A bill to be entitled

An act relating to prescription drug benefits; providing a short title; providing legislative findings; amending s. 465.003, F.S.; providing the definitions of the terms "pharmacy benefit manager" and "pharmacy benefit management services"; creating s. 465.203, F.S.; providing definitions; providing that pharmacy benefit managers have a fiduciary duty and obligation to specified individuals and entities; providing requirements for service performance, contracts, and specified funds for pharmacy benefit managers; authorizing specified pharmacies and pharmacists to contract with pharmacy benefit managers; providing requirements for maximum allowable cost lists; requiring pharmacy benefit managers to respond to certain appeals within a specified timeframe; prohibiting pharmacy benefit managers from engaging in certain practices; requiring pharmacy benefit managers to allow payors access to specified records, data, and information; providing disclosure and reporting requirements; requiring certain income and financial benefits to be passed through to payors; requiring pharmacy benefit managers to allow the Department of Financial Services access to specified records, data, and information; requiring the

department to investigate certain violations; providing penalties; providing that specified violations are subject to the Florida Deceptive and Unfair Trade Practices Act; providing applicability; amending s. 624.490, F.S.; conforming provisions to changes made by the act; creating s. 627.42385, F.S.; providing definitions; requiring group health plans, health insurers, and certain pharmacy benefit managers to base plan beneficiaries' and insureds' coinsurance obligations for certain prescription drugs on specified drug prices; providing applicability; prohibiting such group health plans, health insurers, and pharmacy benefit managers from revealing specified information; requiring such entities to protect such information and impose the confidentiality protections on other entities; providing penalties; requiring the department to investigate certain violations; providing construction; amending ss. 627.64741, 627.6572, and 641.314, F.S.; conforming provisions to changes made by the act; providing circumstances under which contracts between health insurers or health maintenance organizations and pharmacy benefit managers are void and against the public policy; providing requirements for contracts; requiring the department to investigate certain violations;

providing penalties; amending ss. 409.9201, 458.331, 459.015, 465.014, 465.015, 465.0156, 465.016, 465.0197, 465.022, 465.023, 465.1901, 499.003, and 893.02, F.S.; conforming cross-references; providing severability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act may be cited as the "Prescription Drug Cost Reduction Act."

Section 2. The Legislature finds that the use of spread pricing, the practice of directing patients to pharmacies owned in whole or in part by pharmacy benefit managers, and other practices by pharmacy benefit managers such as charging drug manufacturers rebates to be included on a drug formulary and keeping the rebates for their own financial gain rather than passing the savings on to health plans, health plan sponsors and providers, health insurers, and patients contribute to the high cost of prescription drugs. In order to reduce the cost of prescription drugs in this state, such practices should be prohibited.

Section 3. Section 465.003, Florida Statutes, is amended to read:

465.003 Definitions.—As used in this chapter, the term:

(1) "Administration" means the obtaining and giving of a

single dose of medicinal drugs by a legally authorized person to a patient for her or his consumption.

(3) ~~(2)~~ "Board" means the Board of Pharmacy.

(9) ~~(3)~~ "Consultant pharmacist" means a pharmacist licensed by the department and certified as a consultant pharmacist pursuant to s. 465.0125.

(10) ~~(4)~~ "Data communication device" means an electronic device that receives electronic information from one source and transmits or routes it to another, including, but not limited to, any such bridge, router, switch, or gateway.

(11) ~~(5)~~ "Department" means the Department of Health.

(12) ~~(6)~~ "Dispense" means the transfer of possession of one or more doses of a medicinal drug by a pharmacist to the ultimate consumer or her or his agent. As an element of dispensing, the pharmacist shall, prior to the actual physical transfer, interpret and assess the prescription order for potential adverse reactions, interactions, and dosage regimen she or he deems appropriate in the exercise of her or his professional judgment, and the pharmacist shall certify that the medicinal drug called for by the prescription is ready for transfer. The pharmacist shall also provide counseling on proper drug usage, either orally or in writing, if in the exercise of her or his professional judgment counseling is necessary. The actual sales transaction and delivery of such drug shall not be considered dispensing. The administration shall not be

considered dispensing.

