EVALUATION OF A PATIENT ASSISTANCE PROGRAM PILOT PROJECT AT HEALTH CLINICS IN THE APPALACHIAN REGION DURING FISCAL YEAR 2007 & 2008

U.S. Department of Health and Human Services
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Office of Rural Health Policy

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I. Executive Summary

The Federal Office of Rural Health Policy (ORHP), Health Resources and Services Administration, U.S. Department of Health and Human Services partnered with the Appalachian Regional Commission (ARC) to conduct a 2 year pilot project with the intent of decreasing the administrative burdens faced by rural providers in accessing donated medications from pharmaceutical company assistance programs for their low income patients. ORHP provided funding during fiscal years 2007 and 2008 for a pilot project via an interagency agreement with ARC. ARC determined that use of an automated system to assist with patient registration, ordering, and tracking medications obtained through pharmaceutical company assistance programs was an intervention which merited field testing.   ARC identified the successful implementation of an automated prescription Patient Assistance Program (PAP) in North Carolina, the Medication Access and Review Program (MARP), and chose to see if that system could be modified and used successfully with rural practices in other states. Four organizations were invited to participate in the pilot. One organization declined to participate, one did not complete the pilot, and the two remaining organizations completed the pilot and continue to use MARP as of the time of this evaluation.

The staff at the two sites that completed the program found the use of an automated PAP system to be useful for both increasing low income patients' access to medications and reducing their administrative burden of working with free medication programs. The return on the Federal investment was high. ORHP invested $265,000 in the pilot program and well over

$1.1 million in no-cost medications were dispensed to low-income patients (this figure includes 3 years of data from one site, but only 1 year from the second, potentially understating the total value of prescriptions dispensed).

Factors were identified that may limit a broad scale roll-out of the MARP or any other automated PAP software to rural providers. These include State regulations on dispensing medications and the issue of who will bear the costs associated with start-up and ongoing support.

The automated PAP pilot also provided lessons learned that may be applicable to other demonstration projects where new systems or care processes are implemented. These include:

- the importance of prescreening of potential participants to ensure organizational commitment;

- flexible training options; and

- the need to incorporate evaluative components into the design of a pilot program so that all data that are needed for program assessment are collected.

II. Background

Access to prescription medications can be challenging for people with lower incomes. Many pharmaceutical manufacturers offer assistance programs through which they donate prescription medicines to qualified patients. Each program establishes its own patient eligibility criteria, formulary, and application process. Some require patients to be uninsured while others make allowance for Medicare coverage. Most programs require either a physician's

signature or prescription for a specific medicine while some do not. The definition of what

constitutes low income also varies by program, as does acceptable proof of income (i.e.

paycheck stubs, tax records, etc.). Navigating the maze of assistance programs with their

different eligibility criteria and application processes can be time consuming for both patients

and providers. However, prescription assistance programs are an important component of

ensuring access to medications for low-income patients served by rural clinics. Many rural

providers offer Patient Assistance Programs (PAPs) to assist patients in obtaining medications

available through the various pharmaceutical manufacturers' programs.

The U.S. Department of Health and Human Services, Health Resources and Services

Administration, Federal Office of Rural Health Policy (ORHP), partnered with the Appalachian

Regional Commission (ARC) to conduct a 2 year pilot project to identify and implement

practices which would ease the administrative burden of accessing medications through

pharmaceutical company assistance programs as well as enhance the efficiency and improve

the overall management of rural providers' PAPs. ORHP provided funding during fiscal years

2007 and 2008 for the project via an interagency agreement with ARC. ARC determined that

use of an automated system to assist with patient registration, ordering, and tracking

medications obtained through pharmaceutical company assistance programs was an option

that merited field testing. ARC identified the successful implementation of an automated PAP

in North Carolina, the Medication Access and Review Program (MARP), and chose to see if that

system could be modified and used successfully with rural practices in other states. The MARP

software allowed users to:

- access multiple companies' free medication programs;

- automate the application process;

- provides a tracking and reminder system; and

- eliminate the entry of duplicate patient information when a patient receives medications from more than one assistance program.

