House of Delegates

REPORT OF THE

COMMITTEE ON RESOLUTIONS

June 14, 2026

St. Louis, Missouri

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Article 7.2.2.1 of the ASHP Rules of Procedure for the House of Delegates states:

> Resolutions not voluntarily withdrawn by the submitter that meet the requirements of the governing documents shall be presented to the House of Delegates by the Committee on Resolutions at the first meeting and acted upon at the second meeting. They shall be submitted to delegates with one of the following recommendations: (a) recommend adoption, (b) do not recommend adoption, (c) recommend referral for further study, or (d) presented with no recommendation of the Committee on Resolutions.
>
> Action by the House of Delegates shall be on the substance of the resolutions and not on the recommendation of the Committee on Resolutions.

Pursuant to the above article, the Committee on Resolutions presents the attached resolutions (Appendices A, C, and E) to the House of Delegates.

For the first resolution, which is to affirm evidence-based medicine (EBM) as a foundational principle of pharmacy practice, patient care, and the development of ASHP professional policies and advocacy positions, including clinical decision-making and public health guidance, the recommendation of the Committee is to **refer the resolution to the Council on Therapeutics for further study and consideration in September 2026**. The Committee noted that the content of the resolution could be incorporated as a second clause of the policy recommendation, *Evidence-Based Medicine* (Appendix B), which will be considered by the House of Delegates in June. Also, the Committee acknowledge the prevalence of the term *"evidence-based"* throughout ASHP policies.

Delegates are reminded that they are voting on the substance of the resolution, which is approval of the motion as follows:

> To affirm evidence-based medicine (EBM) as a foundational principle of pharmacy practice, patient care, and the development of ASHP professional policies and advocacy positions, including clinical decision-making and public health guidance.

The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion; (b) defeat the motion; (c) refer the motion for further study by a committee or task force to be determined by the Board of Directors **(the option recommended by the Committee on Resolutions)**; or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

For the second resolution, which is to advocate that state boards of pharmacy and regulatory bodies recognize and accept a valid pharmacist license from any U.S. state or territory for the provision of non-dispensing telehealth pharmacy services across all U.S. states, regardless of patient or provider location, the recommendation of the Committee is to **refer the resolution to the Council on Public Policy for further study and consideration in September 2026.** The Committee noted that policy 1310, *Regulation of Telepharmacy Services* (Appendix D) serves as a strong foundation for incorporating provision of non-dispensing telehealth services across state lines by pharmacists. The Committee concluded that the ASHP policy committee process, with its studied reflection and multiple layers of review, would be the best way to arrive at policy that expresses a comprehensive, contemporary view on pharmacist provision of telehealth across state lines.

Delegates are reminded that they are voting on the substance of the resolution, which is approval of the motion as follows:

> To advocate that state boards of pharmacy and regulatory bodies recognize and accept a valid pharmacist license from any U.S. state or territory for the provision of non-dispensing telehealth pharmacy services across all U.S. states, regardless of patient or provider location.

The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion; (b) defeat the motion; (c) refer the motion for further study by a committee or task force to be determined by the Board of Directors **(the option recommended by the Committee on Resolutions)**; or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

For the third resolution, which is to advocate for legislative and regulatory policies that would oppose alternative funding program policies, the recommendation of the Committee is to **refer the resolution to council for further study and consideration in September 2026.** The Committee noted that ASHP policy 1809, *Health Insurance Policy Design* (Appendix F), serves as a strong foundation for considering concepts such as alternative funding programs. The Committee questioned whether adoption of this resolution as written could result in unintended consequences for ASHP by appearing to unduly influence payer business practices at a time when health systems are facing increased scrutiny related to rising healthcare costs. At the same time, the Committee recognized concerns that alternative funding programs may disrupt continuity of care provided through the pharmacy home. The Committee concluded that the ASHP policy committee process, with its studied reflection and multiple layers of review, is the most appropriate mechanism to develop policy that reflects a comprehensive and balanced view of the use of alternative funding programs, particularly as a means by which self-funded employers exclude specialty medications from coverage.

Delegates are reminded that they are voting on the substance of the resolution, which is approval of the motion as follows:

> To advocate for legislative and regulatory policies that would oppose alternative funding program policies; further,
>
> To educate about alternative funding programs and their negative impacts on patient access to treatment; further,
>
> To advocate that plan benefits are transparently communicated to covered patients; further,
>
> To advocate for equitable patient access to treatment and oppose practices that rely on patient financial assistance programs or international sourcing of medications; further,
>
> To oppose mandatory use of power of attorney contracts between patients and alternative funding programs as a component of the medication access process.

The options for House action on the resolution, to be taken at the second meeting, are to (a) approve the motion; (b) defeat the motion; (c) refer the motion for further study by a committee or task force to be

determined by the Board of Directors **(the option recommended by the Committee on Resolutions)**; or (d) amend the resolution, which would then require due consideration by the Board of Directors at its next meeting in September.

Appendix A
Resolution for the 2026 ASHP House of Delegates: Evidence-Based Medicine as a Foundational Principle of Pharmacy Practice

Submitted by:
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Subject: Evidence-Based Medicine as a Foundational Principle of Pharmacy Practice
Received: March 5, 2026

Motion
To affirm evidence-based medicine (EBM) as a foundational principle of pharmacy practice, patient care, and the development of ASHP professional policies and advocacy positions, including clinical decision-making and public health guidance.

Background
Although many ASHP policies refer to EBM, ASHP does not have an overarching policy-level commitment to EBM as a foundational principle for informing pharmacy practice, patient care, advocacy and policy making. EBM integrates the best available scientific evidence with clinical expertise to optimize health outcomes. In an era of rapid therapeutic innovation, proliferating health information (including misinformation), and evolving public health challenges, the consistent application of EBM is essential to maintain the scientific integrity of pharmacy practice and ASHP's policy positions. This resolution underscores EBM's central role in guiding clinical, educational, advocacy, public health and collaborative activities across the pharmacy workforce. It aligns with and reinforces ASHP's broader commitment to rigorous, data-driven standards in all aspects of health-system pharmacy.