(13) ~~(7)~~ "Institutional formulary system" means a method whereby the medical staff evaluates, appraises, and selects those medicinal drugs or proprietary preparations which in the medical staff's clinical judgment are most useful in patient care, and which are available for dispensing by a practicing pharmacist in a Class II or Class III institutional pharmacy.

(14) ~~(8)~~ "Medicinal drugs" or "drugs" means those substances or preparations commonly known as "prescription" or "legend" drugs which are required by federal or state law to be dispensed only on a prescription, but shall not include patents or proprietary preparations as hereafter defined.

(17) ~~(9)~~ "Patent or proprietary preparation" means a medicine in its unbroken, original package which is sold to the public by, or under the authority of, the manufacturer or primary distributor thereof and which is not misbranded under the provisions of the Florida Drug and Cosmetic Act.

(18) ~~(10)~~ "Pharmacist" means any person licensed pursuant to this chapter to practice the profession of pharmacy.

(19) ~~(11)~~(a) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, and an Internet pharmacy.

1. The term "community pharmacy" includes every location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient

basis.

2. The term "institutional pharmacy" includes every location in a hospital, clinic, nursing home, dispensary, sanitarium, extended care facility, or other facility, hereinafter referred to as "health care institutions," where medicinal drugs are compounded, dispensed, stored, or sold.

3. The term "nuclear pharmacy" includes every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold. The term "nuclear pharmacy" does not include hospitals licensed under chapter 395 or the nuclear medicine facilities of such hospitals.

4. The term "special pharmacy" includes every location where medicinal drugs are compounded, dispensed, stored, or sold if such locations are not otherwise defined in this subsection.

5. The term "Internet pharmacy" includes locations not otherwise licensed or issued a permit under this chapter, within or outside this state, which use the Internet to communicate with or obtain information from consumers in this state and use such communication or information to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state. Any act described in this definition constitutes the practice of pharmacy as defined in subsection (23) ~~(13)~~.

(b) The pharmacy department of any permittee shall be

considered closed whenever a Florida licensed pharmacist is not present and on duty. The term "not present and on duty" shall not be construed to prevent a pharmacist from exiting the prescription department for the purposes of consulting or responding to inquiries or providing assistance to patients or customers, attending to personal hygiene needs, or performing any other function for which the pharmacist is responsible, provided that such activities are conducted in a manner consistent with the pharmacist's responsibility to provide pharmacy services.

(20) "Pharmacy benefit manager" means an entity that performs pharmacy benefit management services for a health plan, a health plan sponsor, a health plan provider, a health insurer, or any other payor. The term does not include a provider as defined in s. 641.19, a physician as defined in s. 458.305, or an osteopathic physician as defined in s. 459.003.

(21) "Pharmacy benefit management services" means services that:

(a) Are provided, directly or through another entity, to a health plan, a health plan sponsor, a health plan provider, a health insurer, or any other payor, regardless of whether the services provider and the health plan, health plan sponsor, health plan provider, health insurer, or other payor are related or associated by ownership, common ownership, organization, or otherwise.

(b) Include the procurement of prescription drugs to be dispensed to patients and the administration or management of prescription drug benefits, including, but not limited to, any of the following:

1. Mail service pharmacy or specialty pharmacy.

2. Claims processing, retail network management, or payment of claims to pharmacies for dispensing drugs.

3. Clinical or other formulary or preferred-drug-list development or management.

4. Negotiation, administration, or receipt of rebates, discounts, payment differentials, or other incentives, to include particular drugs in a particular category or to promote the purchase of particular drugs.