Four organizations in four different states were identified by the ARC, including one in the Delta Regional Commission (DRC) which was invited to participate in the pilot. However, the DRC organization, in Missouri, chose not to participate. One organization in Mississippi initially chose to participate but did not complete the pilot. Two organizations, one in Ohio and one in Kentucky, completed the pilot and continue to use MARP as of the time of this evaluation (Figure 1).

Figure 1: Organizations Invited to Participate

Delta Network, Sikeston, Missouri – did not participate
Hickory Flat Clinic, Hickory Flat, Mississippi – did not complete pilot
Monroe Family Health Center, Monroe, Ohio – completed pilot
Kentucky River Community Care, Hazard, Kentucky – completed pilot

ORHP contracted with an independent evaluator to assist in conducting a twofold evaluation. First, to determine if an automated system such as MARP that was developed in one State could be implemented in other States that do not have a pre-existing infrastructure for implementation and long-term support and second, to identify lessons learned that may

help in the creation of other opportunities for rural clinics through informed and sustainable

system dissemination.

III. Evaluation Process

Contract evaluators conducted both key informant interviews and secondary data

reviews as part of the evaluation. The evaluators completed in-person interviews with staff

from the NC Office of Rural Health and Community Care/NC Foundation for Advanced Health

Programs (ORHCC), the agency which developed, disseminated and provides ongoing technical

support for MARP. They also interviewed staff from the three sites in Kentucky, Mississippi,

and Ohio by telephone about their experiences with the pilot (Appendix A). The evaluators

were unable to obtain contact information for the potential pilot site in Missouri and therefore

are unable to comment on their reasons for not participating in the pilot. The evaluators

reviewed secondary data from ORHCC to identify the rural/urban distribution of MARP users in

North Carolina and conducted Internet searches to collect information on other types of

medication assistance programs and provider dispensing privileges by State.

IV. Overview of MARP and its Use in North Carolina

Description of MARP

For the last 10 years the ORHCC has provided support to safety-net providers who

wanted to offer a prescription assistance program (PAP) to their patients. Prior to 2003,

ORHCC's PAP sites utilized a leased software program from the Virginia Health Care Foundation.

The MARP software was developed to add functionality missing from the leased software and

to meet the needs of another pharmacy assistance program managed by ORHCC, the NC Senior

Care Program. Funding for the initial software development was provided by the NC Health

and Wellness Trust Fund, a State foundation established using monies from the Tobacco Master

Settlement Agreement. Practices began using MARP in North Carolina in 2003.

The MARP software assists medical clinics with the administrative tasks necessary for

utilizing pharmaceutical companies' free medication programs. The MARP database houses

demographic and financial information of all patients requesting medications, eliminating

duplicate entry of information for patients receiving drugs from more than one free medication

program. It provides a tracking and reminder system for all of the steps in the medication

ordering and dispensing process, from initial patient data collection to reordering before a

patient runs out of medicine. MARP users are also able to print patient safety/education

materials on the drug dispensed and check for drug interactions, medical allergy warnings, and

duplicate therapies before a medication is ordered. Updates are made to the software daily to

reflect changes in pharmaceutical companies' program requirements such as: modifications to

application forms, revised patient eligibility criteria, or available drugs. The next planned

upgrade of the software will add functions to track hospitalizations of MARP patients and

dispensing of sample medications.

MARP is only designed for use with chronic or maintenance medications, it is not used

for acute medications. MARP is not dispensing software. All organizations using MARP are

responsible for ensuring medications are dispensed legally. For clinics without an on-site

pharmacist, which is the majority of MARP users in North Carolina, dispensing is usually done

through the physician, nurse practitioner, or physician assistant's dispensing privilege under their medical license. To fulfill the legal dispensing requirement, the medical provider must check the packaged medication when it is received to make sure it is correct. Once the provider has completed his or her review, any staff member may physically hand the packaged medication to a patient. However, some practices choose to work with a local pharmacy to dispense the donated medications. The medication will be shipped to the medical practice, logged by staff to document that it was received, and then transferred to the partner pharmacy where it is picked up by the patient.