Suggested Outcome
Adoption of this resolution will reinforce EBM as a core tenet underlying ASHP's professional policies, educational programming, and external advocacy. It will promote widespread integration of evidence-based principles into daily pharmacy practice, interprofessional collaboration, and interactions with public health authorities, payers, and policymakers.

Appendix B: Related ASHP Policy/Materials

The related policies are organized into Sections A, B, and C. Section A includes proposed policies aligned with the intent of this resolution but not yet fully considered by the House. Section B contains approved ASHP policies that are similar in intent to the resolution. Section C links to policies that are not necessarily aligned with the resolution's intent but use the terms "evidence-based" or "evidence-based medicine," which occur 52 times in ASHP policies, making them relevant to this review.

A. Proposed policies that are not yet fully considered by the House of Delegates but are aligned with the intent of the resolution.

Evidence-Based Medicine (Proposed policy to be considered during House of Delegates June 2026)
Source: Council on Therapeutics

To define evidence-based medicine as the conscientious, explicit, and judicious appraisal and application of the best-available current data integrated with provider expertise and patient values to inform the development and implementation of professional policies, standards, and clinical practice decisions.

Rationale
Evidence-based medicine (EBM), also known as evidence-based practice, evidence-based clinical practice, evidence-based healthcare, evidence-based method, and evidence-based approach are all encompassing terms that describe a methodical approach to clinical decision-making. EBM is a cornerstone of modern healthcare, emphasizing the use of the best available research evidence to guide clinical decision-making. The goal of EBM is to improve patient care by using the most current and reliable scientific research—such as randomized controlled trials, systematic reviews, and meta-analyses—to guide diagnosis, treatment, and management decisions. It involves critically evaluating and integrating evidence into the clinical decision-making process, ensuring that the interventions provided are both effective and appropriate for the individual patient.

However, there is controversy surrounding the term. This arises from its ideal of objective, standardized care, which sometimes clashes with the realities of clinical practice, patient individuality, and the inherent limitations of research. In recent years, particularly with the rapidly evolving need for safe and effective treatment during the COVID-19 pandemic, adoption of artificial intelligence, and proliferation of publications, the term evidence-based medicine has evolved from an approach to patient care that uses best available evidence, clinical expertise, and patient values to one that includes these values but also a more nuanced understanding of the complexities inherent in translating research into practice, recognizing that both organizations and clinicians are subject to their own biases. Ultimately, EBM uses diligent, explicit, and sensible use of available evidence to care for individual patients that integrates individual clinical expertise that is diverse in origin. EBM is not a replacement for individual clinical expertise and does not consist only of randomized controlled trials or meta-analyses, nor considers data that is outdated or impossible to practice.

Background
The Council discussed the term evidence-based medicine as a part of the evolution of the amount and quality of information and its role in medication misinformation, clinical decision making, and the practice of pharmacy as well as its use in ASHP Policies. Review found there are 52 references to the term evidence-based in ASHP Policies and rationales. The Council also discussed how other professional organizations use this term, how ASHP should define the term EBM as it pertains to developing professional policy, and the impact of removing

this term from ASHP policy. The Council decided that a policy affirming ASHP's position would be in the organization's best interest.

Role of the Pharmacy Workforce to Combat Public Health Disinformation and Misinformation (Proposed policy to be considered during the House of Delegates June 2026)
Source: Council on Pharmacy Practice

To affirm that disinformation and misinformation undermine public health and trust in health care professionals, increasing risk of potential harm and adverse patient outcomes; further,

To educate the pharmacy workforce and public on how to recognize and counter disinformation and misinformation; further,

To oppose the dissemination of disinformation and misinformation by members of the pharmacy workforce; further,

To encourage state affiliates to actively dispel harmful health-related claims in their communities; further,

To collaborate with key partners to combat disinformation and misinformation.

Rationale
Public health disinformation and misinformation pose a growing threat to patient safety, population health, and trust in healthcare professionals. Disinformation is defined as false or misleading information that is deliberately created, presented, and disseminated with the intent to deceive, mislead, or cause harm. Misinformation is defined as inaccurate or false information shared without intent to deceive, often due to misunderstanding, incomplete information, or rapidly evolving science. In the public health context, disinformation often aims to undermine evidence-based guidance, erode trust in health institutions or professionals, or influence health behaviors in ways that increase risk to individuals or communities.

A longstanding area of concern related to disinformation and misinformation is with vaccines and vaccine preventable diseases. Maintaining public trust in vaccine evidence-based recommendations is essential to protecting patient and public health, and that trust depends on transparent, rigorous processes grounded in scientific evidence. The pharmacy workforce needs to remain steadfast in their commitment to science-driven decision making related to vaccines and patient education in order to support shared clinical decision making. Clinical decisions often require nuance, and pharmacists may reasonably differ in how they interpret evolving evidence, weigh risks and benefits, or apply guidelines to individual patients. Differences in evidence informed professional opinions, including vaccine recommendations based on patient factors or emerging data, are not the same as misinformation. Good faith interpretation of available evidence, even when it does not fully align with a guideline, is an essential part of professional practice. Efforts to address disinformation must distinguish intentional or reckless spread of falsehoods from legitimate clinical judgment that reflects the complexity of real world care.

ASHP, state affiliates, and its members have a professional duty to recognize and combat disinformation and misinformation with their constituencies and in their communities. It is imperative that the pharmacy workforce serve as a source of truth for scientific and evidence-based information. Many leading health professional organizations, including the American Medical Association and the American Nurses Association, have advanced policy statements that outline key elements for addressing disinformation and misinformation

such as conveying clear definitions, reinforcing professional responsibility, providing trusted education and communication, creating accountability, and collaborating with other partners with similar goals and policy positions. ASHP should align and collaborate with peer pharmacy and medical organizations to reinforce shared principles and support critical public health initiatives that uphold scientific integrity and patient safety.

