



To: Senate Health and Welfare Committee
Re: H.611

April 8, 2026

Chair Lyons and members of the committee,

Thank you for hearing testimony today on the amendment on PrEP/PEP proposed by Laura Byrne or the HIV/HCV Resource Center.

In brief, the Vermont Pharmacists Association supports this amendment because we support our patients having options for access to essential preventative care services. Pharmacists are medication experts accessible to Vermonters who may not have ready access to other health care venues. In recognition of the need, the majority of states have implemented pharmacist prescribing authorities for these medications. (Map attached). To illustrate the positive role pharmacists may play in providing these services, VPA member Dr. Andrew Garcia, PharmD provided testimony to House Health Care about his role as a pharmacist and AAHIVM certified practitioner. (Attached)

To ensure that this is a true increase of access, we furthermore support the efforts to ensure the "supportive health services" as defined in the amendment are covered and reimbursable to pharmacist prescribers. Other states have determined that this provision does not incur significant costs to the state in their fiscal deliberations. (Example fiscal note attached)

We have come a long way in the treatment of HIV, but total eradication of the disease once established remains elusive, making prevention of utmost importance. For that reason, with respect to the desire for deliberation in formulation of the regulation, we propose to maintain pharmacist prescribing of PrEP/PEP as a component of the bill this session and work with interested parties to set a reasonable timeline for promulgating necessary regulation as we have done before.

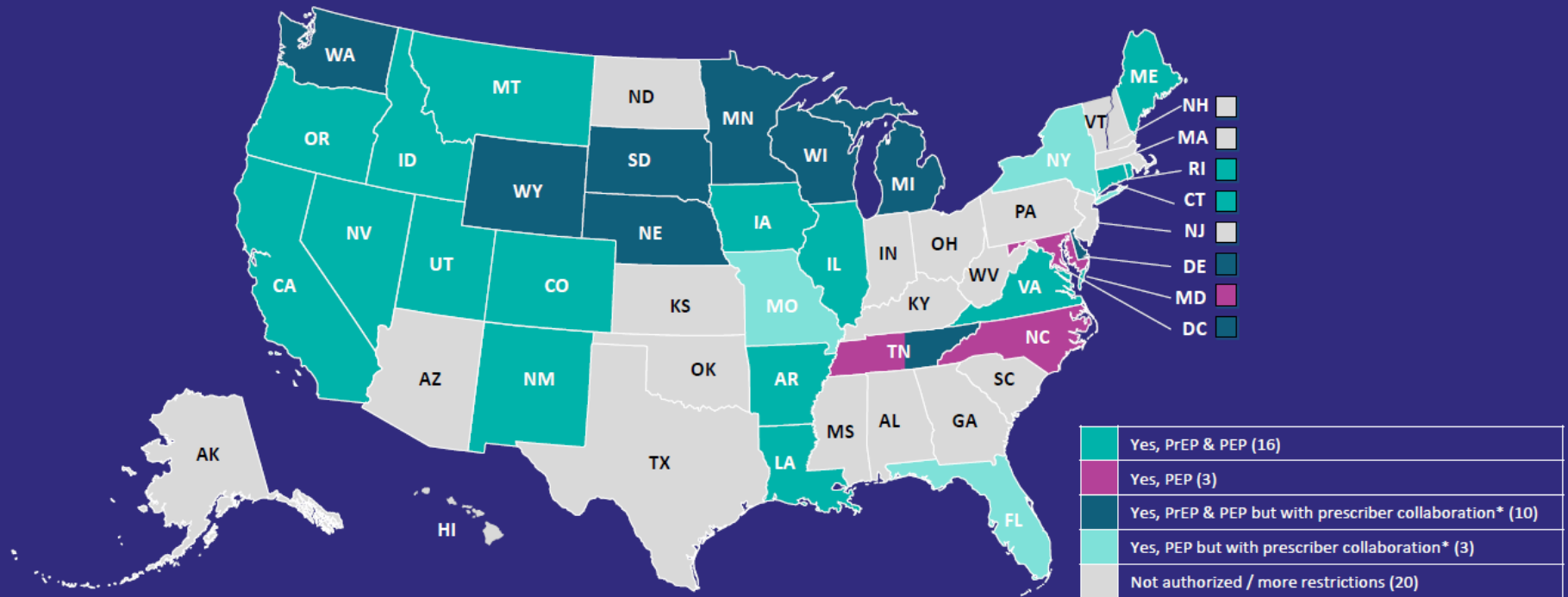
Thank you for your dedication to our state and your consideration of this amendment.

Sincerely,

A handwritten signature in blue ink that reads 'Lauren E. Bode'.

Lauren E. Bode, PharmD, BCACP, CDCES, BC-ADM
Legislative Liaison
Vermont Pharmacists Association

Can pharmacists furnish HIV PrEP/PEP via prescriptive authority, statewide protocol, or other means?