Utilization of MARP in North Carolina

At the time of the evaluation, 127 organizations across North Carolina, many with multiple service delivery sites, used MARP. In order to receive the MARP software, ORHCC requires clinics to have an established prescription assistance program in place. ORHCC considers a program to be established when it averages a minimum of 25 prescription assistance requests per week. This minimum volume must be maintained for the practice to keep the MARP software. Since 2003, less than five practices have had MARP uninstalled due to failure to meet the volume requirement. The types of organizations using MARP in North Carolina include: free clinics, faith based clinics, private practices, rural health clinics (RHCs), federally qualified health centers (FQHCs), mental health clinics and public health departments. Of the organizations using MARP, 52 percent are located in rural (non-metropolitan) communities. Over the last 6 years since MARP was implemented in North Carolina:

- 115,687 patients have been served;

- 955,118 prescriptions have been processed; and

- $357,177,217 worth of donated medications have been dispensed to low income

  patients.[1]

Financing and Cost of MARP in North Carolina

MARP is funded through a yearly State appropriation to ORHCC of approximately $597,000.

ORHCC's annual direct costs to support MARP include:

- $400,000 in personnel cost (6.5 FTEs);

- $60,000 in licensing fees for patient information materials used in MARP, Internet

  connection costs, and equipment, and;

- $137,000 for training and staff travel, supplies, and overhead.

With the average value of dispensed drugs exceeding $59 million per year, North Carolina sees

a return of $99 in donated medications for every $1 dollar of State money invested in MARP.

If the direct cost of MARP had to be supported solely by the 127 organizations using the

software in North Carolina, the annual fee per organization would be approximately $4,700.

However, because MARP is supported by State funds, an organization's only direct costs to

participate are the personnel cost of a prescription assistance coordinator (PAC) and a

computer with Internet access for use by the PAC. To operate an effective prescription

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[1] Source: ORHCC MARP Program, 2003-2009 Cumulative Data, provided 02/2010. Donated medications were originally valued based on average wholesale price (AWP), the valuation basis then changed to average delivered price (exact date of this change is unknown).

assistance program, ORHCC staff recommend an organization have at least a 1.0 FTE PAC; ORHCC staff estimated the average PAC salary in North Carolina at $23,000 per year plus fringe benefits. If MARP was not supported by State dollars and organizations were charged a fee for the software and ongoing support, ORHCC staff concluded that many free and faith-based clinics would not be able to afford the added cost and would be forced to discontinue using MARP and would have to scale back their PAPs.

Alternatives to MARP

According to staff from ORHCC, the MARP software's consistent updates, tracking/reminder capabilities and pharmacy module with patient safety information and drug interaction warning makes it unique. The evaluators conducted an Internet search for other systems designed to assist users with accessing pharmaceutical companies' prescription assistance programs and found several Web-based options. Most of the Web sites they reviewed were free (registration required), provided a searchable directory of companies offering no-cost or reduced prescriptions, listed basic information on eligibility requirements and the application process, and served as a gateway to the pharmaceutical companies' assistance programs. One Web site, designed for providers, offered additional services such as patient tracking and drug prices for an annual subscription fee of $1,350 ($750 for non-profit organizations) with an additional charge of $250 per year for report-generating capabilities. None of the systems reviewed included patient safety or drug interaction information.

The evaluators could not determine how frequently these systems were updated to reflect changes in assistance program requirements or formularies.