5. Patients' compliance, therapeutic intervention, or generic substitution programs.

6. Disease management.

7. Drug use review, step-therapy protocol, or prior authorization.

8. Adjudication of appeals or grievances related to prescription drug coverage.

9. Contracts with network pharmacies.

10. Control of the cost of covered prescription drugs.

(22) ~~(12)~~ "Pharmacy intern" means a person who is currently registered in, and attending, a duly accredited college or school of pharmacy, or who is a graduate of such a school or

college of pharmacy, and who is duly and properly registered with the department as provided for under its rules.

(23) ~~(13)~~ "Practice of the profession of pharmacy" includes compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent or proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and conducting other pharmaceutical services. For purposes of this subsection, "other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication with the patient's prescribing health care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient, regarding the drug therapy. However, nothing in this subsection may be interpreted to permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless otherwise permitted by law. "Practice of the profession of pharmacy" also includes any other act, service, operation, research, or transaction incidental to, or forming a

part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and shall expressly permit a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients. The practice of the profession of pharmacy also includes the administration of vaccines to adults pursuant to s. 465.189 and the preparation of prepackaged drug products in facilities holding Class III institutional pharmacy permits.

(24) ~~(14)~~ "Prescription" includes any order for drugs or medicinal supplies written or transmitted by any means of communication by a duly licensed practitioner authorized by the laws of the state to prescribe such drugs or medicinal supplies and intended to be dispensed by a pharmacist. The term also includes an orally transmitted order by the lawfully designated agent of such practitioner. The term also includes an order written or transmitted by a practitioner licensed to practice in a jurisdiction other than this state, but only if the pharmacist called upon to dispense such order determines, in the exercise of her or his professional judgment, that the order is valid and necessary for the treatment of a chronic or recurrent illness. The term "prescription" also includes a pharmacist's order for a product selected from the formulary created pursuant to s. 465.186. Prescriptions may be retained in written form or the pharmacist may cause them to be recorded in a data processing

system, provided that such order can be produced in printed form upon lawful request.

(15) "Nuclear pharmacist" means a pharmacist licensed by the department and certified as a nuclear pharmacist pursuant to s. 465.0126.

(5) ~~(16)~~ "Centralized prescription filling" means the filling of a prescription by one pharmacy upon request by another pharmacy to fill or refill the prescription. The term includes the performance by one pharmacy for another pharmacy of other pharmacy duties such as drug utilization review, therapeutic drug utilization review, claims adjudication, and the obtaining of refill authorizations.

(2) ~~(17)~~ "Automated pharmacy system" means a mechanical system that delivers prescription drugs received from a Florida licensed pharmacy and maintains related transaction information.

(8) ~~(18)~~ "Compounding" means combining, mixing, or altering the ingredients of one or more drugs or products to create another drug or product.

(16) ~~(19)~~ "Outsourcing facility" means a single physical location registered as an outsourcing facility under the federal Drug Quality and Security Act, Pub. L. No. 113-54, at which sterile compounding of a drug or product is conducted.

(7) ~~(20)~~ "Compounded sterile product" means a drug that is intended for parenteral administration, an ophthalmic or oral inhalation drug in aqueous format, or a drug or product that is

required to be sterile under federal or state law or rule, which is produced through compounding, but is not approved by the United States Food and Drug Administration.

(4) ~~(21)~~ "Central distribution facility" means a facility under common control with a hospital holding a Class III institutional pharmacy permit that may dispense, distribute, compound, or fill prescriptions for medicinal drugs; prepare prepackaged drug products; and conduct other pharmaceutical services.

(6) ~~(22)~~ "Common control" means the power to direct or cause the direction of the management and policies of a person or an organization, whether by ownership of stock, voting rights, contract, or otherwise.