Background

The Council discussed whether ASHP policy was needed related to disinformation and misinformation in public health. The Council felt it was important to discuss the topic based on things they were seeing in their communities and as a result of a recommendation made during the 2025 ASHP House of Delegates related to misinformation and disinformation. The recommendation was entitled, "Defending evidence-based immunization policies and safeguarding the integrity of scientific advisory committees in public health." The intent of the recommendation was to defend the core values of the pharmacy profession and immunization practices. Delegates to the ASHP House of Delegates from the following states endorsed the recommendation: MI, OR, OH, DC, IN, MO, TX, MD, PA, SC, UT, IA, TN, WI, IL, MA, WA, NJ, AZ, AL, AK, DE, CT. Council members determined that a new policy was needed to reinforce ASHP's and the pharmacy workforce's role as a source of truth during a time when misinformation and disinformation is so prevalent. The Council also noted that disinformation and misinformation needs to be included in the ASHP Statement on the Pharmacist's Role in Public Health in a future revision.

B. Approved ASHP policies that are similar in intent to the resolution.

1822 RATIONAL USE OF MEDICATIONS

Source: Council on Therapeutics

To promote evidence-based prescribing and deprescribing for indication, efficacy, safety, duration, cost, and suitability for the patient; further,

To advocate that pharmacists lead interprofessional efforts to promote the rational use of medications, including engaging in strategies to monitor, detect, and address patterns of irrational medication use in patient populations.

This policy supersedes ASHP policy 1312.

This policy was reviewed in 2023 by the Council on Therapeutics and by the Board of Directors and was found to still be appropriate.

Rationale

The World Health Organization (WHO) identifies that rational use of medications requires that "patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community." The overuse, underuse, or misuse of medicines results in wastage of scarce resources and widespread health hazards. Examples of irrational use of medicines include use of too many medicines per patient, inappropriate use of antimicrobials, inadequate dosage, overuse of injections when oral formulations would be more appropriate, failure to prescribe in accordance with clinical guidelines, inappropriate self-medication, decreased access to medicines, and nonadherence to dosing regimens. These actions can negatively affect the quality of patient care, raise

healthcare costs, and increase the number of adverse reactions and events, and may cause adverse reactions or negative psychosocial effects.

Strategies to address irrational medication use can be characterized as educational, managerial, economic, or regulatory in nature. Furthermore, the WHO advocates 12 key interventions to promote more rational use of medications:

- establishment of a multidisciplinary national body to coordinate policies on medication use;
- use of clinical guidelines;
- development and use of national essential medications list;
- establishment of drug and therapeutics committees in districts and hospitals;
- inclusion of problem-based pharmacotherapy training in undergraduate curricula;
- continuing in-service medical education as a licensure requirement;
- supervision, audit, and feedback;
- use of independent information on medications;
- public education about medications;
- avoidance of perverse financial incentives;
- use of appropriate and enforced regulation; and
- sufficient government expenditure to ensure availability of medications and staff.

These recommendations are echoed by the Joint Commission of Pharmacy Practitioners, whose tenets of the pharmacists' patient care process include the collection of necessary subjective and objective information about the patient in order to understand the relevant medical/medication history and clinical status of the patient; assessment of information collected and analysis of the clinical effects of the patient's therapy in the context of the patient's overall health goals in order to identify and prioritize problems and achieve optimal care; development of an individualized patient-centered care plan, in collaboration with other healthcare professionals and the patient or caregiver that is evidence-based and cost-effective; implementation of the care plan in collaboration with other healthcare professionals and the patient or caregiver; and monitoring and evaluation of the effectiveness of the care plan and modification of the plan in collaboration with other healthcare professionals and the patient or caregiver as needed. ASHP also supports the use of stewardship programs with pharmacists in a lead role, as these have been shown to demonstrate the rational use of medications.

2208 PHARMACIST'S ROLE IN TEAM-BASED CARE

Source: Council on Pharmacy Practice

To recognize that pharmacists, as core members and medication-use experts on interprofessional healthcare teams, increase the capacity and efficiency of teams for delivering evidence-based, safe, high-quality, and cost-effective patient-centered care; further,

To advocate to policymakers, payers, and other stakeholders for the inclusion of pharmacists as care providers within team-based care and as the provider of comprehensive medication management services; further,

To assert that all members of the interprofessional care team have a shared responsibility in coordinating the care they provide and are accountable to the patient and each other for the outcomes of that care; further,

To urge pharmacists on healthcare teams to collaborate with other team members in establishing and implementing quality and outcome measures for care provided by those teams.

This policy supersedes ASHP policy 1215.

Rationale

There is a growing consensus among healthcare providers and payers that patient-centered care by a collaborative team is the optimal model of care. A collaborative care model provides pharmacists with an opportunity to contribute their expertise in medication use to improving patient outcomes.

The pharmacy profession appears to be struggling, however, with implementation of this care model. Not unexpectedly, there is a wide variation in the way "team-based care" is interpreted and applied. Therefore, states currently in the process of rewriting practice acts have been challenged to find guidance on the fundamental roles and responsibilities of pharmacists in various care settings. This policy recommendation builds on concepts in ASHP policy 1114, Pharmacist Accountability for Patient Outcomes; sets the expectation for other providers that teams with pharmacists will improve the quality, safety, and efficiency of care; and supports advocacy to the broader healthcare community on the value of care delivery by teams that include pharmacists.

C. Existing ASHP policies using terms "evidence-based" are linked here.

Appendix C
Resolution for the 2026 ASHP House of Delegates: Recognition of Pharmacist Licensure in Non-Dispensing Telehealth Pharmacy Services

Submitted by:
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Subject: Recognition of Pharmacist Licensure in Non-Dispensing Telehealth Pharmacy Services

Received: March 16, 2026

Motion
To advocate that state boards of pharmacy and regulatory bodies recognize and accept a valid pharmacist license from any U.S. state or territory for the provision of non-dispensing telehealth pharmacy services across all U.S. states, regardless of patient or provider location.