VI. Expansion Sites' Experiences

Mississippi

The pilot site in Mississippi, Hickory Flat Clinic (HFC), is a rural health clinic located in Hickory Flat. According to ORHCC, HFC staff received training and the MARP software was installed during the first year of the pilot but the practice chose to never fully implement the program and demonstrated limited interest in developing a comprehensive prescription assistance program for their patients. The one staff member who championed the program left the practice and the MARP software was uninstalled in March 2008. When the evaluators contacted HFC they found the practice had changed owners and only one staff member remained who worked at the practice during the MARP pilot. When they spoke with this staff member she remembered very little about the pilot program (she was not directly involved with their PAP at that time) and did not know why the practice chose not to complete the pilot. She did recall the MARP software was supposed to be very easy to use. She also thought the current nurse practitioner might be interested in the program if it was offered again. No data on number of patients served or number and dollar value of prescriptions dispensed were available either from ORHCC or HFC. Consequently, no data was obtained from this site.

Description of Sites Completing the Pilot

Two sites, one in Kentucky and one in Ohio completed the pilot. Kentucky River

Community Care (KRCC) is a community mental health center based in Hazard, Kentucky that

operates 44 sites in 8 counties. Seven of the sites use the MARP software. System-wide, KRCC

employs 3 psychiatrists and 5 advanced practice registered nurses in addition to counselors and

social workers and treats 12,400 patients annually. Primary care for KRCC's patients is provided

through a telehealth arrangement with an independent family practice group. KRCC employs

one PAC whose responsibilities are split between coordinating housing services and residential

placement for patients and overseeing the use of MARP by the other 30 staff at KRCC with

access to the software.

The other site, Monroe Family Health Center (MFHC), is located in Monroe, Ohio. MFHC

is one of three clinics operated by Ohio Hills Health Services, a federally qualified health center

(FQHC). MFHC is staffed by 1.4 FTE physicians and a 1.0 FTE nurse practitioner who serve

approximately 2,200 patients annually. MFHC employs one PAC whose responsibilities are split

between nursing (25 percent) and prescription assistance (75 percent).

Training & Implementation

Staff training and MARP software installation for both sites took place during early FY

2007. Implementing MARP posed few challenges for MRHC and these were easily resolved as

staff gained familiarity with the software. KRCC experienced more implementation difficulties

due to staff turnover. In addition to the original training sessions held in North Carolina for

staff from the pilot sites, staff from ORHCC traveled to Kentucky twice to provide on-site

training for new MARP users, once during FY 2007 and once in FY 2009 after the pilot ended

(travel costs for the first on-site training were supported by pilot program funds, KRCC paid the

costs of the second training). KRCC staff also reported their providers did not fully understand

MARP and what the program could and could not do.

Impact of MARP on PAPs

      MFHC's prescription assistance program has steadily increased since MARP was installed

(Table 1). Prior to the pilot program, MFHC staff estimated they provided prescription

assistance to approximately 100 patients and distributed $100,000 worth of prescriptions

annually. Before the implementation of MARP, KRCC staff also completed prescription

assistance requests manually but they were uncertain of the number of patients served or the

value of medications dispensed.

Table 1: Prescription assistance utilization since MARP implementation

	KRCC * (Kentucky)				MFHC (Ohio)			
	2007	2008	2009	Total	2007	2008	2009	Total
Patients served	Data		1,124	1,124	60	94	130	284
Rxs dispensed	not		3,452	3,452	182	396	484	1,062
$ value of Rxs	available		$731,824	$731,824	$76,711	$152,267	$202,609	$431,587

* KRCC staff did not provide 2007 and 2008 data.

Using the MARP software has improved access to medications for low income patients at both pilot sites. KRCC staff noted they receive more approvals and fewer denials than when they used a manual system; they also receive refills in a more timely manner. MFHC staff also commented on the increased speed with which they are able to get medications and the increased variety of drugs they are able to provide using MARP.

Staff from both pilot sites described MARP as having a significant impact on their overall efficiency. Their former manual processes involved looking up medications in the Physicians' Desk Reference to identify the manufacturer, research to see if the manufacturer offered a free medication program, calling the program to request a current application, and then completing the application by hand. MFHC staff estimated that using MARP saves them on average 15 minutes per prescription compared to their manual process. If MARP was no longer available both sites stated that they would have to return to a manual process unless they could find another software program.