Section 4. Section 465.203, Florida Statutes, is created to read:

465.203 Pharmacy benefit managers.—

(1) As used in this section, the term:

(a) "Affiliate" means a pharmacy:

1. In which a pharmacy benefit manager, directly or indirectly, has an investment, financial interest, or ownership interest; or

2. The ownership of which is shared, directly or indirectly, with a pharmacy benefit manager.

(b) "Covered individual" means a member, participant, enrollee, contract holder, policyholder, or beneficiary of a

payor.

(c) "Make a referral" means any of the following:

1. To order, direct, or influence, orally or in writing, a covered individual to use an affiliate, including by sending messages to the covered individual through electronic mail, a cellular telephone, or a facsimile machine, or by making telephone calls.

2. To offer or implement plan designs that require a covered individual to use an affiliate.

3. To target a covered individual or a prospective patient with advertisement, marketing, or promotion of an affiliate, including by placing a specific pharmacy name on an insurance card or health plan card supplied to the covered individual.

(d) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacy or pharmacist for a generic drug, brand name drug, specialty drug, biological product, or other prescription drug, excluding dispensing fees, before the application of copayments, coinsurance, and other cost-sharing charges, if any.

(e) "Maximum allowable cost list" means a listing of generic drugs, brand name drugs, specialty drugs, biological products, or other prescription drugs or other methodology used directly or indirectly by a pharmacy benefit manager to set the maximum allowable costs for the drugs.

(f) "Payor" means a health plan, a health plan sponsor, a

health plan provider, a health insurer, or any other payor that uses pharmacy benefit management services in this state.

(g) "Spread pricing" means the practice by a pharmacy benefit manager of charging or claiming from a payor an amount that is more than the amount the pharmacy benefit manager paid to the pharmacy or pharmacist who filled the prescription or who provided the pharmacy services.

(2)(a) A pharmacy benefit manager has a fiduciary duty and obligation to the covered individuals and the payor. A pharmacy benefit manager shall perform pharmacy benefit management services with care, skill, prudence, diligence, and professionalism and for the best interests of the covered individuals and the payor.

(b) Any provision in a contract between a pharmacy benefit manager and a payor which limits or prohibits the fiduciary duty or obligation of a pharmacy benefit manager to the covered individuals and the payor is void and against the public policy of the state.

(c) All funds received by a pharmacy benefit manager in relation to providing pharmacy benefit management services shall be received by the pharmacy benefit manager in trust for the payor. A pharmacy benefit manager shall use or distribute such funds only for the benefit of the covered individuals or the payor.

(3) A pharmacy or pharmacist licensed or registered under

this chapter which has a pharmacy permit and is in good standing with the Board of Pharmacy may contract directly or indirectly with a pharmacy benefit manager within 30 days after filing an application with the pharmacy benefit manager, without a probation period, an exclusion period, or minimum inventory requirements.

(4)(a) A maximum allowable cost list must include:

1. Average acquisition cost, including national average drug acquisition cost.

2. Average manufacturer price.

3. Average wholesale price.

4. Brand effective rate or generic effective rate.

5. Discount indexing.

6. Federal upper limits.

7. Wholesale acquisition cost.

8. Any other item that a pharmacy benefit manager or a payor may use to establish reimbursement rates to a pharmacist or pharmacy for filling prescriptions or providing other pharmacy services.

(b) A pharmacy benefit manager must respond within 7 days after receipt of an appeal to a maximum allowable cost by a pharmacy, a pharmacist, or a pharmacy services administrative organization on behalf of a pharmacy or pharmacist. The pharmacy benefit manager's failure to respond within 7 days shall be deemed approval of the appeal.

(5) A pharmacy benefit manager may not do any of the following:

(a) Conduct or participate in spread pricing in this state.

(b) Charge a pharmacy or pharmacist a fee related to the adjudication of a claim, including, without limitation, a fee for:

1. The submission of a claim;

2. The enrollment or participation in a retail pharmacy network; or

3. The development or management of claims processing services or claims payment services related to participation in a retail pharmacy network.