Background
By advocating for the recognition of valid pharmacist licenses in the provision of non-dispensing telehealth pharmacy services, regardless of patient or provider location, ASHP can empower pharmacists to optimize their contributions to patient care and address the healthcare needs of diverse populations across the nation. This approach is particularly beneficial for pharmacists practicing in large multi-state health systems or networks, as it enables them to deliver care efficiently across state boundaries without regulatory delays. Additionally, pharmacists serving rural communities can leverage streamlined licensure recognition to provide timely and consistent access to pharmaceutical care, helping to bridge gaps in medication management and reduce care fragmentation. Allowing pharmacists to provide non-dispensing telehealth services across state lines would expand patient access to high-quality medication management and reduce care fragmentation.

While existing ASHP policy broadly addresses interstate licensure (2507,1310, 0909, and ASHP Statement on Telehealth Pharmacy Practice), focused efforts to recognize non-dispensing telehealth pharmacy services across state lines will help advance practice while comprehensive interstate licensure models continue to be pursued.

This policy should address:

1. Recognition of Licensure: uniform recognition of pharmacist licensure that enables pharmacists to provide non-dispensing telehealth services (audio and video) without the impediment of state-specific regulations that may hinder their practice.
2. Scope of Practice: Pharmacists should be permitted to engage in telehealth services, including medication therapy management, patient consultations, and chronic disease management, irrespective of the state in which the patient resides, as long as the pharmacist holds a valid license, in good standing, in at least one state.

3. Patient-Centered Care: This recognition will support the delivery of patient-centered care by ensuring that qualified pharmacists can leverage telehealth technologies to enhance access to pharmaceutical care, improve health outcomes, and facilitate adherence to treatment regimens.
4. Interstate Collaboration: collaboration among state boards of pharmacy, telehealth organizations, and other stakeholders to establish best practices and frameworks that sustain the quality and integrity of non-dispensing telehealth pharmacy services while ensuring patient safety.
5. Advocacy for Legislative Measures: support of legislative efforts and policy initiatives that promote the recognition of pharmacist licensure and the establishment of a flexible regulatory environment conducive to telehealth practices.

Suggested Outcome

Adoption of this resolution as professional policy would strengthen advocacy to allow pharmacists to provide non-dispensing telehealth services across state lines, therefore expanding patient access to medication management and reducing care fragmentation. Modernizing regulatory frameworks to recognize pharmacist licensure for non-dispensing telehealth services across all U.S. states would strengthen continuity of care, regardless of geographic barriers.

Appendix D: Related ASHP Policy/Materials

1310 REGULATION OF TELEPHARMACY SERVICES

Source: Council on Public Policy

To advocate that state governments adopt laws and regulations that standardize telepharmacy practices across state lines and facilitate the use of United States-based telepharmacy services; further,

To advocate that boards of pharmacy and state agencies that regulate pharmacy practice include the following in regulations for telepharmacy services: (1) education and training of participating pharmacists; (2) education, training, certification by the Pharmacy Technician Certification Board, and licensure of participating pharmacy technicians; (3) communication and information systems requirements; (4) remote order entry, prospective order review, verification of the completed medication order before dispensing, and dispensing; (5) direct patient-care services, including medication therapy management services and patient counseling and education; (6) licensure (including reciprocity) of participating pharmacies and pharmacists; (7) service arrangements that cross state borders; (8) service arrangements within the same corporate entity or between different corporate entities; (9) service arrangements for workload relief in the point-of-care pharmacy during peak periods; (10) pharmacist access to all applicable patient information; and (11) development and monitoring of patient safety, quality, and outcomes measures; further,

To identify additional legal and professional issues in the provision of telepharmacy services to and from sites located outside the United States.

This policy was reviewed in 2023 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Rationale

In light of continuing advances in technology, there an increasingly urgent need for state board of pharmacy regulation of the provision of pharmacist care services from offsite locations through electronic technology, which is often referred to, especially in regulation, as *telepharmacy*. In the ASHP Statement on Telehealth Pharmacy Practice, ASHP explains why it prefers the term *telehealth pharmacy practice* to describe both the provision of team-based patient care and oversight of aspects of pharmacy operations (e.g., remote dispensing, order verification, supervision of staff) by pharmacists using electronic information and telecommunications technology.

It is important to acknowledge the regulatory purview of state boards of pharmacy regarding the use of telepharmacy and recognize that the intent of such regulations should be to balance protection of the public health with the increased patient access to the patient care services of pharmacists provided by telepharmacy. Although such regulations should allow for various arrangements across state borders and within or between health systems, they all need to address a number of common concerns.

ASHP advocates that the provision of medication therapy management and other direct patient care services be addressed in any regulation of telepharmacy services and that patient safety, quality, and outcomes measures for these services be developed and monitored. Further, ASHP urges state governments to harmonize the practice of pharmacy across state lines and to require that pharmacy technicians providing telepharmacy services be certified by the Pharmacy Technician Certification Board and licensed by the state

board of pharmacy. Finally, ASHP recognizes the need to continue efforts to identify additional legal and professional issues in the provision of international telepharmacy services.

2227 ASHP STATEMENT ON TELEHEALTH PHARMACY PRACTICE

Source: Section of Pharmacy Informatics and Technology

To approve the ASHP Statement on Telehealth Pharmacy Practice

This statement supersedes the ASHP Statement on Telepharmacy dated November 18, 2016.

2507 INTERSTATE PHARMACIST LICENSURE

Source: Council on Public Policy

To advocate for improved timeliness of the pharmacist licensure application approval process; further,

To advocate for interstate pharmacist licensure; further,

To support streamlined reciprocity processes, including temporary licensure mechanisms, as progress toward interstate licensure.

