology that provides
139 a continuous real-time audio and video link. The required technology must allow the
140 supervising pharmacist to provide the personal assistance, direction and approval needed to
141 verify and ensure remote tasks are safely and properly performed. The supervising pharmacist
142 must be employed by the supervising pharmacy, as required by § 338.215, and must be
143 competent to perform the services being supervised. A pharmacist cannot supervise more than
144 two (2) Class R pharmacies at the same time.

145 (E) A Class R pharmacy may not be operated if the required supervision technology is
146 unavailable or not in working order unless a pharmacist is onsite. The no pharmacist on duty
147 sign required by 20 CSR 2220-2.010 must be posted in the event of a technology or system
148 malfunction that requires the Class R pharmacy to cease operations.

149

150 (5) Medication Dispensing. Prescriptions/Medication orders may be prepared, dispensed or
151 compounded at a Class R pharmacy, as authorized by § 338.215, RSMo, and the rules of the
152 Board.

153 (A) The final contents and label of a prescription/medication order must be verified by a
154 Missouri licensed pharmacist at the Class R pharmacy, or remotely verified by a Missouri
155 licensed pharmacist located at the supervising pharmacy through the use of technology that
156 includes bar coding and visual review of the medication contents and [affixed] label via remote
157 video. The verifying pharmacist must be employed by the supervising pharmacy, as required by
158 § 338.215.

159 (B) Patient counseling must be provided for all new and refill prescriptions, unless
160 refused by the patient. The required patient counseling must be provided by a Missouri licensed
161 pharmacist at the Class R pharmacy or remotely provided by a Missouri licensed pharmacist at
162 the supervising pharmacy via a HIPAA-compliant continuous real-time video and audio link, as
163 authorized by § 338.215. Medication may not be dispensed without a pharmacist physically
164 present at the Class R pharmacy if the required counseling technology is not available or in
165 working order. Remote patient counseling via technology may not be delegated to an intern
166 pharmacist.

167 (C) Policies and procedures must be established to ensure appropriate pharmacist review
168 of verbal prescription orders received by an intern pharmacist or qualified pharmacy technician
169 at a Class R pharmacy when a pharmacist is not present.

170
171 (6) Adequate security and supervision must be maintained at all times to prevent unauthorized
172 access to a Class R pharmacy and prevent medication theft and diversion.
173 (A) An alarm mechanism must be maintained that alerts the supervising pharmacy or the
174 Class R pharmacist-in-charge in the event of unauthorized access to the remote dispensing site.
175 Unauthorized access to a Class R pharmacy must be documented and reported to the board in
176 writing within seven (7) days of discovery.
177 (B) Confidential records must be securely maintained to prevent unauthorized access and
178 ensure secure data access and storage at all times.
179
180 (7) Record-Keeping.
181 (A) Except as otherwise provided by law, Class R pharmacies shall comply with all
182 applicable record-keeping and documentation requirements of Chapter 338, RSMo, and the
183 Board's rules.
184 (B) Class R pharmacies must also maintain documentation of:
185 1. The number of prescriptions dispensed by the Class R pharmacy each calendar
186 quarter; and
187 2. Proof that qualified pharmacy technicians and intern pharmacists assisting at a Class
188 R pharmacy have completed the experience, training and competency assessment
189 required by this rule.
190 (C) Records required by this rule must be manually or electronically maintained for two (2)
191 years at the Class R pharmacy, or at the supervising pharmacy if the Class R pharmacy is no
192 longer operating, and must be readily retrievable on request of the Board or the Board's
193 authorized designee.



Words

And



Title XXII OCCUPATIONS AND PROFESSIONS

Chapter 338

Effective - 28 Aug 2020

338.215. Remote dispensing site pharmacy — definitions — requirements — supervision — location — staffing — license required, when — rulemaking authority. —

1. For purposes of this section, the following terms mean:

(1) "**Remote dispensing site pharmacy**", any location in this state where the practice of pharmacy occurs and that is licensed as a pharmacy to dispense prescription drugs and is staffed by one or more qualified pharmacy technicians, as defined by the board, or intern pharmacists, whose activities are supervised by a pharmacist at a supervising pharmacy through a continuous real-time audio and video link. "Remote dispensing site pharmacy" does not include the office of a dispensing prescriber or an automated device;

(2) "**Supervising pharmacy**", a pharmacy licensed in this state under the provisions of this chapter that oversees the dispensation activities of a remote dispensing site pharmacy.

2. A supervising pharmacy that operates a remote dispensing site pharmacy, and the remote dispensing site pharmacy, shall be licensed as a pharmacy by the board of pharmacy. The board shall issue a license to a remote dispensing site pharmacy that meets the requirements of this subsection. The remote dispensing site pharmacy shall:

- (1) Submit an application and pay the licensing fee established by the board;
- (2) Be jointly owned by a supervising pharmacy; and
- (3) Maintain a policy and procedures manual that includes the following:
 - (a) A description of how the supervising pharmacy and remote dispensing site pharmacy will comply with federal and state laws, rules, and regulations;
 - (b) The procedure for the supervising pharmacy to supervise the remote dispensing site pharmacy and counsel patients in accordance with the laws of this state prior to the dispensing of a prescription drug under this section;
 - (c) The procedure for reviewing the prescription drug inventory and drug records maintained by the remote dispensing site pharmacy;

(d) The policy and procedure for providing appropriate security to protect the confidentiality and integrity of patient information;

(e) The written plan for recovery from an event that interrupts or prevents a pharmacist from supervising the operation of the remote dispensing site pharmacy;

(f) The specific duties, tasks, and functions that a registered pharmacy technician or intern pharmacist is authorized to perform at the remote dispensing site pharmacy under the remote supervision of a licensed pharmacist at the supervising pharmacy; and

(g) The procedure for maintaining an up-to-date inventory of all controlled substances.

3. A remote dispensing site pharmacy shall be under the supervision and control of a supervising pharmacist employed by the supervising pharmacy. The supervising pharmacist shall not be required to be immediately physically present to supervise activities at the remote dispensing site pharmacy, but shall make monthly visits to the remote dispensing site pharmacy in order to ensure compliance with this section.

4. A supervising pharmacist and a remote dispensing site pharmacy shall share common ownership. A pharmacist shall neither be designated nor act as a supervising pharmacist for more than two remote dispensing site pharmacies at one time.

5. A pharmacist at the supervising pharmacy shall verify each prescription before it leaves the remote dispensing site pharmacy. Verification shall occur through the use of technology that includes bar coding and visual review via remote video. As applicable, a pharmacist, intern pharmacist, and pharmacy technician's initials or unique identifier shall appear in the prescription record to identify the name and specific activities of each pharmacist, intern pharmacist, or pharmacy technician involved in the dispensing process.