(c) Deny a pharmacy or pharmacist the opportunity to participate in a pharmacy network at the preferred participation status even though the pharmacy or pharmacist is willing to accept, as a condition of the preferred participation status, the terms and conditions that the pharmacy benefit manager has established for other pharmacies that are in a pharmacy network at the preferred participation status and that are not owned in whole or in part by the pharmacy benefit manager.

(d) Impose registration or permit requirements for a pharmacy or accreditation standards or recertification requirements for a pharmacist which are inconsistent with, more stringent than, or in addition to federal and state requirements

for licensure as a pharmacy or pharmacist in this state.

(e) Pay or reimburse a pharmacy or pharmacist an amount for a drug, product, or pharmacy service in the state which is:

1. Less than the amount the pharmacy benefit manager reimburses a pharmacy benefit manager affiliate for providing the same drug, product, or pharmacy service in this state;

2. Less than the actual cost incurred by the pharmacy or pharmacist for providing the drug, product, or pharmacy service in this state; or

3. Different from the combined maximum allowable cost and dispensing fees for a drug. The dispensing fees must be a least equal to the fees for service set by the Agency for Health Care Administration.

(f) Retroactively deny, hold back, or reduce reimbursement for a covered service claim after paying a claim, unless the original claim was submitted fraudulently.

(g) Prohibit a pharmacy or pharmacist from providing information regarding drug pricing, contract terms, or drug reimbursement rates to a member of the Legislature.

(h) Drop a pharmacy or pharmacist from a pharmacy network or plan or otherwise engage in any action to retaliate against a pharmacy or pharmacist for providing information regarding drug pricing, contract terms, or drug reimbursement rates to a member of the Legislature.

(i) Engage in the practice of the profession of pharmacy.

(j) Engage in the practice of medicine as defined s. 458.305 or the practice of osteopathic medicine as defined in s. 459.003.

(k) Make a referral.

(l) Publish or otherwise reveal information regarding the actual amount of rebates, discounts, payment differentials, concessions, reductions, or any other incentives that the pharmacy benefit plan receives on a product-, manufacturer-, or pharmacy-specific basis. The pharmacy benefit manager shall protect such information as a trade secret and shall impose the confidentiality protections on any vendor or third-party entity performing services on behalf of the pharmacy benefit manager that has access to rebate, discount, payment differential, concession, reduction, or any other incentive information.

(6) A payor shall have access to all financial and utilization records, data, and information used by the pharmacy benefit manager in relation to the pharmacy benefit management services provided to the payor.

(7) A pharmacy benefit manager shall:

(a) Disclose in writing to the payor any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager which directly or indirectly presents conflicts of interest with the pharmacy benefit manager's relationship with, or fiduciary duty or obligation to, the covered individuals and the payor.

(b) Report quarterly to the payor any income resulting from pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other financial benefits received by the pharmacy benefit manager from any person or entity. The pharmacy benefit manager shall ensure that such income and financial benefits are passed through in full, at least quarterly, to the payor to reduce the cost of prescription drugs and pharmacy services to covered individuals.

(8) The Department of Financial Services shall have access to all financial and utilization records, data, and information used by pharmacy benefit managers in relation to pharmacy benefit management services provided to payors in this state. The department shall investigate any alleged violation of this section.

(9)(a) A pharmacy benefit manager that violates this section is liable for a civil fine of $10,000 for each violation and may have its registration revoked by the Department of Financial Services.

(b) A violation of this section which is committed or performed with such frequency as to indicate a general business practice is subject to the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(10) This section applies to contracts entered into or renewed on or after January 1, 2021.