This policy supersedes ASHP policy 1621.

Rationale

Pharmacists sometimes face challenges from delays in obtaining licensure by transfer or reciprocity when moving their practice from one jurisdiction to another. Such delay may be due to the need for boards to review pharmacists' licensure records in all jurisdictions in which they are licensed, administer a state pharmacy law exam, complete a criminal background check, and, in some cases, schedule an interview with the board. To address these challenges, boards of pharmacy should allow pharmacists in good standing to immediately practice in a different jurisdiction when they change employment or enter a residency program. Granting pharmacists a temporary license for a period of up to six months while the board completes its review would help meet workforce demands while continuing to safeguard the public health. In some cases, pharmacists who are unable to obtain a license in a timely manner are unable to fully use the skills in which they have been trained. Without a license, the pharmacist may temporarily have to function as a technician or perform other tasks. For pharmacists participating in residency programs outside their jurisdiction of licensure, several months of their residency program can elapse before they receive licensure transfer or reciprocity. Upon completion of a year-long residency program, many residents move to another jurisdiction to practice and have to start the transfer or reciprocity process again.

Members in several states have reported that in recent years boards of pharmacy have been slow to issue pharmacy licenses. This delay is especially problematic for pharmacy residents from another jurisdiction who rely on boards to grant them a license prior to performing in a clinical capacity. Given that the licensing period can take several months, this delay has presented a problem for pharmacy residents who have a limited timeframe to successfully complete their duties, typically one year. In some cases, state boards are urging residents to obtain a pharmacy technician license; however, this is inappropriate given the

expertise and education residents have and the level of practice they're expected to engage in. Given its national scope, NABP is well-positioned to explore a broad solution to this problem rather than the current, incremental, state-by-state approach.

0909 REGULATION OF INTERSTATE PHARMACY PRACTICE
Source: Council on Public Policy

To advocate that state governments, including legislatures and boards of pharmacy, adopt laws and regulations that harmonize the practice of pharmacy across state lines in order to provide a consistent, transparent, safe, and accountable framework for pharmacy practice.

This policy was reviewed in 2024 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Rationale
With the emergence of new technology, state borders are becoming more artificial and coordination between states is increasingly needed. To achieve the highest level of patient safety possible, state regulatory bodies need to work closely together to provide a consistent and transparent regulatory framework for pharmacy practice. Dialogue between the National Association of Boards of Pharmacy and individual state boards can help harmonize the practice of pharmacy across state lines by producing model language that can be adopted by individual states.

2220
PROMOTING TELEHEALTH PHARMACY SERVICES
Source: Council on Pharmacy Practice

To advocate for innovative telehealth pharmacy practice models that (1) enable the pharmacy workforce to promote clinical patient care delivery, patient counseling and education, and efficient pharmacy operations; (2) improve access to pharmacist comprehensive medication management services; (3) advance patient-centric care and the patient care experience; and (4) facilitate pharmacist-led population and public health services and outreach; further,

To advocate for removal of barriers to access to telehealth services; further,

To advocate for laws, regulations, and payment models for telehealth services that are equitable to similar services provided in person by health systems, with appropriate accountability and oversight; further,

To encourage comparative effectiveness and outcomes research on telehealth pharmacy services.

Rationale
The definitions and terminology used to describe telehealth vary. Many refer to virtual health, telehealth, telemedicine, and/or telepharmacy interchangeably. The Centers for Medicare & Medicaid Services (CMS) describes telemedicine as a means for improving a patient's health by permitting two-way, real-time, interactive communication between a patient and a healthcare provider who are geographically separated.

ASHP defines telehealth as a method used in pharmacy practice in which a pharmacist utilizes telecommunications technology to oversee aspects of pharmacy operations or provide patient care services.

Telehealth is part of a larger digital transformation in healthcare. Patients are increasingly making decisions about who delivers their care and engaging in the delivery of that care digitally. As a result, hospitals and health systems need a strategy for their own digital transformation and to meet patient demands. In general, telehealth includes a broader scope of remote healthcare services than telemedicine and telepharmacy; therefore, ASHP considers telehealth to be the overarching term for the remote delivery of patient care services.

The availability of telehealth services in rural areas facilitates greater access to care by eliminating the need to travel long distances to see a qualified healthcare provider. It promises to save patients time and money, reduces patient transfers, emergency department and urgent care center visits, and delivers savings to payers (American Hospital Association [AHA]. Fact Sheet: Telehealth; AHA. Optimizing Pharmacy Services: Managing your hospital pharmacy during the COVID-19 pandemic and beyond). Pharmacists' role in telehealth is instrumental, as telehealth serves are a valuable tool for the profession of pharmacy to extend its reach to patients for the provision of medication management and complex patient care (AHA. Optimizing Pharmacy Services: Managing your hospital pharmacy during the COVID-19 pandemic and beyond; ASHP Statement on Telepharmacy). Telehealth services have grown significantly over recent years, especially during the COVID-19 pandemic. Telehealth services have the potential to improve patient access to care, cost efficiencies, and quality while meeting consumer demand. They also offer patients the convenience of remote drug therapy monitoring, authorization for prescriptions, patient counseling, and monitoring patients' compliance with prescriptions, and they can be offered remotely to patients with diabetes, congestive heart failure, and other chronic diseases. Pharmacists may also use telehealth when suitable to remotely verify sterile compounding, offer pre- and postoperative medication order review, provide interactive postoperative patient medication counseling, or deliver drug information to a facility that is geographically isolated (ASHP Statement on Telemedicine). To ensure the best patient care outcomes and most efficient use of healthcare resources, additional research will be needed to compare telehealth pharmacy services with those offered in person.