6. Unless a pharmacist is onsite at the remote dispensing site pharmacy, counseling shall be done by a supervising pharmacist at the supervising pharmacy via a HIPAA-compliant continuous real-time video and audio link before a drug or medical device is released to the patient. The system being used to perform the consultation shall retain the initials or unique identifier of the pharmacist who performs the consultation. The pharmacist providing counseling under this subsection shall be employed by and located at the supervising pharmacy and have access to all relevant patient information maintained by the remote dispensing site pharmacy.

7. A remote dispensing site pharmacy shall be located at least ten miles from an existing retail pharmacy unless:

(1) The remote dispensing site pharmacy is part of a community mental health center, federally qualified health center, rural health clinic, or outpatient clinic setting; or

(2) An applicant of a proposed remote dispensing site pharmacy demonstrates to the board how the proposed remote dispensing site pharmacy will promote public health.

8. The remote dispensing pharmacy shall be staffed by a pharmacist at least eight hours a month and shall reconcile the up-to-date controlled substance inventory twice a month. The supervising pharmacist may provide services as allowed in section [338.010](#) and as provided by policies and procedures.

9. If the average number of prescriptions dispensed per day by the remote dispensing site pharmacy exceeds one hundred fifty prescriptions, the remote dispensing site pharmacy shall, within ten days, apply to the board for licensure as a class A, B, or C pharmacy, as applicable. The average number of prescriptions dispensed per day shall be determined by averaging the number of prescriptions dispensed per day over the previous ninety-day period.

10. Unless otherwise approved by the board, the supervising pharmacy shall be located in this state and within fifty road miles of a remote dispensing site pharmacy to ensure that the remote dispensing site pharmacy is sufficiently supported by the supervising pharmacy and that necessary personnel or supplies may be delivered to the remote dispensing site pharmacy within a reasonable period of time of an identified need.

11. The board of pharmacy may promulgate all necessary rules and regulations for the implementation of this section, provided that no such rules and regulations shall restrict the practice of pharmacy at a remote dispensing site pharmacy. Any rule or portion of a rule, as that term is defined in section [536.010](#), that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of [chapter 536](#) and, if applicable, section [536.028](#). This section and [chapter 536](#) are nonseverable and if any of the powers vested with the general assembly pursuant to [chapter 536](#) to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2020, shall be invalid and void.

(L. 2020 H.B. 1682)

---- end of effective 28 Aug 2020 ----

[use this link to bookmark section 338.215](#) 

In accordance with Section **3.090**, the language of statutory sections enacted during a legislative session are updated and available on this website **on the effective date** of such enacted statutory section.



Other Information Other Links



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@15:58:27.4 25 :)

- #5. HHS Guidance on Pharmacist Immunizations of Pediatric Vaccines
 - d. HHS Pharmacist Immunization Announcement (8/19/20)
 - e. HHS Third Amendment to PREP Declaration Against COVID-19
 - f. Board COVID-19 Guidance (4-13-20)

Visit [cdc.gov/coronavirus](https://www.cdc.gov/coronavirus) for the latest Coronavirus Disease (COVID-19) updates.



HHS.gov

U.S. Department of Health & Human Services

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FOR IMMEDIATE RELEASE
August 19, 2020

Contact: HHS Press Office
202-690-6343
media@hhs.gov

HHS Expands Access to Childhood Vaccines during COVID-19 Pandemic

The U.S. Department of Health and Human Services (HHS) [issued a third amendment - PDF*](#) to the Declaration under the Public Readiness and Emergency Preparedness Act (PREP Act) to increase access to lifesaving childhood vaccines and decrease the risk of vaccine-preventable disease outbreaks as children across the United States return to daycare, preschool and school.

"Today's action means easier access to lifesaving vaccines for our children, as we seek to ensure immunization rates remain high during the COVID-19 pandemic," said HHS Secretary Alex Azar. "The Trump Administration has worked to allow pharmacists—alongside all of America's heroic healthcare workers—to practice at the top of their license, empowering the public with more options to protect their health and well-being."

The amendment authorizes State-licensed pharmacists (and pharmacy interns acting under their supervision to administer vaccines, if the pharmacy intern is licensed or registered by his or her State board of pharmacy) to order and administer vaccines to individuals ages three through 18 years, subject to several requirements:

- The vaccine must be approved or licensed by the Food and Drug Administration (FDA).
- The vaccination must be ordered and administered according to the CDC's Advisory Committee on Immunization Practices (ACIP) immunization schedules.
- The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.
- The licensed or registered pharmacy intern must complete a practical training program that is

approved by the ACPE. This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.

- The licensed pharmacist and licensed or registered pharmacy intern must have a current certificate in basic cardiopulmonary resuscitation.
- The licensed pharmacist must complete a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education during each State licensing period.
- The licensed pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which he or she administers vaccines, including informing the patient's primary-care provider when available, submitting the required immunization information to the State or local immunization information system (vaccine registry), complying with requirements with respect to reporting adverse events, and complying with requirements whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering a vaccine.
- The licensed pharmacist must inform his or her childhood-vaccination patients and the adult caregivers accompanying the children of the importance of a well-child visit with a pediatrician or other licensed primary care provider and refer patients as appropriate.

The above requirements are consistent with many States that already permit licensed pharmacists to order and administer vaccines to children.

A May 2020 Centers for Disease Control and Prevention (CDC) report found a troubling drop in routine childhood immunizations as a result of families staying at home. While families followed public health warnings about going out, an unfortunate result was many missed routine vaccinations. This decrease in childhood-vaccination rates is a public health threat and a collateral harm caused by the COVID-19 pandemic.

"As a pediatric critical care physician who has treated critically ill children suffering from vaccine preventable diseases, I know first-hand the devastation to the child – and to the family and community – of a death or severe brain damage that could have been avoided by a safe and effective vaccine," said HHS Assistant Secretary for Health Brett P. Giroir, M.D. "The cornerstone of public health, vaccines, makes these dreaded diseases preventable. As we expand options during the COVID-19 response, we are also reminding parents, grandparents, and caretakers that there is no substitute for a critically important well-child visit with a pediatrician or other licensed primary care provider when available."

HHS is expanding access to childhood vaccines to avoid preventable diseases in children, additional strains on the healthcare system, and any further increase in avoidable adverse health consequences—particularly if such complications coincide with an additional resurgence of COVID-19.

For CDC guidance on Routine Vaccination during the COVID-19 Outbreak, click [here](#).

For more information on National Immunization Awareness Month, click [here](#).

For the latest CDC Immunization Schedule, click [here](#).

For clinical resources on vaccines, including continuing education training on best practices, click [here](#).

