WAC 246-955-005 Definitions
The definitions in RCW 18.64.011 and WAC 246-945-010 apply throughout this chapter unless the context clearly requires otherwise.

WAC 246-955-006 Responsibility for Compliance
The responsible pharmacy manager, all pharmacy credentialed personnel, and the pharmacy each have responsibility for compliance with applicable state and federal laws.

WAC 246-955-010 Pharmacist’s Professional Responsibilities
(1) A pharmacist shall act within the accepted standard of care of the practice setting they work in.
(2) A pharmacist shall be knowledgeable of and comply with all applicable rules and laws.
(3) A pharmacist’s primary responsibility is to providing patients with safe and appropriate medication therapy.
(4) A pharmacist shall be responsible for any delegated act performed by pharmacy interns, pharmacy technicians and pharmacy assistants under their supervision.
(5) A pharmacist shall ensure that delegation of pharmacy functions is in accordance with WAC 246-955-040.

WAC 246-955-020 Responsible Pharmacy Manager
(1) The responsible pharmacy manager must be licensed to practice pharmacy in the state of Washington. The responsible pharmacy manager designated by a facility shall have the authority and responsibility to assure that the area(s) within the facility where drugs are stored, compounded, delivered or dispensed are operated in compliance with all applicable state and federal statutes and regulations.
(2) It shall be the responsibility of the responsible pharmacy manager:
   (a) To create and implement policy and procedures relating to:
      (i) Purchasing, ordering, storing, compounding, delivering, dispensing or administering of controlled substances or legend drugs.
      (ii) Accuracy of inventory records, patient medical records as related to the administration of controlled substances and legend drugs, and any other records required to be kept by state and federal regulations.
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(iii) Adequate security of legend drugs and controlled substances.
(iv) Controlling access to controlled substances and legend drugs.
(b) To assure that the commission is in possession of all current policies and procedures identified in subsection (a) of this section.
(c) To execute all forms for the purchase and order of legend drugs and controlled substances.
(d) To verify receipt of all legend drugs and controlled substances purchased and ordered by the health care facility.

WAC 246-955-030 Delegation of Pharmacy Functions to Pharmacy Ancillary Personnel
(1) All delegated pharmacy functions are performed under a pharmacist’s immediate supervision.
(2) When delegating a pharmacy function to a pharmacy technician:
   (a) A pharmacist shall consider the pharmacy technician’s scope of practice, education, skill, and experience into account, and
   (b) A pharmacist will not delegate a pharmacy function that is listed in WAC 246-955-040.
(3) A pharmacist may delegate to a pharmacy assistant those limited functions defined in RCW 18.64A.030 and the following:
   (a) Prepackage and label drugs for subsequent use in prescription dispensing operations.
   (b) Count, pour, and label for individual prescriptions.

WAC 246 – 955 – 040 Non Delegable Tasks
(1) A pharmacist shall not delegate the following:
   (a) Receipt or transfer of a verbal prescription other than refill authorization from a prescriber.
   (b) Consultation with the patient regarding the prescription, both prior to and after the prescription filling and/or regarding any information contained in a patient medication record system provided that this shall not prohibit pharmacy ancillary personnel from providing to or receiving from the patient or the patient’s health care giver certain information where no professional judgment is required.
   (c) Consultation with the prescriber regarding the patient and the patient's prescription.
   (d) Interpretation of data in a patient medication record system.
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(e) Dispense and deliver prescriptions to patient with proper patient information.

(f) Substitution of a biological or drug product in accordance with WAC 246-955-090.

(g) Decision to not dispense lawfully prescribed drugs or devices or to not distribute drugs and devices approved by the FDA for restricted distribution by pharmacies.

(h) Prescription modification in accordance with WAC 246-955-080.

(i) Exercising their prescriptive authority under a collaborative drug therapy agreement; and

(j) Ultimate responsibility for pharmacy functions delegated to pharmacy interns or ancillary personnel performed under the supervision and direction of the pharmacist.

WAC 246-955-045 Patient Counseling

When a drug is dispensed, the pharmacist shall counsel the patient or patient’s agent in person, or the patient shall be provided with effective communication on how to contact a pharmacist for counseling and information about the medication. This does not apply to medications that are administered by a licensed health professional authorized to administer medications acting within their scope of practice.

WAC 246-955-070 Refilling Prescriptions

(1) A prescription may be refilled when permitted by state and federal law and only as specifically authorized by the prescriber.

(2) Notwithstanding subsection (1) a pharmacist may renew a prescription for a non-controlled drug one (1) time in a six (6)-month period when the prescriber is not available for authorization.

(3) If a pharmacist renews a prescription under subsection (2) the amount dispensed may be the quantity on the most recent fill or a thirty (30)-day supply, whichever is less.

WAC 246-955-080 Prescription Modification.

(1) A pharmacist may change or modify the quantity, dosage, dosage form, or direction of medication dispensed if it meets the intent of the prescriber.