Section 5. Subsection (1) of section 624.490, Florida Statutes, is amended to read:

624.490 Registration of pharmacy benefit managers.—

(1) As used in this section, the term "pharmacy benefit manager" means an ~~a person or~~ entity that performs pharmacy benefit management services for a health plan, a health plan sponsor, a health plan provider, a health insurer, or any other payor that uses pharmacy benefit management services ~~doing business in this state which contracts to administer prescription drug benefits on behalf of a health insurer or a health maintenance organization to residents of this state~~. The term does not include a provider as defined in s. 641.19, a physician as defined in s. 458.305, or an osteopathic physician as defined in s. 459.003. As used in this subsection, the term "pharmacy benefit management services" means services that:

(a) Are provided, directly or through another entity, to a health plan, a health plan sponsor, a health plan provider, a health insurer, or any other payor, regardless of whether the services provider and the health plan, health plan sponsor, health plan provider, health insurer, or other payor are related or associated by ownership, common ownership, organization, or otherwise.

(b) Include the procurement of prescription drugs to be dispensed to patients and the administration or management of prescription drug benefits, including, but not limited to, any

of the following:

1. Mail service pharmacy or specialty pharmacy.

2. Claims processing, retail network management, or payment of claims to pharmacies for dispensing drugs.

3. Clinical or other formulary or preferred-drug-list development or management.

4. Negotiation, administration, or receipt of rebates, discounts, payment differentials, or other incentives, to include particular drugs in a particular category or to promote the purchase of particular drugs.

5. Patients' compliance, therapeutic intervention, or generic substitution programs.

6. Disease management.

7. Drug use review, step-therapy protocol, or prior authorization.

8. Adjudication of appeals or grievances related to prescription drug coverage.

9. Contracts with network pharmacies.

10. Control of the cost of covered prescription drugs.

Section 6. Section 627.42385, Florida Statutes, is created to read:

627.42385 Coinsurance obligations for prescription drugs.—

(1) As used in this section, the term:

(a) "Coinsurance" means, with respect to prescription drug coverage under a group health plan or health insurance coverage,

a payment obligation of a plan beneficiary or an insured that is based on a percentage of the specified cost of a prescription drug, which may be up to 100 percent of that cost.

(b) "Deductible" means the payment obligation of a group health plan beneficiary or a health insurance coverage insured before the plan or coverage will pay any portion of the cost of prescription drug coverage.

(c) "Health insurer" has the same meaning as provided in s. 627.42392.

(d) "List price" means the manufacturer's price for a drug for wholesalers or direct purchasers in this country, not including any rebate, discount, payment differential, concession, or reduction in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

(e) "Net price" means the price of a drug paid by a group health plan or a health insurer, or a pharmacy benefit manager performing pharmacy benefit management services for a group health plan or a health insurer, after all rebates, discounts, payment differentials, concessions, and reductions in price have been applied to the list price.

(f) "Pharmacy benefit manager" has the same meaning as provided in s. 465.003.

(g) "Pharmacy benefit management services" has the same

meaning as provided in s. 465.003.

(h) "Prescription drug" has the same meaning as provided in s. 409.9201.

(2) Unless otherwise expressly provided in this section, a group health plan or a health insurer offering group or individual health insurance coverage, or a pharmacy benefit manager performing pharmacy benefit management services for a group health plan or a health insurer, shall base a plan beneficiary's or an insured's coinsurance obligation for a prescription drug covered by the plan or coverage on the net price, and not the list price, of the drug.

(3)(a) Subsection (2) applies to a prescription drug benefit if a plan beneficiary or an insured is required to pay a deductible with respect to such benefit and if the plan beneficiary or insured:

1. Has not yet satisfied the deductible under the plan or coverage; or

2. Has another coinsurance obligation with respect to such benefit under the plan or coverage.

(b) Subsection (2) does not apply if, with respect to the dispensed quantity of a prescription drug, the net price and list price of the drug are different by not more than 1 percent.