Assessment of MARP Software & Support

Staff from each of the pilot sites rated the difficulty of using the MARP. Staff at both stated that the software was simple to use, rating it as 2 on a 10 point scale where 1 = very simple and 10 = very difficult. Staff were also asked if their practices used all of the MARP features and if there were other features they needed which the software lacked. MFHC staff used all of the features except the letter and label printing and the pharmacist module (tools for use by pharmacists conducting patient medication reviews). KRCC staff stated they used all

of the components. Neither site recommended any additional features or modules. MFHC

staff commented that MARP does everything they need it to do and that it is fantastic. Staff

from both sites also stated that they continue to receive ongoing support and regular software

updates and feel the level of user support is appropriate.

Continued Use of MARP

When asked if they plan to keep using MARP, staff from both pilot sites expressed a

desire to continue using the software but noted their future use could depend on whether they

are charged a user fee. MFHC's CEO felt the practice would be able to continue using MARP as

long as any fees were less than $500 per year. KRCC staff stated that although an annual fee up

to $2,500 would be reasonable, they were not sure the practice would be able to afford this

amount given their current budget situation.

VI: Return on Investment

From FY 2006 through FY 2009, ORHP invested $265,000 in the ARC's automated PAP pilot.

Funds were used by ARC (via interagency agreement) and ORHP for:

- Modifications to MARP software for use outside North Carolina and implementation of

  MARP software at pilot sites (FY 2007 - $100,000 / FY 2008 - $50,000);

- Cost of two training classes for pilot site staff held in North Carolina (FY 2006 / $75,000);

- ORHP staff time and travel and program evaluation (FY 2009 - $40,000).

The actual return on investment (ROI) of these funds cannot be calculated because KRCC staff could only provide participation data for 2009. At a minimum, though, considering only 4 of 6 site-years, this Federal investment resulted in over 1,400 low-income rural patients receiving access to medications valued in excess of $1.1 million at the two pilot sites. The rate of return on investment for the pilot program is likely significantly lower than the return on investment experienced by North Carolina. Assuming that KRCC had identical performance in all 3 years (which probably overstates the programs benefit), almost $10 in donated medications would have been received for every $1 of Federal funds.

Differences in ROI between North Carolina and the pilot can be explained by a number of factors. As demonstrated by MFHC, as providers gain familiarity with the software program the number of patients served as well as the number and dollar value of prescriptions dispensed increases. Most North Carolina practices using MARP are past the initial learning curve experienced by MFHC and KRCC during the 2 years of the pilot program. In addition with North Carolina's established infrastructure the incremental cost to enroll new providers in MARP is minimal; and with only two pilot sites, it is not possible to realize any economies of scale. Finally, it should be noted that none of these calculations include the cost to providers of hiring PACs.

<u>VII. Conclusion</u>

Feasibility of Future Expansion and Sustainability

The MARP software was successfully adapted for use in other States. The two sites completing the pilot found the use of an automated PAP to be useful for both increasing low income patients' access to medications and reducing their administrative burden of working with pharmaceutical companies' assistance programs.

However there are some factors that may limit a broad scale roll-out of the MARP or other PAP software to rural providers. The majority of ambulatory care practices do not employ a pharmacist on site. Therefore, either an arrangement must be made for a local pharmacy to dispense the donated medications to patients or the medications must be dispensed under the auspices of a provider's medical license. Dispensing privileges for providers vary by State (see Appendix B), and 14 states have some form of restricted dispensing privileges for physicians. Dispensing privileges are more limited for physician assistants and nurse practitioners. Sixteen states do not allow physician assistants to dispense prescriptions (some allow samples to be dispensed) and in 20 States nurse practitioners are not allowed to dispense with some exceptions for samples. For those States where providers are not allowed to dispense medications, the ability to use a system such as MARP will be limited by the ability to find partner pharmacies. Since the medications are dispensed at no cost to the patient, finding such partners will depend on the goodwill of local pharmacies, as they will not be reimbursed for their services.