Appendix E
Resolution for the 2026 ASHP House of Delegates: Alternative Funding Programs

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Subject: Alternative Funding Programs

Received: March 5, 2026

Motion
To advocate for legislative and regulatory policies that would oppose alternative funding program policies; further,

To educate about alternative funding programs and their negative impacts on patient access to treatment; further,

To advocate that plan benefits are transparently communicated to covered patients; further,

To advocate for equitable patient access to treatment and oppose practices that rely on patient financial assistance programs or international sourcing of medications; further,

To oppose mandatory use of power of attorney contracts between patients and alternative funding programs as a component of the medication access process.

Background

Alternative funding programs (AFPs) have emerged as a controversial solution aimed at reducing the financial burden of high-cost specialty medications for employer-sponsored health plans. While these programs may seem beneficial to employers, they introduce complexities and unintended consequences that significantly impact patient care and the broader healthcare system.

There are distinct differences between Alternative Funding Programs (AFPs) and Patient Assistance Programs (PAPs), Foundation Support, and Copayment Programs:

- Alternative Funding Programs (AFPs): These programs shift the cost of expensive drugs from health plans by seeking to procure medication through non-traditional fill methods such as patient assistance programs or international pharmacies by labeling these medications as "non-essential health benefits." In turn, these drugs are removed from the list of covered medications, leaving patients without insurance coverage for their prescribed treatments.

- Patient Assistance Programs (PAPs): Sponsored by pharmaceutical manufacturers, PAPs provide low-income and uninsured individuals access to their medications at reduced rates or for free. PAPs aim to support patients who cannot afford their medications, ensuring they receive necessary treatments without incurring prohibitive costs.
- Foundation Support: Similar to PAPs, foundation grants are supported by non-profits and often are disease-specific. They are designed to be used by qualifying patients who are uninsured or severely underinsured. There are typically income restrictions to foundation support, similar to PAP programs.
- Copayment Programs: Copayment is the portion of the medication cost that patients must pay out-of-pocket, even with insurance coverage. Manufacturer copay assistance programs help patients cover these copayments, reducing the patient's financial burden.

Alternative Funding Programs (AFPs) impact patients and the healthcare system in four primary ways:

- Treatment Delays: Procuring medication through an AFP is a complex and unclear process. AFPs often lack clarity and infrequently provide a clear process for how medication will be obtained for patients and healthcare staff helping patients navigate access. The enrollment process is time-consuming and labor-intensive, often resulting in treatment delays that can span weeks. Many patients do not qualify for PAPs due to income requirements. Increasingly, manufacturer PAPs are able to identify patients as being enrolled in an AFP or are closing PAPs to commercial patients altogether to combat AFP practices.
- Added Complexity/Workload for Accessing Treatment: Patients are required to enroll in the AFP, including providing financial information and clinically-sensitive details about their condition/treatment. This process is labor-intensive and often results in treatment delays.
- Unsafe and Potentially Illegal Medication Procurement Procedures: Another increasingly common method of medication procurement by AFPs is international pharmacy use. Often if patients are denied PAP, the AFP will pivot to seek medication internationally, most often from Canada and Mexico. Other tactics seen in practice include changing patients to a medication covered on their medical benefit or using preferred (often small) retail pharmacies for fulfillment.
- Suboptimal Treatments and Poor Outcomes: AFPs inadvertently create an "income gap trap". Many working individuals earn too much to qualify for patient assistance programs or government-funded insurance but not enough to afford their medications out-of-pocket. This scenario forces patients into a prolonged and uncertain process to access their necessary treatments, exacerbating their health risks and financial burdens. Some patients have already been stabilized on therapies. Due to long wait times, some patients risk developing antibodies to treatments and losing the clinical benefit from the therapy.

The financial implications of AFPs extend beyond treatment delays. Even when patients qualify for assistance, the support provided often has a cap, leaving patients to cover substantial costs once this threshold is reached. This situation undermines the fundamental purpose of health insurance, which is to protect patients from unmanageable financial obligations when they require expensive healthcare treatments. Instead, AFPs cause patients' insurance to fail them precisely when they need it most.

Reliance on third-party vendors to manage AFPs introduces another layer of complexity and potential risk. These vendors may resort to importing medications from international sources outside the secure drug supply chain, exposing patients to drugs that may lack safety and efficacy guarantees. This practice jeopardizes patient health and undermines the integrity of the healthcare system.

The broader implications of AFPs are equally concerning. By diverting resources intended for vulnerable populations, AFPs create a zero-sum game where insured patients compete with low-income and uninsured individuals for limited assistance funding. This diversion risks leaving both groups without access to their necessary medications, defeating the purpose of patient assistance programs. Additionally, manufacturers are changing the requirements for their programs and excluding these patients altogether, further complicating access to necessary medications.

Employers face challenges with AFPs as well. While these programs promise cost savings, the reality is that the administrative costs and bureaucratic complexities often offset these savings. Moreover, the health complications and treatment disruptions caused by AFPs can lead to increased absenteeism, presenteeism, and staff turnover, ultimately affecting organizational productivity and employee well-being. Research indicates that employers incur substantial costs due to absenteeism and reduced productivity associated with chronic diseases and uncontrolled symptoms. Changes in insurance coverage for medications force many patients to stop receiving their medication, leading to increased absenteeism, presenteeism, and staff turnover. For many patients, these medications were what allowed them to be physically able to re-enter the workforce in the first place.

Conclusion: Alternative funding programs, while intended to reduce costs for employer-sponsored health plans, often result in significant harm to patients and the broader healthcare system. By implementing policies that promote transparency, protect patient access to necessary medications, and ensure the integrity of health insurance, the negative impacts of these programs can be mitigated, thereby improving patient outcomes.

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Suggested Outcome

Changes in legislative and regulatory policies to oppose alternative funding program policies.

Appendix F: Related ASHP Policy/Materials

1809
HEALTH INSURANCE POLICY DESIGN
Source: Council on Pharmacy Management

To advocate that all health insurance policies be designed and coverage decisions made in a way that preserves the patient–practitioner relationship; further,

To advocate that health insurance payers and pharmacy benefit managers provide public transparency regarding and accept accountability for coverage decisions and policies; further,

To oppose provisions in health insurance policies that interfere with established drug distribution and clinical services designed to ensure patient safety, quality, and continuity of care; further,

To advocate for the inclusion of hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.