*Limited to collaborative practice agreements or prescriber protocols that allow multiple patients and do not require past prescriber-patient relationship

Andrew Garcia, PharmD, AAHIVM

Testimony to House Health Care Committee re. amendment to H.611

Thank you all for having me. My name is Andrew Garcia and I am currently the clinical pharmacist at the outpatient infectious disease clinic at The University of Vermont Medical Center. I work closely with the infectious disease physician group to provide direct patient care to folks with a variety of conditions, including HIV and those seeking HIV prevention care. My background includes extensive training in clinical pharmacy at the University of Pittsburgh Medical Center, where I completed a pharmacy residency focused in underserved care and global health, and I am also credentialed as an HIV Pharmacist through the American Academy of HIV Medicine. I have had the privilege of working directly with patients who are marginalized or face large barriers to care, as do many of our HIV patients, and I am very happy to be here today to speak in support of this amendment that would allow pharmacists in the state of Vermont to directly provide care for HIV prevention.

As a nation, we have come a long way from the 1980s and 1990s, when the AIDS crisis was hitting its peak. In 1994, AIDS was the leading cause of death for young adults in America and the only available medication at the time, AZT, could lose efficacy and cause serious side effects. It was because of the dedication of activists and the tireless work of researchers from across the globe that many new HIV medications were developed. Today, not only is HIV not a death sentence, but the medications we have are extremely effective at preventing HIV acquisition when started either before or within 72 hours after exposure to an HIV positive source. For exposure via sex, we are talking almost 100% effective when these medications are taken as prescribed. And for folks who use injection drugs, these medications are over 75% effective in preventing HIV through exposure via an infected needle. And yet, despite having highly effective medications to prevent HIV, the HIV epidemic continues worldwide. In 2022, the Centers for Disease Control reported 38,000 new HIV diagnosis across the country. And while Vermont has a relatively low incidence of HIV compared to other parts of the country, the Vermont Department of Health reported over 100 new cases between 2008 and 2017. This number should be zero. We have the public health tools needed to end HIV, but still see new cases every year. What is happening that people continue to become infected when we have such great preventative medications?

Well, I can tell you what I see every day as part of my job. A patient might go to the emergency room, urgent care, or their primary care doctor and report that they stepped on a needle or maybe they had condomless sex with someone of unknown HIV status or

maybe they were sexually assaulted. Their physician does the right thing and prescribes them HIV prevention medication – something extremely effective if started within 72 hours of exposure. And the patient goes to their pharmacy and is met with one or multiple barriers. The co-pay for the medication is in the thousands of dollars. The physician didn't prescribe the HIV medication that the pharmacy has in stock and it will take at least a day to order. The patient's insurance forces them to fill at a mail-order pharmacy. Or the patient doesn't have insurance at all, and a 28 day course of preventative HIV medicine will be over \$4,000 out of pocket. These aren't hypotheticals – I have gotten every single one of these calls from patients or from pharmacies. The pharmacy is the exact point where ideal medical care breaks down and the unfortunate harsh realities of our healthcare system set in – financial and logistical barriers that make the difference between a patient's being able to start their HIV prevention medication in time. And so, I strongly believe that pharmacists are in the perfect position to remedy that, should the legislature empower them to do so. The pharmacist would be able to say "We don't have this medication, let me switch that to a different one". Or – "this medication is expensive, but this other medication has a co-pay card available or a free drug voucher available – let's switch you to that one". Those actions might literally be life-saving when we are talking about a very short window to start prevention treatment. And that is only talking about the best-case scenarios – when patients have already sought care from a physician. In Vermont, where emergency room and primary care wait times can be extensive and visits often are accompanied by a large bill, and where folks living in rural areas may have significant barriers to quickly accessing care, patients may be discouraged from seeking HIV prevention at all. The community pharmacist might be the only healthcare professional these patients can or feel comfortable going to for help, and should absolutely be able to do so.

But – you don't have to take my personal experience with these patients as the only proof that the current system is not working. In 2022, the Centers for Disease Control published an alarming finding. Out of every American who would benefit from taking HIV pre-exposure prophylaxis, also known as PrEP, to prevent HIV acquisition, only 36% of those people were actually prescribed PrEP. That means almost 2 in 3 people that we should be reaching are completely left out. And unfortunately, the statistics show that these are already marginalized folks – for example only 13% of Black patients who would benefit from PrEP received PrEP, while 94% of white Americans who would benefit did. Further disparities exist in other groups like women, who are greatly under prescribed PrEP, as well as folks experiencing substance use disorder. We really need all hands on deck to expand the provision of PrEP and to ensure all Vermonters who need it can access it free of charge. Pharmacists have the clinical knowledge and the proximity to patients and will be a

necessary part of expanding PrEP access. For these reasons, I wholeheartedly support this amendment and welcome any questions you may have. Thank you for your time.



Fiscal Note

Legislative Council Staff

Nonpartisan Services for Colorado's Legislature

HB 26-1336: INCREASE ACCESS TO PHARMACY SERVICES

Prime Sponsors:

Rep. Lindsay; Winter T.
Sen. Pelton R.