Program cost is another factor to weigh when considering expansion of MARP or another program like it. Currently the two expansion sites are supported by ORHCC at no charge. A significant expansion would require additional funding for both start-up costs and ongoing support. Start-up costs may be supported by one-time grant funds but sustaining ongoing operational costs raises the issue of establishing user fees. Many rural providers may not be able to afford an annual subscription fee that covers the cost of support and software upgrades. KRCC and MFHC both estimated they could only afford annual fees significantly lower than North Carolina's current cost per organization of $4,700.

In addition, staff turnover, similar to that experienced by KRCC, may also affect the feasibility of expanding systems such as MARP into States with limited infrastructure support if training costs are too high or require too much time away from the practice due to travel to another State.

Lessons Learned Applicable to Other Types of System Dissemination

The automated PAP pilot provides lessons learned that may be applicable to other demonstration projects where new systems or care processes are implemented:

- Selection of participants – It is very important to adequately prescreen potential participants. This may involve site visits and interviews with multiple staff, to ensure there is commitment to the pilot programs' objectives and to verify the organization has the resources and support to be a meaningful participant.
- Practice champion – A single project champion at a site ties the success or failure of the pilot to the career trajectory of that individual. It would be preferable to have multiple

persons in a practice that will be champions and advocates for the objectives of the pilot/demonstration.

- Train the trainer – A train-the-trainer approach could be used where possible to help address issues with staff turnover that may arise, especially if a demonstration spans multiple years.

- Provider education/buy-in – Upfront and ongoing provider education would ensure that medical staff understand the parameters of the demonstration project, including what it can and cannot do.

- Plan for the evaluation – The evaluation was limited by the lack of historical data. Ideally, evaluation criteria should be identified and an evaluation plan developed before a demonstration project is launched, and data would be collected at predetermined points throughout a pilot.

Appendix A

PILOT SITE QUESTIONS

Description of practice

1. Name and location of practice

2. Type of practice (FQHC/private practice/RHC etc)

3. Number of service delivery sites

4. Number and type of providers (MDs/mid-levels)

5. Total number of unduplicated patients (users) or total number of patient visits in the last year (all patients not just those receiving prescription assistance)

Implementation of MARP

6. What type of prescription assistance program/method did you use before MARP? About how many patients did you serve? (Dollar value and number of prescriptions if possible)

7. How did you become involved in the MARP demonstration project?

8. When was the MARP software installed at your practice?

9. How were you or your staff trained to use the MARP software? How effective was that training?

10. What challenges did you face in implementing the MARP system?

Current use

11. Description of MARP – including what it can and cannot do. On a scale of 1(very simple) to 10 (extremely difficult) how difficult is the MARP software to use?

12. Are there any MARP features you choose not to use? Which ones and why? Are there features you would like that MARP does not have?

13. Do you receive ongoing user support? Is the level of support appropriate (i.e. do you need more or less)?

14. Number of prescription assistance coordinators – full-time on prescription assistance or do they have other job responsibilities? At every clinic site?

Outcomes

15. How has using MARP affected your low income patients' ability to access medications?

16. How has using MARP affected your organization's administrative efficiency?

17. Number of patients receiving prescription assistance, number of prescriptions distributed and dollar value? Timeframe.

Future use

18. Do you expect to continue using MARP long-term?

19. If you were charged an annual software/maintenance fee would you continue to use MARP? What do you think a reasonable fee would be? Could you afford to pay this?

20. If you no longer had MARP what process/system would you use for prescription assistance?

21. In terms of this demonstration project, what worked, what didn't work, and if you were starting the project again what would you do differently?

DISPENSING AUTHORITY BY STATE

Source: National Association of Boards of Pharmacy (2008) Survey of Pharmacy Law 2009, pp 90-94.