This policy supersedes ASHP policy 1520.

This policy was reviewed in 2023 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

Evolving practices by health insurers are negatively affecting patient care decisions and impacting the relationships between patients and their care providers. One common health insurance practice restricts management of and access to certain drugs to specialty suppliers. Another problematic practice is that certain drugs are not reimbursed by the insurer when used as part of the patient's hospital or health-system care. Medicare, for example, deems certain drugs as self-administered drugs, which are not reimbursed when provided to a patient because they are not considered integral to the reason for admission. These practices increase the number of patients that "brown bag" medications when they are admitted to a hospital to avoid being charged personally for the uncovered medications. ASHP has identified a number of concerns about these practices, including impact on continuity of care, integrity of the drug supply, patient satisfaction, and public perception of healthcare organizations.

It is the responsibility of the pharmacist to ensure the integrity of drugs used in the care of patients in the healthcare facility in which he or she practices. Having to verify products that patients bring with them from multiple suppliers disrupts the care process. Having patients go unreimbursed for a medication because it was administered in and supplied by the healthcare organization is confusing to the patient and damaging to the patient–provider relationship. More broadly, lack of understanding of the differing payment systems in different care settings leads to public relations challenges. In addition, the lack of transparency regarding how payers make certain coverage determinations and apply performance penalties (e.g., direct and indirect remuneration fees) creates a significant challenge for healthcare providers as they care for patients.

ASHP advocates reforming these insurance practices. Coverage of medications should not interfere with the safe and effective provision of care and should recognize the responsibility of pharmacists to ensure product integrity for care provided where they practice. In addition, ASHP advocates that the Centers for

Medicare & Medicaid Services, commercial payers, and others include hospital and health-system outpatient and ambulatory care services in health insurance coverage determinations for their patients.

2320
ACCESS TO MEDICATIONS
Source: Council on Pharmacy Practice

To raise awareness that lack of access to medications in clinical practice negatively impacts healthcare outcomes; further,

To recognize the impact of social determinants of health on patient outcomes; further,
To advocate for drug availability, drug pricing structures, pricing transparency, and insurance coverage determinations that promote fair access to medications; further,

To advocate that the pharmacy workforce identify and address risks and vulnerabilities to access as part of comprehensive medication management services; further,

To advocate for resources, including technology, that improve access to care for all populations where pharmacy access is limited; further,

To encourage the pharmacy workforce to identify and mitigate biases in healthcare decision-making that compromise access to medications.

This policy supersedes ASHP policy 9820.

This policy was revised in 2025 by the ASHP Board of Directors on April 3, 2025, to ensure compliance with federal law.

Rationale
Barriers contributing to the lack of access to medications include decreased access to care, increased costs of care, and differences in care based on provider bias. Decreased access to care may be due to insufficient prescription drug coverage or residing in a pharmacy desert. The current trends in the price of prescription drugs, combined with lack of insurance or underinsurance, results in lower use of prescribed medications and nonadherence. Ensuring that all individuals have access to the highest quality medications required to meet their needs will require a multifaceted approach.

2239
DRUG PRICING PROPOSALS
Source: Council on Public Policy

To advocate for drug pricing and transparency mechanisms that ensure patient access to affordable medications, preserve existing clinical services and patient safety standards, and do not increase the complexity of the medication-use system.

Rationale

As drug prices have continued to climb, policymakers have proposed numerous solutions. While each proposal will need to be evaluated on its merits, it is critical that, at a minimum, policy solutions promote transparency, protect patient access to medications, and limit or reduce patient out-of-pocket costs. However, drug pricing solutions should not threaten programs that support expanded patient services (e.g., the 340B Drug Pricing Program), create patient safety risks (e.g., certain drug importation proposals), or add to the administrative or practice burden of healthcare providers.

2508

PATIENT'S RIGHT TO CHOOSE

Source: Council on Public Policy

To acknowledge that patients or their representative have the right to be fully informed about their medication options and to be involved in the decision-making process; further,

To support the right of patients or their representative to have their preferences considered respectfully, within the limits of clinical appropriateness, formulary considerations, safety, and legal requirements; further,

To recognize the right of the patient or their representative to refuse care and have those decisions respected.

This policy supersedes ASHP policy 0013.

Rationale

ASHP supports the right of the patient, or their representative as allowed under law to make informed decisions regarding the patient's care plan. The patient's right to choose includes being entitled to be informed of their health status, involved with care and treatment, allowed to request or refuse treatment, execute advance directives, and have healthcare practitioners adhere to those directives.

2016

MEDICATION FORMULARY SYSTEM MANAGEMENT

Source: Council on Pharmacy Management

To declare that decisions on the management of a medication formulary system, including criteria for use, (1) should be based on clinical, ethical, legal, social, philosophical, quality-of-life, safety, comparative effectiveness, and pharmacoeconomic factors that result in optimal patient care; (2) must include the active and direct involvement of physicians, pharmacists, and other appropriate healthcare professionals; and (3) should not be based solely on economic factors; further,

To support the concept of a standardized medication formulary system among components of integrated health systems when standardization leads to improved patient outcomes; further,

To oppose independent payer-directed formulary decisions that would increase the complexity of the medication-use system.

This policy supersedes ASHP policies 9601 and 1805.

This policy was reviewed in 2025 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

2019
ACCESS TO AFFORDABLE HEALTHCARE
Source: Council on Public Policy

To advocate for access to affordable healthcare for all, including coverage of medications and related pharmacist patient care services; further,

To advocate that the full range of available methods be used to (1) ensure the provision of appropriate, safe, and cost-effective healthcare services; (2) optimize treatment outcomes; (3) minimize overall costs without compromising quality; and (4) ensure patient choice of healthcare providers, including pharmacy services; further,

To advocate that healthcare payers seek to optimize continuity of care in their design of benefit plans.