To view the Notice of Amendment, click [here - PDF](#).*

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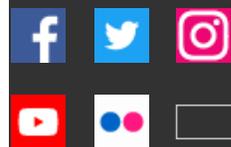
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BILLING CODE: 4150-03

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Third Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19

ACTION: Notice of amendment.

SUMMARY: The Secretary issues this amendment pursuant to section 319F-3 of the Public Health Service Act to add additional categories of Qualified Persons and amend the category of disease, health condition, or threat for which he recommends the administration or use of the Covered Countermeasures.

DATES: This amendment to the Declaration published on March 17, 2020 (85 FR 15198) is effective as of [DATE THIS AMENDMENT UPON PUBLICATION INTO THE FEDERAL REGISTER].

FOR FURTHER INFORMATION CONTACT: Robert P. Kadlec, MD, MTM&H, MS, Assistant Secretary for Preparedness and Response, Office of the Secretary, Department of Health and Human Services, 200 Independence Avenue SW, Washington, DC 20201; Telephone: 202-205-2882.

SUPPLEMENTARY INFORMATION: The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of Health and Human Services (the Secretary) to issue a Declaration to provide liability immunity to certain individuals and entities (Covered Persons) against any claim of loss caused by, arising out of, relating to, or resulting from the manufacture, distribution, administration, or use of medical countermeasures (Covered Countermeasures), except for claims involving “willful misconduct” as defined in the PREP Act. Under the PREP Act, a Declaration may be amended as circumstances warrant.

The PREP Act was enacted on December 30, 2005, as Public Law 109–148, Division C, § 2. It amended the Public Health Service (PHS) Act, adding section 319F–3, which addresses liability immunity, and section 319F–4, which creates a compensation program. These sections are codified at 42 U.S.C. 247d–6d and 42 U.S.C. 247d–6e, respectively. Section 319F-3 of the PHS Act has been amended by the Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA), Public Law 113-5, enacted on March 13, 2013 and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law 116–136, enacted on March 27, 2020, to expand Covered Countermeasures under the PREP Act.

On January 31, 2020, the Secretary declared a public health emergency pursuant to section 319 of the PHS Act, 42 U.S.C. 247d, effective January 27, 2020, for the entire United States to aid in the response of the nation’s health care community to the COVID–19 outbreak. Pursuant to section 319 of the PHS Act, the Secretary renewed that declaration on April 26, 2020, and July 25, 2020. On March 10, 2020, the Secretary issued a Declaration under the PREP Act for medical countermeasures against COVID–19 (85 FR 15198, Mar. 17, 2020) (the Declaration). On April 10, the Secretary amended the Declaration under the PREP Act to extend liability immunity to covered countermeasures authorized under the CARES Act (85 FR 21012, Apr. 15, 2020). On June 4, the Secretary

amended the Declaration to clarify that covered countermeasures under the Declaration include qualified countermeasures that limit the harm COVID-19 might otherwise cause.

The Secretary now amends section V of the Declaration to identify as qualified persons covered under the PREP Act, and thus authorizes, certain State-licensed pharmacists to order and administer, and pharmacy interns (who are licensed or registered by their State board of pharmacy and acting under the supervision of a State-licensed pharmacist) to administer, any vaccine that the Advisory Committee on Immunization Practices (ACIP) recommends to persons ages three through 18 according to ACIP's standard immunization schedule (ACIP-recommended vaccines).¹

The Secretary also amends section VIII of the Declaration to clarify that the category of disease, health condition, or threat for which he recommends the administration or use of the Covered Countermeasures includes not only COVID-19 caused by SARS-CoV-2 or a virus mutating therefrom, but also other diseases, health conditions, or threats that may have been caused by COVID-19, SARS-CoV-2, or a virus mutating therefrom, including the decrease in the rate of childhood immunizations, which will lead to an increase in the rate of infectious diseases.

Description of This Amendment by Section

Section V. Covered Persons

Under the PREP Act and the Declaration, a “qualified person” is a “covered person.” Subject to certain limitations, a covered person is immune from suit and liability under Federal and State law with respect to all claims for loss caused by, arising out of, relating to, or resulting from the administration or use of a covered countermeasure if a declaration under subsection (b) has been issued with respect to such countermeasure. “Qualified person” includes

- (A) a licensed health professional or other individual who is authorized to prescribe, administer, or dispense such countermeasures under

¹ The only vaccines that ACIP has recommended are authorized or licensed by the Food and Drug Administration (FDA). PREP Act coverage here is limited to covered persons ordering and administering FDA-authorized or FDA-licensed vaccines.

the law of the State in which the countermeasure was prescribed, administered, or dispensed; or

(B) “a person within a category of persons so identified in a declaration by the Secretary” under subsection (b) of the PREP Act.

42 U.S.C. 247d-6d(i)(8).²

By this amendment to the Declaration, the Secretary identifies an additional category of persons who are qualified persons under section 247d-6d(i)(8)(B).³

On May 8, 2020, CDC reported, “The identified declines in routine pediatric vaccine ordering and doses administered might indicate that U.S. children and their communities face increased risks for outbreaks of vaccine-preventable diseases,” and suggested that a decrease in rates of routine childhood vaccinations were due to changes in healthcare access, social distancing, and other COVID-19 mitigation strategies.⁴ The report also stated that “[p]arental concerns about potentially exposing their children to COVID-19 during well child visits might contribute to the declines observed.”⁵

On July 10, 2020, CDC reported its findings of a May survey it conducted to assess the capacity of pediatric health care practices to provide immunization services to children during the COVID-19

² See Advisory Opinion on the Public Readiness and Emergency Preparedness Act and the March 10, 2020 Declaration under the Act, 5-6 (May 19, 2020), <https://www.hhs.gov/sites/default/files/prep-act-advisory-opinion-hhs-ogc.pdf> (last visited Aug. 5, 2020).

³ See Advisory Opinion 20-02 on the Public Readiness and Emergency Preparedness Act and the Secretary’s Declaration under the Act, 3-5 (May 19, 2020), <https://www.hhs.gov/sites/default/files/advisory-opinion-20-02-hhs-ogc-prep-act.pdf> (setting forth PREP Act’s legal framework for identifying a “qualified person” and preemption of state law that is different from, or is in conflict with, that designation).

⁴ Jeanne M. Santoli et al., *Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020*, 69 MMWR 591, 592 (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6919e2-H.pdf> (last visited July 15, 2020); see also Melissa Jenco, *AAP urges vaccination as rates drop due to COVID-19*, AAP NEWS (May 8, 2020), <https://www.aappublications.org/news/2020/05/08/covid19vaccinations050820> (last visited July 15, 2020).