Commented [GCO(3)]: Moved from Operational Standards

Commented [GCO(4)]: Suggested additions from Chris for commission consideration.

Commented [GCO(5)]: Comment from Chris: I know there has been some back and forth on where this rule should be located. I am wondering whether this should be a separate rule by itself titled "Delegation of Pharmacy Functions to Pharmacy Interns" and include this sentence as well as the supervision subsection for ancillary personnel in -030(1).

If this is removed, then the rest of the section would need to be renumbered.

Commented [GCO(6)]: Do we need additional language for suicide prevention materials to be provided when deemed appropriate? This is not going to show up in RCW.

Commented [GCO(7)]: Staff feels this requires additional discussion before removal, important guardrail.

WAC 246-955-095 Patient counseling policy statement

Commented [WTM(8)]: Easier for citations later if not in a full paragraph.
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(2) A pharmacist may complete missing information on a prescription if there is sufficient evidence to support the change.
(3) A pharmacist may extend a maintenance drug for the limited quantity necessary to coordinate a patient’s refills in a medication synchronization program in accordance with RCW 48.43.096.
(4) A pharmacist who modifies, completes or extends a prescription in accordance with these rules must document the modification, supplementation, or extension in the patient’s record.

WAC 246-955-090 Prescriptions: Drug Product Substitution.

(1) The substitution of a drug or biologic product dispensed pursuant to a prescription shall be in compliance with applicable laws and rules.
(2) A pharmacist may substitute a drug product or a biologic product when any of the following applies:
   (a) The substitution is permitted by RCW 69.41.120;
   (b) The substitution is permitted by a formulary developed by an interdisciplinary team of an institutional facility; or
   (c) The substitution is otherwise permitted by law.
(3) In addition to any other applicable requirements, a pharmacist shall only substitute a drug or a biologic product pursuant to WAC 246-955-090(2)(b) if:
   (a) An employee or contractor of the institutional facility prescribed the drug or biologic product to be substituted;
   (b) The interdisciplinary team was composed of a non-pharmacist prescriber listed in RCW 69.41.030 and a pharmacist; and
   (c) The formulary is readily retrievable by the pharmacist.

WAC 246-955-100 Prescriptions: Transfers.

(1) Upon patient request, a prescription may be transferred within the limits of state and federal law.
(2) Sufficient information needs to be exchanged in the transfer of a prescription to maintain an auditable trail, and all elements of a valid prescription.
(3) Pharmacies electronically sharing a secure real-time database are not required to transfer prescription information for dispensing.
(4) Prescriptions must be transferred by electronic means or facsimile, except in emergent situations.
(5) The above subsections apply to the transfer of prescription information for noncontrolled substances. The transfer of controlled substance prescription information must conform to the requirements of 21 C.F.R. 1306.25.

WAC 246-955-110 Collaborative Drug Therapy Agreements.

Commented [GCO(9]: Language provided by Chris

Commented [GCO(10]: Wondering if this should be structured like the current rule:
(1) These requirements apply to noncontrolled drugs: (a) through (d) For controlled substances 1306.25
(1) A pharmacist exercising prescriptive authority in their practice must have a valid Collaborative Drug Therapy Agreement (CDTA) on file with the commission and their practice location.

(2) A CDTA must include:

(a) A statement identifying the practitioner authorized to prescribe and the pharmacist(s) who are party to the agreement.

(i) The practitioner authorized to prescribe must be in active practice, and

(ii) The authority granted must be within the scope of the practitioners’ current practice.

(b) A statement of the type of prescriptive authority decisions which the pharmacist(s) is (are) authorized to make, which includes:

(i) A statement of the types of diseases, drugs, or drug categories involved, and the type of prescriptive authority activity (e.g., modification or initiation of drug therapy) authorized in each case.

(ii) A general statement of the training required, procedures, decision criteria, or plan the pharmacist(s) is (are) to follow when making therapeutic decisions, particularly when modification or initiation of drug therapy is involved.

(c) A statement of the activities pharmacist(s) is (are) to follow in the course of exercising prescriptive authority, including:

(i) Documentation of decisions made, and

(ii) A plan for communication or feedback to the authorizing practitioner concerning specific decisions made.

(3) A CDTA is only valid for two years from the date of signing.

(4) Any modification of the written guideline or protocol shall be treated as a new CDTA.

WAC 246-955-120 Monitoring of drug therapy by pharmacists.

The term "monitoring drug therapy" used in RCW 18.64.011 shall mean a review of the drug therapy regimen of patients by a pharmacist for the purpose of evaluating and rendering advice to the prescribing practitioner regarding adjustment of the regimen. Monitoring of drug therapy shall include, but not be limited to:

(1) Performing patient assessment; and

(2) Ordering, administering, and evaluating the results of laboratory tests.