This policy supersedes ASHP policy 1001.

This policy was reviewed in 2025 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Rationale
This policy expresses ASHP's stance on access to healthcare in the United States. The policy emanated from ASHP policies dealing with affordability and accessibility of pharmaceuticals. ASHP believes that it is important to address the larger issue of healthcare access, particularly due to the impact of the cost of medications on the nation's overall healthcare budget as well as pharmacy budgets in hospitals and health systems. The cost of healthcare is high throughout the United States, for people across all income groups and backgrounds, but even more so for vulnerable and underserved populations. Healthcare should be affordable, but also sufficient to ensure patient access to services.

1806
MANUFACTURER-SPONSORED PATIENT ASSISTANCE PROGRAMS
Source: Council on Pharmacy Management

To advocate that pharmaceutical manufacturers extend their patient assistance programs (PAPs) to serve the needs of both uninsured and underinsured patients, regardless of distribution channels; further,

To advocate expansion of PAPs to inpatient settings; further,

To advocate that pharmaceutical manufacturers and PAP administrators enhance the efficiency of PAPs by standardizing application criteria, processes, and forms; further,

To advocate that pharmaceutical manufacturers and PAP administrators enhance access to and visibility of PAPs to pharmacy personnel and other healthcare providers; further,

To encourage pharmacy personnel, other healthcare providers, and pharmaceutical manufacturers to work cooperatively to ensure PAPs include the essential elements of pharmacist patient care, are patient-centered, and are transparent; further,

To develop education for pharmacy personnel and other healthcare providers on the risks and benefits of PAPs.

This policy supersedes ASHP policy 1420.

This policy was reviewed in 2023 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

ASHP recognizes the value of patient assistance programs (PAPs) in improving continuity of care while controlling costs and advocates expanded use of these programs for uninsured and underinsured patients in ambulatory and inpatient care settings. Some organizations have demonstrated success in achieving the benefits of these programs through dedicated resources and a mastery of the many programs available. Simplification of these programs (similar eligibility criteria, a common data format) would reduce the resources required to participate and improve access and utilization. Other barriers for enrolling patients in PAPs include annual out-of-pocket spend requirements to re-enroll, confusing forms, and inability to renew in advance of new year. ASHP notes that while the number of PAPs in ambulatory care settings has increased, there has been little growth in programs for inpatients. Hospitals must then absorb the costs of patient care, which results in fewer resources in the overall healthcare system. ASHP believes that expansion of PAPs to indigent inpatients would significantly offset some of the costs to hospitals and ultimately improve care. In addition, interprofessional cooperation will be needed to support patients in accessing drug products when the PAP doesn't cover the cost of the drug product due to high deductibles or co-pays. To ensure that these programs achieve their objectives, ASHP advocates that development of these programs ensure that they contain the elements of pharmacist patient care to enhance access to and visibility of PAPs.

1521

IDENTIFICATION OF PRESCRIPTION DRUG COVERAGE AND ELIGIBILITY FOR PATIENT ASSISTANCE PROGRAMS

Source: Council on Pharmacy Management

To advocate that pharmacists or pharmacy technicians ensure that the use of patient assistance programs is optimized and documented to promote continuity of care and patient access to needed medications; further,

To advocate that patient assistance programs should incorporate the pharmacist-patient relationship, including evaluation by a pharmacist as part of comprehensive medication management; further,

To support the principle that medications provided through manufacturer patient assistance programs should be stored, packaged, labeled, dispensed, and recorded using systems that ensure the same level of safety as prescription-based programs that incorporate a pharmacist-patient relationship.

This policy was reviewed in 2025 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

Ensuring accurate medication histories and continuity of medication therapies are critical pharmacists' roles in monitoring and documenting patient transition through the healthcare system. Additionally, pharmacists have an important role in ensuring patients have means to access their medications, both upon hospital admission and discharge. With the numerous channels patients use to obtain their medications, it has become increasingly difficult to verify this information and, in some cases, obtain the medications needed to care for a patient.

Patient assistance programs (PAPs) present a unique challenge for healthcare providers. Documentation of the utilization of a PAP by a patient is important information for providers accessing the patient electronic health record and improving that documentation should be a priority for healthcare providers. Additionally, pharmacists need to provide leadership in facilitating the utilization of PAPs to ensure continuity of care, the patient's ability to access needed medications when appropriate, and a comprehensive pharmacist-patient relationship.

1301

PAYER PROCESSES FOR PAYMENT AUTHORIZATION AND COVERAGE VERIFICATION

Source: Council on Pharmacy Management

To advocate that public and private payers collaborate with each other and with health care providers to create standardized and efficient processes for authorizing payment or verifying coverage for care; further,

To advocate that payment authorization and coverage verification processes (1) facilitate communication among patients, providers, and payers prior to therapy; (2) provide timely payment or coverage decisions; (3) facilitate access to information that allows the pharmacist to provide prescribed medications and medication therapy management to the patient; and (4) foster continuity in patient care.

This policy was reviewed in 2023 by the Council on Pharmacy Management and by the Board of Directors and was found to still be appropriate.

Rationale

Patients and health care providers are required to navigate an array of payment requirements from private and public payers. Private insurers enforce their own prior authorization procedures, state Medicaid programs have their individual program requirements, and Medicare has its local and national coverage determinations. These payment authorization and verification processes vary considerably from payer to payer and are time consuming and needlessly complex. The required data, forms of documentation required, submission processes, coverage verification procedures, and delivery of approval vary widely among payers. These processes are often not integrated into the patient-care process and require manual documentation and submission. The lack of timely review and approval may delay patient care. Payment authorization and verification processes should effectively facilitate communication among both patients and providers, should be standardized and automated, and should result in timely decisions that do not disrupt patient care.