⁵ Jeanne M. Santoli et al., *Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020*, 69 MMWR 591, 592 (2020), <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6919e2-H.pdf> (last visited July 15, 2020).

pandemic. The survey, which was limited to practices participating in the Vaccines for Children program, found that, as of mid-May, 15 percent of Northeast pediatric practices were closed, 12.5 percent of Midwest practices were closed, 6.2 percent of practices in the South were closed, and 10 percent of practices in the West were closed. Most practices had reduced office hours for in-person visits. When asked whether their practices would likely be able to accommodate new patients for immunization services through August, 418 practices (21.3 percent) either responded that this was not likely or the practice was permanently closed or not resuming immunization services for all patients, and 380 (19.6 percent) responded that they were unsure. Urban practices and those in the Northeast were less likely to be able to accommodate new patients compared with rural practices and those in the South, Midwest, or West.⁶

In response to these troubling developments, CDC and the American Academy of Pediatrics have stressed, “Well-child visits and vaccinations are essential services and help make sure children are protected.”⁷

The Secretary re-emphasizes that important recommendation to parents and legal guardians here: If your child is due for a well-child visit, contact your pediatrician’s or other primary-care provider’s office and ask about ways that the office safely offers well-child visits and vaccinations.

Many medical offices are taking extra steps to make sure that well-child visits can occur safely during the COVID-19 pandemic, including:

- Scheduling sick visits and well-child visits during different times of the day or days of the week, or at different locations.

⁶ Tara M. Vogt, *Provision of Pediatric Immunization Services During the COVID-19 Pandemic: an Assessment of Capacity Among Pediatric Immunization Providers Participating in the Vaccines for Children Program — United States, May 2020*, 69 MMWR 859, 859-61, <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6927a2-H.pdf> (last visited July 15, 2020).

⁷ *Routine Vaccination During the COVID-19 Outbreak*, CDC, <https://www.cdc.gov/vaccines/parents/visit/vaccination-during-COVID-19.html> (last visited July 14, 2020).

- Asking patients to remain outside until it is time for their appointments to reduce the number of people in waiting rooms.
- Adhering to recommended social (physical) distancing and other infection-control practices, such as the use of masks.

The decrease in childhood-vaccination rates is a public health threat and a collateral harm caused by COVID-19. Together, the United States must turn to available medical professionals to limit the harm and public health threats that may result from decreased immunization rates. We must quickly do so to avoid preventable infections in children, additional strains on our healthcare system, and any further increase in avoidable adverse health consequences—particularly if such complications coincide with additional resurgence of COVID-19.

Together with pediatricians and other healthcare professionals, pharmacists are positioned to expand access to childhood vaccinations. Many States already allow pharmacists to administer vaccines to children of any age.^{8,9} Other States permit pharmacists to administer vaccines to children

⁸ For purposes of this amendment, “State” shall have the same meaning ascribed to it in 42 U.S.C. 201(f). Under section 201(f), “State” includes the several States, the District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, American Samoa, and the Trust Territory of the Pacific Islands.

⁹ See, e.g., Ala. Code § 34-23-1(5), (21) (2020); Ala. Admin. Code r. 680-X-2-.14(1) (2000); Alaska Stat. Ann. § 08.80.168(a) (West 2020); Cal. Bus. & Prof. Code § 4052(a)(11) (West 2020); Colo. Code Regs. § 719-1:19.00.00 (West 2020); Ga. Code Ann. § 43-34-26.1 (West 2020); Idaho Code Ann. § 54-1704 (West 2020); Idaho Code Ann. § 37-201 (West 2020); Ind. Code Ann. § 25-26-13-31.2(a) (West 2020); Iowa Admin. Code § 657-39.10(6) (2020); La. Admin. Code tit. 46, Pt. LIII, § 521 (2020); Mich. Comp. Laws Ann. § 333.9204 (2020); Miss. Code Ann. § 73-21-73(a), (dd) (West 2000); MO 20 CSR 2220-6.040; MO 20 CSR 2220-6.050; Neb. Rev. Stat. Ann. §§ 38-2806, 38-2837 (West 2000); 175 Neb. Admin. Code. § 8.003.01A(3)(m)(4)(a) (2020); N.H. Rev. Stat. § 318:16-b (2020); Nev. Admin. Code § 639.2971 (2020); N.M. Stat. Ann. § 61-11-2(A), (G), (CC) (West 2020); Okla. Stat. Ann. tit. 59, § 353.30 (West 2020); Or. Rev. Stat. § 689.645 (West 2020); <https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRESOURCES/Pages/pharmacy.aspx#:~:text=Immunization%20Resources%20for%20Oregon%20Pharmacists,a%20patient%20of%20any%20age> (last visited Aug. 13, 2020); S.C. Code Ann. § 40-43-190 (2020); S.D. Codified Laws § 36-11-2, S.D. Codified Laws § 36-11-19.1; Tenn. Code Ann. § 63-10-204(1), 39(A) (West 2020); Tex. Occ. Code Ann. § 551.003(33) (2020); 22 Tex. Admin. Code § 295.15(e) (2020); Utah Code Ann. § 58-17b-102(1), (57) (West 2020); Utah Admin. Code R156-17b-621(5) (2020); Va. Code Ann. § 54.1-3408(I) (2020); Wash. Rev. Code Ann. § 18.64.011(1), (28) (West

depending on the age—for example, 2, 3, 5, 6, 7, 9, 10, 11, or 12 years of age and older.¹⁰ Few States restrict pharmacist-administered vaccinations to only adults.¹¹ Many States also allow properly trained individuals under the supervision of a trained pharmacist to administer those vaccines.¹²

Pharmacists are well positioned to increase access to vaccinations, particularly in certain areas or for certain populations that have too few pediatricians and other primary-care providers, or that are otherwise medically underserved.¹³ As of 2018, nearly 90 percent of Americans lived within five

2020); Wis. Stat. Ann. § 450.035 (West 2020). While these states allow pharmacists to administer vaccines to children of any age, some impose additional requirements. *See, e.g.*, Cal. Bus. & Prof. Code §§ 4052(a)(11), 4052.8 (permitting pharmacists to administer any vaccine listed on the routine immunization schedules recommended by the Advisory Committee on Immunization Practices to persons three years of age and older, but requiring the pharmacist to administer immunizations to persons under three years of age only pursuant to a protocol with a prescriber); Colo. Code Regs. § 719-1:19.00.00 (West 2020) (requiring that pharmacists administer vaccines and immunizations “per authorization of a physician”).