(4) In complying with this section, a group health plan or a health insurer, or a pharmacy benefit manager performing pharmacy benefit management services for a group health plan or

a health insurer, may not publish or otherwise reveal information regarding the actual amount of rebates, discounts, payment differentials, concessions, or reductions in price that the plan, health insurer, or pharmacy benefit plan receives on a product-, manufacturer-, or pharmacy-specific basis. The plan, health insurer, or pharmacy benefit manager shall protect such information as a trade secret and shall impose the confidentiality protections on any vendor or third party performing health care or pharmacy administrative services on behalf of the plan, health insurer, or pharmacy benefit manager that have access to rebate, discount, payment differential, concession, or reduction information.

(5) A group health plan, health insurer, or pharmacy benefit manager that violates any provision of this section is liable for a civil fine of $10,000 for each violation and may be required to discontinue the issuance or renewal of the plan or health insurance coverage or the provision of pharmacy benefit management services, as applicable.

(6) The department shall investigate any alleged violation of this section.

(7) This section does not prevent a group health plan, health insurer, or pharmacy benefit manager from requiring a copayment for any prescription drug if such copayment is not tied to a percentage of the cost of the drug.

Section 7. Section 627.64741, Florida Statutes, is amended

to read:

627.64741 Pharmacy benefit manager contracts.—

(1) As used in this section, the term:

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacy or pharmacist for a generic drug, brand name drug, specialty drug, biological product, or other prescription drug, excluding dispensing fees, before ~~prior to~~ the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) "Maximum allowable cost list" means a listing of generic drugs, brand name drugs, specialty drugs, biological products, or other prescription drugs or other methodology used directly or indirectly by a pharmacy benefit manager to set the maximum allowable costs for the drugs.

(c) "Payor" means a health plan, a health plan sponsor, a health plan provider, or any other payor that uses pharmacy benefit management services in this state.

(d) ~~(b)~~ "Pharmacy benefit manager" means an ~~a person or~~ entity that performs pharmacy benefit management services for ~~doing business in this state which contracts to administer or manage prescription drug benefits on behalf of~~ a health insurer or payor ~~to residents of this state~~. The term does not include a provider as defined in s. 641.19, a physician as defined in s. 458.305, or an osteopathic physician as defined in s. 459.003.

(e) "Pharmacy benefit management services" means services

that:

1. Are provided, directly or through another entity, to a health insurer or payor, regardless of whether the services provider and the health insurer or payor are related or associated by ownership, common ownership, organization, or otherwise.

2. Include the procurement of prescription drugs to be dispensed to patients and the administration or management of prescription drug benefits, including, but not limited to, any of the following:

a. Mail service pharmacy or specialty pharmacy.

b. Claims processing, retail network management, or payment of claims to pharmacies for dispensing drugs.

c. Clinical or other formulary or preferred-drug-list development or management.

d. Negotiation, administration, or receipt of rebates, discounts, payment differentials, or other incentives, to include particular drugs in a particular category or to promote the purchase of particular drugs.

e. Patients' compliance, therapeutic intervention, or generic substitution programs.

f. Disease management.

g. Drug use review, step-therapy protocol, or prior authorization.

h. Adjudication of appeals or grievances related to

prescription drug coverage.

i. Contracts with network pharmacies.

j. Control of the cost of covered prescription drugs.

(2) A contract between a health insurer or payor and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer or payor and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacy's or pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer or payor and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5)(a) A pharmacy benefit manager has a fiduciary duty and obligation to the insureds and to the health insurer that uses pharmacy benefit management services or the payor. The pharmacy benefit manager must meet all the requirements of s. 465.203 and must perform pharmacy benefit management services with care, skill, prudence, diligence, and professionalism and for the best interests of the insureds and the health insurer or payor.

(b) A provision in a contract between a health insurer or payor and a pharmacy benefit manager is void and against the public policy of the state if the policy:

1. Limits or prohibits the fiduciary duty or obligation of the pharmacy benefit manager to the insureds and the health insurer or payor; or

2. Violates any provision of s. 465.203.

(c) All funds received by a pharmacy benefit manager in relation to providing pharmacy benefit management services shall be received by the pharmacy benefit manager in trust for the health insurer or payor and shall be used or distributed only for the benefit of the insureds or the health insurer or payor.