WAC 246 – 955 – 125 Patient Rights
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Any person authorized to practice or assist in the practice of pharmacy will not engage in any of the following:

1. Destroy unfilled lawful prescription;
2. Refuse to return unfilled lawful prescriptions;
3. Violate a patient's privacy;
4. Discriminate against patients or their agent in a manner prohibited by state or federal laws;
or
5. Intimidate or harass a patient.

WAC 246-955-130 Intent and approval of impaired practitioner substance abuse monitoring program.

The commission will approve practitioner recovery, assistance, and monitoring programs, which will participate in the commission's substance abuse monitoring program under RCW 18.130.175.

WAC 246-955-140 Sexual Misconduct

1. These rules do not prohibit:
   (a) Providing health care services in case of emergency where the services cannot or will not be provided by another health care provider;
   (b) Contact that is necessary for a legitimate health care purpose and that meets the standard of care appropriate to that profession; or
   (c) Providing health care services for a legitimate health care purpose to a person who is in a preexisting, established personal relationship with the health care provider where there is no evidence of, or potential for, exploiting the patient or client.

2. A pharmacy health care practitioner must not engage, or attempt to engage, in sexual misconduct with a current patient, client, or key party, inside or outside the health care setting. Sexual misconduct shall constitute grounds for disciplinary action.

3. Practitioner under this section shall be defined as any person credentialed under RCW 18.64.080, or Chapter 18.64A RCW.

4. Sexual misconduct includes, but is not limited to:
   (a) Sexual intercourse;
   (b) Touching the breasts, genitals, anus or any sexualized body part except as consistent with accepted community standards of practice within the health care practitioner's scope of practice;
   (c) Rubbing against a patient or client or key party for sexual gratification;
   (d) Kissing;
   (e) Hugging, touching, fondling or caressing of a romantic or sexual nature;
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(f) Not allowing a patient or client privacy to dress or undress except as may be necessary in emergencies or custodial situations;
(g) Not providing the patient or client a gown or draping except as may be necessary in emergencies;
(h) Dressing or undressing in the presence of the patient, client or key party;
(i) Removing patient's or client's clothing or gown or draping without consent, except emergent medical necessity or being in a custodial setting;
(j) Encouraging masturbation or other sex act in the presence of the health care provider;
(k) Masturbation or other sex act by the health care provider in the presence of the patient, client or key party;
(l) Suggesting or discussing the possibility of a dating, sexual or romantic relationship after the professional relationship ends;
(m) Terminating a professional relationship for the purpose of dating or pursuing a romantic or sexual relationship;
(n) Soliciting a date with a patient, client or key party;
(o) Discussing the sexual history, preferences or fantasies of the health care provider;
(p) Any behavior, gestures, or expressions that may reasonably be interpreted as seductive or sexual;
(q) Making statements regarding the patient, client or key party's body, appearance, sexual history, or sexual orientation other than for legitimate health care purposes;
(r) Sexually demeaning behavior including any verbal or physical contact which may reasonably be interpreted as demeaning, humiliating, embarrassing, threatening or harming a patient, client or key party;
(s) Photographing or filming the body or any body part or pose of a patient, client, or key party, other than for legitimate health care purposes; and
(t) Showing a patient, client or key party sexually explicit photographs, other than for legitimate health care purposes.

(5) Sexual misconduct also includes sexual contact with any person involving force, intimidation, or lack of consent; or a conviction of a sex offense as defined in RCW 9.94A.030.

(6) A health care practitioner must not:
(a) Offer to provide health care services in exchange for sexual favors;
(b) Use health care information to contact the patient, client or key party for the purpose of engaging in sexual misconduct;
(c) Use health care information or access to health care information to meet or attempt to meet the health care practitioner's sexual needs.

(7) A health care practitioner must not engage or attempt to engage, in the activities listed in subsection (1) of this section with a former patient, client, or key party if:
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(a) There is a significant likelihood that the patient, client or key party will seek or require additional services from the health care practitioner; or
(b) There is an imbalance of power, influence, opportunity and/or special knowledge of the professional relationship.

(8) When evaluating whether a health care provider engaged or attempted to engage, in sexual misconduct, the commission will consider factors including, but not limited to:
(a) Documentation of a formal termination and the circumstances of termination of the practitioner-patient relationship;
(b) Transfer of care to another health care practitioner;
(c) Duration of the practitioner-patient relationship;
(d) Amount of time that has passed since the last health care services to the patient or client;
(e) Communication between the health care practitioner and the patient or client between the last health care services rendered and commencement of the personal relationship;
(f) Extent to which the patient's or client's personal or private information was shared with the health care practitioner;
(g) Nature of the patient or client's health condition during and since the professional relationship;
(h) The patient or client's emotional dependence and vulnerability; and
(i) Normal revisit cycle for the profession and service.

(9) Patient, client or key party initiation or consent does not excuse or negate the health care practitioner's responsibility.