¹⁰ *See, e.g.*, Ariz. Rev. Stat. Ann. § 32-1974(B) (2020); Ark. Code Ann. § 17-92-101 (2020); D.C. Mun. Reg. Tit. 17 sec. 6512.10 (2012); Haw. Rev. Stat. § 461-11.4 (West 2019); 225 Ill. Comp. Stat. Ann. 85/3(d) (West 2020); Kan. Stat. Ann. § 65-1635a (2020); Ky. Rev. Stat. Ann. § 315.010(22) (West 2020); Me. Rev. Stat. Ann. tit. 32, § 13831 (West 2020); Md. Code Ann., Health Occ. § 12-508 (2020); 247 Mass. Code Regs. 16.03 (2020); Minn. Stat. Ann. § 151.01 (West 2020); Mont. Code Ann. § 37-7-105 (West 2019); N.J. Stat. Ann. § 45:14-63 (West 2020); N.Y. Comp. Codes R. & Regs. tit. 8, § 63.9 (2020); N.C. Gen. Stat. Ann. § 90-85.15B (West 2020); N.D. Cent. Code Ann. § 43-15-01 (West 2020); Ohio Rev. Code Ann. § 4729.41 (West 2020); 63 Pa. Cons. Stat. § 390-9.2 (West 2020); P.R. Laws tit. 20, § 410c (2018); 5 R.I. Gen. Laws Ann. § 5-19.1-31 (West 2020); W. Va. Code Ann. § 30-5-7 (West 2020); Wyo Stat. Ann. § 33-24-157 (2020).

¹¹ *See, e.g.*, Conn. Gen. Stat. § 20-633(a) (West 2012); 24 Del. Code Ann. § 2502(23)(h) (West 2020); Fla. Stat. Ann. § 465.189(1) (West 2020); Vt. Admin. R. of Board of Pharm. § 10.35 (West 2020).

¹² *See, e.g.*, Or. Admin. R. 855-019-0270 (2020) (“[A]n intern who is appropriately trained and qualified in accordance with Section (3) of this rule may perform the same duties as a pharmacist, provided that the intern is supervised by an appropriately trained and qualified pharmacist.”).

¹³ *See, e.g., Guidance for Pharmacists and Pharmacy Technicians in Community Pharmacies during the COVID-19 Response*, CDC, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/pharmacies.html> (last updated June 28, 2020) (“As a vital part of the healthcare system, pharmacies play an important role in providing medicines, therapeutics, vaccines, and critical health services to the public.”); Kimberly McKeirnan & Gregory Sarchet, *Implementing Immunizing Pharmacy Technicians in a Federal Healthcare Facility*, 7 PHARMACY 1, 7 (2019), <https://www.mdpi.com/2226-4787/7/4/152/htm> (last visited Aug. 5, 2020) (HHS Indian Health Service study demonstrating “the effective implementation of immunization-trained pharmacy technicians and the positive impact utilization of pharmacy support personnel can create” on childhood vaccination rates in medically underserved populations).

miles of a community pharmacy.¹⁴ Pharmacies often offer extended hours and added convenience. What is more, pharmacists are trusted healthcare professionals with established relationships with their patients. Pharmacists also have strong relationships with local medical providers and hospitals to refer patients as appropriate.

For example, pharmacists already play a significant role in annual influenza vaccination. In the early 2018-19 season, they administered the influenza vaccine to nearly a third of all adults who received the vaccine.¹⁵ Given the potential danger of serious influenza and continuing COVID-19 outbreaks this autumn and the impact that such concurrent outbreaks may have on our population, our healthcare system, and our whole-of-nation response to the COVID-19 pandemic, we must quickly expand access to influenza vaccinations. Allowing more qualified pharmacists to administer the influenza vaccine to children will make vaccinations more accessible.

Therefore, the Secretary amends the Declaration to identify State-licensed pharmacists (and pharmacy interns acting under their supervision if the pharmacy intern is licensed or registered by his or her State board of pharmacy) as qualified persons under section 247d-6d(i)(8)(B) when the pharmacist orders and either the pharmacist or the supervised pharmacy intern administers vaccines to individuals ages three through 18 pursuant to the following requirements:

- The vaccine must be FDA-authorized or FDA-licensed.
- The vaccination must be ordered and administered according to ACIP's standard immunization schedule.¹⁶

¹⁴ *Get to Know Your Pharmacist*, CDC, <https://www.cdc.gov/features/pharmacist-month/index.html> (last visited July 14, 2020).

¹⁵ *Early-Season Flu Vaccination Coverage – United States, November 2018*, CDC, <https://www.cdc.gov/flu/fluview/nifs-estimates-nov2018.htm> (last visited July 14, 2020).

¹⁶ *See Immunization Schedules: For Health Care Providers*, CDC, <https://www.cdc.gov/vaccines/schedules/hcp/index.html> (last visited July 14, 2020). The immunization schedule recommends that certain vaccines be administered only to children of a certain age. For example, the second dose of both the measles, mumps, and rubella vaccine, as well as the varicella vaccine, should not be administered until a child is between four and six years old. *See Recommended Child and Adolescent Immunization Schedule for*

- The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.¹⁷
- The licensed or registered pharmacy intern must complete a practical training program that is approved by the ACPE. This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.¹⁸
- The licensed pharmacist and licensed or registered pharmacy intern must have a current certificate in basic cardiopulmonary resuscitation.¹⁹
- The licensed pharmacist must complete a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education during each State licensing period.²⁰
- The licensed pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which he or she administers vaccines, including informing the patient's primary-care provider when available, submitting the required immunization information to the State or local immunization information system (vaccine registry), complying with requirements with respect to reporting adverse events, and complying with requirements

ages 18 years or younger, United States, 2020, CDC (Jan. 29, 2020), <https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf> (last visited Aug. 5, 2020).

¹⁷ *Cf., e.g.*, Cal. Bus. & Prof. Code § 4052.8; 3 Colo. Code Regs. § 719-1:19.00.00; 856 Ind. Admin. Code 4-1-1; 46 La. Admin. Code tit. 46Part LIII, § 521; Nev. Admin. Code § 639.2973; 22 Tex. Admin. Code § 295.15(c).

¹⁸ *Cf., e.g.*, Ark. Admin. Code § 070.00.9-09-00-0002; 3 Colo. Code Regs. § 719-1:19.00.00; Nev. Admin. Code § 639.2973; N.H. Rev. Stat. § 318:16-d; Ohio Rev. Code Ann. § 4729.41(B); Or. Admin. R. 855-019-0270 (2020); S.C. Code Ann. §§ 40-43-190(B)(1), (4); Utah Admin. Code r. 156R-17b-621(5); Vt. Admin. Code 20-4-1400:10.35.