Fiscal Analyst:

Brendan Fung, 303-866-4781
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Published for: House Health & Human Services**Drafting number:** LLS 26-0863**Version:** Initial Fiscal Note**Date:** March 24, 2026**Fiscal note status:** This fiscal note reflects the introduced bill.

Summary Information

Overview. The bill modifies statutes related to pharmacy services, including insurance coverage requirements, Medicaid reimbursement, prescriptive authority, and final product verification.

Types of impacts. The bill is projected to affect the following areas on an ongoing basis:

- Minimal State Expenditures

Appropriations. No appropriation is required.

Table 1
State Fiscal Impacts

Type of Impact	Budget Year FY 2026-27	Out Year FY 2027-28
State Revenue	\$0	\$0
State Expenditures	\$0	\$0
Transferred Funds	\$0	\$0
Change in TABOR Refunds	\$0	\$0
Change in State FTE	0.0 FTE	0.0 FTE

Summary of Legislation

The bill modifies statutes related to pharmacy services by requiring insurance coverage of certain services, aligning Medicaid reimbursement with pharmacists' scope of practice, expanding prescriptive authority, and authorizing delegation of final product verification tasks.

Insurance Coverage Requirements

The bill requires health benefit plans that provide hospital, surgical, or medical expense insurance to cover health care services provided by a pharmacist if the services are within the pharmacist's scope of practice. The bill specifies that:

- health benefit plans and carriers must not discriminate against pharmacists acting within their scope of practice based solely on licensure type; and
- health benefit plans must not prohibit pharmacists from participation in provider networks if they meet plan requirements.

Medicaid Reimbursement

The bill authorizes reimbursement under the state's Medicaid program for pharmacist-provided services that are within the pharmacist's scope of practice and are not duplicative of other pharmacist services or programs reimbursed by Medicaid.

Prescriptive Authority

The bill expands the definition of "practice of pharmacy" to include independent prescriptive authority for certain drugs, drug categories, or devices for patients under 12 years of age when certain conditions are met. This authority applies only to non-controlled substances prescribed in accordance with FDA-approved labeling and excludes medications requiring certified education programs or limited distribution networks.

Task Delegation to Sub-Pharmacists

The bill authorizes supervising pharmacists to delegate certain tasks, including final product verification, to pharmacy technicians or interns under certain circumstances. The bill defines "final product verification" as the physical verification that a drug, device, or product matches the prescription or order after entry and review in a pharmacy system.

The State Board of Pharmacy in the Department of Regulatory Agencies (DORA) must adopt rules related to final product verification, including training requirements and other standards.

State Expenditures

The bill minimally impacts workload and expenditures in DORA, the Department of Health Care Policy and Financing, and the Department of Personnel and Administration, as discussed below.

Department of Regulatory Agencies

Workload will minimally increase in the Division of Professions and Occupations to conduct rulemaking related to final product verification and provide outreach to licensees. The Division of Insurance may also experience an increase in workload to review additional or revised rate filings associated with the bill. These impacts are expected to be minimal and absorbable within existing appropriations.

DORA may require legal services, provided by the Department of Law, which can be accomplished within existing legal services appropriations. Legal counsel is related to rulemaking and ongoing administration of the program, as well as a rise in complaints.

Department of Health Care Policy and Financing

The bill may minimally impact expenditures in the Department of Health Care Policy and Financing for Medicaid. The bill does not add new Medicaid benefits, but instead expands access to services provided by pharmacists, which may potentially result in both costs and savings. On one hand, savings may result if Medicaid members choose to receive services from pharmacists that would otherwise occur in higher-cost settings, such as hospitals or urgent care. At the same time, to the extent pharmacists are more accessible than other types of health providers and Medicaid members access services when they otherwise would not have, overall utilization may increase. Any potential costs and savings are assumed to be minimal and offsetting, and any necessary changes to appropriations will be addressed through the annual budget process.

Department of Personnel and Administration

Similar to the Medicaid impact above, the bill may impact costs for state employee health insurance. State employee insurance is offered through two carriers—Kaiser Permanente and Cigna. Kaiser Permanente offers fully insured plans subject to state regulation, while Cigna administers self-funded plans regulated under federal law that are also required to offer all mandatory benefits outlined in state law. To the extent expanded coverage for services provided by pharmacists results in costs or savings for both health plans, premiums paid by the state may minimally increase or decrease. Insurance premium costs are shared by state agencies and employees. Any change in premium costs will be handled through the annual budget process.

Workload may also minimally increase in the Office of Administrative Courts to the extent that expanded scope of practice for pharmacists results in additional disciplinary cases. This workload is expected to be minimal and no change in appropriations is required.

Effective Date

The bill takes effect 90 days following adjournment of the General Assembly sine die, assuming no referendum petition is filed.

State and Local Government Contacts

Health Care Policy and Financing

Personnel

Law

Regulatory Agencies