State	Physician	Physician Assistant	Nurse Practitioner	Advanced Registered Nurse Practitioner
Alabama	Yes	Yes	Yes	Yes
Alaska	Yes	Yes	Yes [4]	Yes [4]
Arizona	Yes	Yes	Yes	Yes
Arkansas	Yes [3]	No	No	No
California	Yes	Yes [2]	Yes [2]	Yes [2]
Colorado	Yes	Yes	No	No [1]
Connecticut	Yes	Yes	Yes [4]	Yes
Delaware	Yes	Yes	Yes [3]	Yes [3]
District of Columbia	Yes	Yes [2]	No	Yes [4]
Florida	Yes	No [1]	No	Yes
Georgia	Yes	Yes [2]	Yes [2]	Yes [2]
Hawaii	Yes	Yes	No [1]	Yes
Idaho	Yes	Yes	Yes	Yes
Illinois	Yes	Yes	Yes	Yes
Indiana	Yes	Yes [2]	Yes [2]	Yes [2]
Iowa	Yes	No	No [4]	Yes
Kansas	Yes	No	No	No
Kentucky	Yes	No [1]	No [1]	No [1]
Louisiana	Yes	No	No	No
Maine	Yes	Yes	Yes	Yes
Maryland	Yes [2, 3, 13]	Yes [2]	Yes [2]	Yes [2]

Massachusetts	Yes [2]	Yes [2]	Yes [2]	Yes [2]
Michigan	Yes [2]	Yes [2]	Yes [2]	Yes [2]
Minnesota	Yes	Yes	Yes	Yes
Mississippi	Yes	No	No	No
Missouri	Yes [2]	Yes [6]	Yes [6]	Yes [6]
Montana	No [12]	No [12]	No [12]	No [12]
Nebraska	Yes	No [1]	No [1]	No [1]
Nevada	Yes	Yes	No	Yes
New Hampshire	Yes	Yes	Yes	Yes
New Jersey	Yes	No	Yes	Yes
New Mexico	Yes	Yes	Yes [2]	Yes [2]
New York	Yes [2]	Yes [2]	Yes [2]	Yes [2]
North Carolina	Yes [3]	Yes [2]	Yes [2]	Yes [2]
North Dakota	Yes	Yes	Yes	Yes
Ohio	Yes [2]	Yes [2]	Yes [2]	Yes [2]
Oklahoma	Yes	No [1]	No	No [1]
Oregon	Yes [3]	Yes [2]	Yes [2]	Yes [2]
Pennsylvania	Yes	Yes [2]	Yes [2]	Yes [2]
Rhode Island	Yes	Yes	No	Yes
South Carolina	Yes [2]	No [1]	No [1]	No [1]
South Dakota	Yes	Yes [7]	Yes	No
Tennessee	Yes	Yes	Yes	Yes
Texas	No [9]	No [9]	No [9]	No [9]
Utah	No [1]	No [1]	No [1]	No [1]
Vermont	Yes	Yes	Yes	Yes
Virginia	Yes [10]	No [1]	No [1]	No [1]
Washington	Yes	Yes	Yes [4]	Yes
West Virginia	see 11	see 11	see 11	see 11

Wisconsin	Yes	No	No	Yes [8]
Wyoming	Yes	Yes	No	Yes [4]

<u>Legend</u>

1 Samples only

2 Restrictions apply

3 Requires special permit, registration, or approval

4 Must be advanced/ARNP classification

5 Limited by national scope of specialty

6 Requires collaborative practice arrangement with physician; limited to 72 hour supply

7 When acting as agent of physician

8 Samples only unless 30 miles from nearest pharmacy

9 Severely restricted

10 Expect for samples, must be licensed by Board of Pharmacy

11 State pharmacy laws do not apply; regulated by Boards of Medicine, Osteopathy, and Registered Professional Nurses

12 May dispense under extremely limited conditions, including if no community pharmacy is available

13 Doctor of Osteopathy not permitted to dispense medications