¹⁹ *Cf., e.g.*, Ariz. Admin. Code § R4-23-411(D)(3); Conn. Gen. Stat. § 20-633(b); D.C. Mun. Regs. tit. 17, § 6512.3; 856 Ind. Admin. Code 4-1-1(c); Iowa Admin. Code r. 657-39.10(2)(A); Kan. Stat. Ann. § 65-1635a(a); La. Admin. Code tit. 46 Part LIII, § 521(D); Me. Rev. Stat. Ann. tit. 32, § 13832; Md. Code Ann., Health Occ. § 12-508(b)(2)(ii); Mont. Code Ann. § 37-7-101(24)(b); N.J. Admin. Code § 13:39-4.21(b)(2); N.D. Cent. Code Ann. § 43-15-31.5; Or. Admin. R. 855-019-0270 (2020); 63 Pa. Stat. Ann. § 390-9.2;(a)(2) 216 R.I. Code R. § 40-15-1.11; S.C. Code Ann. §§ 40-43-190(B)(4); S.D. Admin. R. 20:51:28:02; W. Va. Code St. R. § 15-12-4; Wyo. Admin. Code 059.0001.16 § 7.

²⁰ *Cf., e.g.*, AR ADC § 070.00.9-09-00-0002; 3 Colo. Code Regs. § 719-1:19.00.00; N.J. Stat. Ann. § 13:39-4.21; S.C. Code Ann. §§ 40-43-190(B)(1), (5); 22 Tex. Admin. Code § 295.15(c); Utah Admin. Code r. 156-17b-621(5); 59-0001-16 Wyo. Code R. § 7.

whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering a vaccine.²¹

- The licensed pharmacist must inform his or her childhood-vaccination patients and the adult caregivers accompanying the children of the importance of a well-child visit with a pediatrician or other licensed primary-care provider and refer patients as appropriate.²²

These requirements are consistent with those in many States that permit licensed pharmacists to order and administer vaccines to children and permit licensed or registered pharmacy interns acting under their supervision to administer vaccines to children.²³

Administering vaccinations to children age three and older is less complicated and requires less training and resources than administering vaccinations to younger children. That is because ACIP generally recommends administering intramuscular injections in the deltoid muscle for individuals age three and older.²⁴ For individuals less than three years of age, ACIP generally recommends administering intramuscular injections in the anterolateral aspect of the thigh muscle.²⁵ Administering injections in the thigh muscle often presents additional complexities and requires additional training and

²¹ *Cf.*, e.g., Ala. Admin. Code r. 680-X-2.14; Ariz. Admin. Code § R4-23-411(E); AR ADC § 070.00.9-09-00-0002; Cal. Code Regs. tit. 16, § 1746.4; Conn. Gen. Stat. § 20-633(b); 225 Ill. Comp. Stat. Ann. 85/3(d)(4); Kan. Stat. Ann. § 65-1635a(a); Mont. Admin. R. 24.174.503; Nev. Rev. Stat. Ann. § 454.213(s); N.H. Rev. Stat. § 318:16-d; N.J. Stat. Ann. § 45:14-63; N.Y. Comp. Codes R. & Regs. tit. 8, § 63.9; N.D. Cent. Code Ann. § 43-15-31.5; Or. Admin. r. 855-019-0280; 216-40; R.I. Code R. § 15-1.11; S.C. Code Ann. §§ 40-43-190(B)(1), (5); S.D. Admin. R. 20:51:28:04; Tenn. Code Ann. § 53-10-211; 22 Tex. Admin. Code § 295.15(c); 04-230 Vt. Code R. § 10.35; Va. Code Ann. § 54.1-3408; Wis. Stat. Ann. § 450.035.

²² *See, e.g.*, Letter from Kathleen E. Toomey, M.D., M.P.H., Comm'r and State Health Officer, Ga. Dep't of Pub. Health, available at <https://www.gpha.org/immunization/> (last visited July 15, 2020).

²³ *See, e.g.*, AL ST § 34-23-53; 12 AAC 52.992; Cal. Bus. & Prof. Code § 4052; Cal. Bus. & Prof. Code § 4052.8(b); 3 Colo. Code Regs. § 719-1:19.00.00; Ga. Code Ann., § 43-34-26.1; 856 IAC 4-1-1; Iowa Code § 39.10(2)(a); N.M. Admin. Code 16.19.26; Okla. Admin. Code 535:10-11-5; Code 1976 § 40-43-190 (South Carolina).

²⁴ Vaccine Recommendations and Guidelines of the ACIP, <https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/administration.html> (last visited July 29, 2020).

²⁵ *Id.*

resources including additional personnel to safely position the child while another healthcare professional injects the vaccine.²⁶

Moreover, as of 2018, 40% of three-year-olds were enrolled in preprimary programs (i.e. preschool or kindergarten programs).²⁷ Preprimary programs are beginning in the coming weeks or months, so the Secretary has concluded that it is particularly important for individuals ages three through 18 to receive ACIP-recommended vaccines according to ACIP's standard immunization schedule. All States require children to be vaccinated against certain communicable diseases as a condition of school attendance. These laws often apply to both public and private schools with identical immunization and exemption provisions.²⁸ As nurseries, preschools, kindergartens, and schools reopen, increased access to childhood vaccinations is essential to ensuring children can return.

Notwithstanding any State or local scope-of-practice legal requirements, (1) qualified licensed pharmacists are identified as qualified persons to order and administer ACIP-recommended vaccines and (2) qualified State-licensed or registered pharmacy interns are identified as qualified persons to administer the ACIP-recommended vaccines ordered by their supervising qualified licensed pharmacist.²⁹

²⁶ *Id.*; Nicole E. Omecene, *et al.*, *Implementation of pharmacist-administered pediatric vaccines in the United States: major barriers and potential solutions for the outpatient setting*, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6594428/> (last visited July 29, 2020).

²⁷ Preschool and Kindergarten Enrollment, https://nces.ed.gov/programs/coe/indicator_cfa.asp (last visited July 29, 2020).

²⁸ State School Immunization Requirements and Vaccine Exemption Laws, <https://www.cdc.gov/php/docs/school-vaccinations.pdf>, (last visited July 29, 2020).

²⁹ Nothing herein shall affect federal law requirements in 42 C.F.R. Part 455, subpart E regarding screening and enrollment of Medicare and Medicaid providers. Moreover, nothing herein shall preempt State laws that permit additional individuals to administer vaccines that ACIP recommends to persons age 18 or younger according to ACIP's standard immunization schedule. For example, Idaho permits pharmacy technicians who meet certain requirements to administer vaccines under the supervision of an immunizing pharmacist. Such technicians can still administer vaccines to the extent they would have been able to absent publication of this amendment. Moreover, pharmacists and pharmacy interns may still order or administer vaccines to individuals ages two or younger to the extent authorized under State law.

Both the PREP Act and the June 4, 2020 Second Amendment to the Declaration define “covered countermeasures” to include qualified pandemic and epidemic products that “limit the harm such pandemic or epidemic might otherwise cause.”³⁰ The troubling decrease in ACIP-recommended childhood vaccinations and the resulting increased risk of associated diseases, adverse health conditions, and other threats are categories of harms otherwise caused by COVID-19 as set forth in Sections VI and VIII of this Declaration.³¹ Hence, such vaccinations are “covered countermeasures” under the PREP Act and the June 4, 2020 Second Amendment to the Declaration.

Nothing in this Declaration shall be construed to affect the National Vaccine Injury Compensation Program, including an injured party’s ability to obtain compensation under that program. Covered countermeasures that are subject to the National Vaccine Injury Compensation Program authorized under 42 U.S.C. 300aa-10 *et seq.* are covered under this Declaration for the purposes of liability immunity and injury compensation only to the extent that injury compensation is not provided under that Program. All other terms and conditions of the Declaration apply to such covered countermeasures.

Section VIII. Category of Disease, Health Condition, or Threat

As discussed, the troubling decrease in ACIP-recommended childhood vaccinations and the resulting increased risk of associated diseases, adverse health conditions, and other threats are categories of harms otherwise caused by COVID-19. The Secretary therefore amends section VIII, which describes the category of disease, health condition, or threat for which he recommends the admin-

³⁰ 42 U.S.C. § 247d-d6(i)(7)(A); 85 FR 35-100, 35-102.

³¹Jeanne M. Santoli et al., *Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration — United States, 2020*, 69 MMWR No. 19, at 591–93 (May 15, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm>; Cristi A. Bramer et al., *Decline in Child Vaccination Coverage During the COVID-19 Pandemic — Michigan Care Improvement Registry, May 2016–May 2020*, 69 MMWR No. 20, at 630–31 (May 22, 2020), <https://www.cdc.gov/mmwr/volumes/69/wr/mm6920e1.htm>.

istration or use of the Covered Countermeasures, to clarify that the category of disease, health condition, or threat for which he recommends the administration or use of the Covered Countermeasures is not only COVID-19 caused by SARS-CoV-2 or a virus mutating therefrom, but also other diseases, health conditions, or threats that may have been caused by COVID-19, SARS-CoV-2, or a virus mutating therefrom, including the decrease in the rate of childhood immunizations, which will lead to an increase in the rate of infectious diseases.

Amendments to Declaration

Amended Declaration for Public Readiness and Emergency Preparedness Act Coverage for medical countermeasures against COVID-19.

Sections V and VIII of the March 10, 2020 Declaration under the PREP Act for medical countermeasures against COVID-19, as amended April 10, 2020 and June 4, 2020, are further amended pursuant to section 319F-3(b)(4) of the PHS Act as described below. All other sections of the Declaration remain in effect as published at 85 FR 15198 (Mar. 17, 2020) and amended at 85 FR 21012 (Apr. 15, 2020) and 85 FR 35100 (June 8, 2020).

1. Covered Persons, section V, delete in full and replace with:

V. Covered Persons

42 U.S.C. 247d-6d(i)(2), (3), (4), (6), (8)(A) and (B)

Covered Persons who are afforded liability immunity under this Declaration are “manufacturers,” “distributors,” “program planners,” “qualified persons,” and their officials, agents, and employees, as those terms are defined in the PREP Act, and the United States.

In addition, I have determined that the following additional persons are qualified persons: (a) Any person authorized in accordance with the public health and medical emergency response of the Authority Having Jurisdiction, as described in Section VII below, to prescribe, administer, deliver, distribute or dispense the Covered Countermeasures, and their officials, agents, employees, contractors and volunteers, following a Declaration of an emergency; (b) any person authorized to prescribe, administer, or dispense the Covered Countermeasures or who is otherwise authorized to perform an activity under an Emergency Use Authorization in accordance with Section 564 of the FD&C Act; (c) any person authorized to prescribe, administer, or dispense Covered Countermeasures in accordance with Section 564A of the FD&C Act; and (d) a State-licensed pharmacist who orders and administers, and pharmacy interns who administer (if the pharmacy intern acts under the supervision of such pharmacist and the pharmacy intern is licensed or registered by his or her State board of pharmacy), vaccines that the Advisory Committee on Immunization Practices (ACIP) recommends to persons ages three through 18 according to ACIP's standard immunization schedule.

Such State-licensed pharmacists and the State-licensed or registered interns under their supervision are qualified persons only if the following requirements are met:

- The vaccine must be FDA-authorized or FDA-licensed.
- The vaccination must be ordered and administered according to ACIP's standard immunization schedule.
- The licensed pharmacist must complete a practical training program of at least 20 hours that is approved by the Accreditation Council for Pharmacy Education (ACPE). This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.
- The licensed or registered pharmacy intern must complete a practical training program that is approved by the ACPE. This training program must include hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines.

- The licensed pharmacist and licensed or registered pharmacy intern must have a current certificate in basic cardiopulmonary resuscitation.
- The licensed pharmacist must complete a minimum of two hours of ACPE-approved, immunization-related continuing pharmacy education during each State licensing period.
- The licensed pharmacist must comply with recordkeeping and reporting requirements of the jurisdiction in which he or she administers vaccines, including informing the patient's primary-care provider when available, submitting the required immunization information to the State or local immunization information system (vaccine registry), complying with requirements with respect to reporting adverse events, and complying with requirements whereby the person administering a vaccine must review the vaccine registry or other vaccination records prior to administering a vaccine.
- The licensed pharmacist must inform his or her childhood-vaccination patients and the adult caregiver accompanying the child of the importance of a well-child visit with a pediatrician or other licensed primary-care provider and refer patients as appropriate.

Nothing in this Declaration shall be construed to affect the National Vaccine Injury Compensation Program, including an injured party's ability to obtain compensation under that program. Covered countermeasures that are subject to the National Vaccine Injury Compensation Program authorized under 42 U.S.C. 300aa-10 *et seq.* are covered under this Declaration for the purposes of liability immunity and injury compensation only to the extent that injury compensation is not provided under that Program. All other terms and conditions of the Declaration apply to such covered countermeasures.

2. Category of Disease, Health Condition, or Threat, section VIII, delete in full and replace with:

VIII. Category of Disease, Health Condition, or Threat
42 U.S.C. 247d-6d(b)(2)(A)

The category of disease, health condition, or threat for which I recommend the administration or use of the Covered Countermeasures is not only COVID-19 caused by SARS-CoV-2 or a virus mutating therefrom, but also other diseases, health conditions, or threats that may have been caused

by COVID-19, SARS-CoV-2, or a virus mutating therefrom, including the decrease in the rate of childhood immunizations, which will lead to an increase in the rate of infectious diseases.

Authority: 42 U.S.C. § 247d–6d.

Dated:

Alex M. Azar II,

Secretary of Health and Human Services.

MISSOURI BOARD OF PHARMACY

MISSOURI BOARD OF PHARMACY STATEMENT ON COVID-19 TESTING (4-13-20)

The U.S. Department of Health and Human Services (HHS) recently released a [statement authorizing licensed pharmacists to order and administer COVID-19 testing](#). As recognized by HHS, pharmacists have been on the frontline in providing patient care during this unprecedented pandemic. HHS' authorization provides another tool to assist pharmacists in protecting the health and welfare of Missouri citizens. The Board encourages pharmacists to be a part of the solution and is issuing the following guidance to assist Missouri licensees:

GENERAL INFORMATION

To protect patients, pharmacists ordering/administering COVID-19 testing pursuant to HHS' authorization should be appropriately educated/trained to perform the services provided and comply with professional standards of practice. Permit holders should also ensure testing services provided at or on behalf of the pharmacy comply with all applicable law and practice standards. Additionally:

- The Board recommends documenting the patient care services provided. Patients should be referred to their primary care provider for additional treatment/medical care when appropriate.
- Pursuant to [§ 338.035.4](#), intern pharmacists may assist with COVID-19 testing under the direct supervision of a pharmacist.
- COVID-19 testing is a non-dispensing function that can be performed outside of a licensed pharmacy pursuant to [20 CSR 2220-6.055](#). A Board medication therapeutic services (MTS) certificate is not required to order/administer COVID-19 testing pursuant to DHHS' authorization.
- The Board cannot give guidance on specific test selection/requirements, patient screening or payment/reimbursement opportunities. However, review the resource section below for additional CDC recommendations/guidance.

To ensure patient safety, licensees administering testing should take necessary precautions to ensure proper sanitation and prevent unnecessary exposure. Licensees and permit holders should review the CDC's "[Considerations for Pharmacies During the COVID-19 Pandemic](#)" guidance document for cautionary measures to help minimize risk to patients and pharmacy staff. The Board also recommends the following:

- A separately designated patient testing area is recommended to prevent unnecessary exposure and minimize risk for pharmacy personnel and patients. Testing areas should be regularly cleaned and sanitized between patient visits.
- Pharmacy staff should wear personal protective equipment (PPE) when testing. CDC guidance on donning PPE is available online at <https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf>. Pharmacists should be trained on proper garbing technique and evaluated on garbing procedures prior to administering testing.
- In the event of a positive test, permit holders should establish an infection control and response procedure to prevent further risk of exposure (e.g., immediate sanitation/cleaning, quarantining staff or supplies). Appropriate action must be taken to ensure pharmacy safety and sanitation.

*****SEE THE ATTACHED DHSS STATEMENT ON REPORTING POSITIVE RESULTS*****



ADDITIONAL FEDERAL REQUIREMENTS

Licensees should consult with legal counsel to ensure compliance with applicable state and federal laws, including, the [Clinical Laboratory Improvement Amendments of 1988](#) (CLIA). At this time, the federal government has not waived [CLIA](#) requirements.

- **CLIA-Waived Testing:** The Board has been advised by the Missouri Department of Health and Senior Services (DHSS) that a CLIA certificate is required for pharmacies providing diagnostic testing. DHSS administers the CLIA program in the state of Missouri. Information on applying for a CLIA certificate is available on DHSS' website at <https://health.mo.gov/safety/clia/>. The Missouri CLIA Program can also be contacted at: CLIA@health.mo.gov or by telephone at 573-751-6318. Only waived testing is allowed with a CLIA certificate of waiver.

The FDA is continuously reviewing and approving new COVID-19 testing kits. Please refer to the FDA website for COVID 19 approved tests and complexity. The FDA is continuously making updates and changes. A link to the FDA EUA approved tests can be found here: <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#covid19ivd>

Questions regarding CLIA certification applications/requirements should be addressed to DHSS/CLIA. The Board of Pharmacy cannot answer CLIA questions.

- **Non-Waived CLIA Testing:** For non-waived CLIA testing (moderate and high complexity testing), a CLIA compliance certificate is required. DHSS/CLIA will expedite all applications, but regulatory standards will be applicable. Questions regarding non-waived CLIA testing should also be addressed to the Missouri CLIA Program at the e-mail address/phone number listed above.

ADDITIONAL RESOURCES

The following CDC resources are recommended:

1. [Considerations for Pharmacies during the COVID-19 Pandemic](#)
2. [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons with Coronavirus Disease 2019 \(COVID-19\)](#)
3. [Evaluating and Testing Persons for Coronavirus Disease 2019 \(COVID-19\): https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html](#)
4. [PPE Recommendations](#)
5. [CDC Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#)





Missouri Department of Health and Senior Services

P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired and Voice dial: 711

Randall W. Williams, MD, FACOG
Director



Michael L. Parson
Governor

Date March 24, 2020

Regarding: Mandatory Reporting for all MO medical facilities/laboratories providing testing for COVID-19:

Please be advised that it is now required by Executive Order for facilities in Missouri to report all positive and negative results for COVID-19 only to the Missouri Department of Health and Senior Services. See link below: (<https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/pdf/reporting-of-covid-19-lab-results.pdf>).

The following technical guidance is provided to assist laboratories and providers in meeting this requirement.

Laboratories:

- Laboratories reporting through electronic laboratory reporting prior to March 20, 2020, can continue to provide results through that method.
- Other laboratories may provide results electronically by submitting Excel line listings via the state's secure file transfer protocol (SFTP) site. Laboratories may request access to the SFTP site by contacting Becca Mickels with the Bureau of Reportable Disease Informatics at Becca.Mickels@health.mo.gov or Angela McKee at Angela.McKee@health.mo.gov.
- Laboratories unable to provide COVID-19 results electronically may fax results to 573-751-6417.

Hospitals and Other Medical Providers:

- Per 19 CSR 20-20.020, both laboratories and hospitals are required to report. Due to the expected volume of negative test results, ***hospitals that are working with a separate commercial laboratory that is reporting do not need to submit negative laboratory results.***
- Hospital laboratories need to submit all results as required for other laboratories above.
- Hospitals and other providers must submit case reports on positive and indeterminate cases.

Please let me know if you have questions regarding reporting.

Thank you,

Becca Mickels, Chief
Bureau of Reportable Disease Informatics
MO Dept of Health and Senior Services
Phone: (573) 751-6119
Email: becca.mickels@health.mo.gov

Sent via MO CLIA Program
Bureau of Diagnostic Services
Missouri Department of Health & Senior Services

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- #6 General Office Updates
- c. Office Updates
- d. COVID-19 Updates