(6) A contract between a health insurer or payor and a pharmacy benefit manager must require the maximum allowable cost list to include:

(a) Average acquisition cost, including national average

drug acquisition cost.

(b) Average manufacturer price.

(c) Average wholesale price.

(d) Brand effective rate or generic effective rate.

(e) Discount indexing.

(f) Federal upper limits.

(g) Wholesale acquisition cost.

(h) Any other item that a pharmacy benefit manager or a health insurer or payor may use to establish reimbursement rates to a pharmacist or pharmacy for filling prescriptions or providing other pharmacy services.

(7) A health insurer that uses pharmacy benefit management services or a payor shall have access to all financial and utilization records, data, and information used by the pharmacy benefit manager in relation to the pharmacy benefit management services provided to the health insurer or payor.

(8) A pharmacy benefit manager shall:

(a) Disclose in writing to the health insurer that uses pharmacy benefit management services or payor any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager which directly or indirectly presents conflicts of interest with the pharmacy benefit manager's relationship with, or fiduciary duty or obligation to, the insureds and the health insurer or payor.

(b) Report quarterly to the health insurer or payor any

income resulting from pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other financial benefits received by the pharmacy benefit manager from any person or entity. The pharmacy benefit manager shall ensure that such income and financial benefits are passed through in full, at least quarterly, to the health insurer or payor to reduce the cost of prescription drugs and pharmacy services to the insureds.

(9) The department shall investigate any alleged violation of this section.

(10)(a) A pharmacy benefit manager that violates any provision of this section is liable for a civil fine of $10,000 for each violation and may have its registration revoked by the department.

(b) A violation by a pharmacy benefit manager of any provision of this section which is committed or performed with such frequency as to indicate a general business practice is subject to the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(11)~~(5)~~ This section applies to contracts entered into or renewed on or after January 1, 2021 ~~July 1, 2018~~.

Section 8. Section 627.6572, Florida Statutes, is amended to read:

627.6572 Pharmacy benefit manager contracts.—

(1) As used in this section, the term:

(a) "Maximum allowable cost" means the per-unit amount that a pharmacy benefit manager reimburses a pharmacy or pharmacist for a generic drug, brand name drug, specialty drug, biological product, or other prescription drug, excluding dispensing fees, before ~~prior to~~ the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) "Maximum allowable cost list" means a listing of generic drugs, brand name drugs, specialty drugs, biological products, or other prescription drugs or other methodology used directly or indirectly by a pharmacy benefit manager to set the maximum allowable costs for the drugs.

(c) "Payor" means a health plan, a health plan sponsor, a health plan provider, or any other payor that uses pharmacy benefit management services in this state.

(d) ~~(b)~~ "Pharmacy benefit manager" means an ~~a person or~~ entity that performs pharmacy benefit management services for ~~doing business in this state which contracts to administer or manage prescription drug benefits on behalf of~~ a health insurer or payor ~~to residents of this state~~. The term does not include a provider as defined in s. 641.19, a physician as defined in s. 458.305, or an osteopathic physician as defined in s. 459.003.

(e) "Pharmacy benefit management services" means services that:

1. Are provided, directly or through another entity, to a

health insurer or payor, regardless of whether the services provider and the health insurer or payor are related or associated by ownership, common ownership, organization, or otherwise.

2. Include the procurement of prescription drugs to be dispensed to patients and the administration or management of prescription drug benefits, including, but not limited to, any of the following:

a. Mail service pharmacy or specialty pharmacy.

b. Claims processing, retail network management, or payment of claims to pharmacies for dispensing drugs.

c. Clinical or other formulary or preferred-drug-list development or management.

d. Negotiation, administration, or receipt of rebates, discounts, payment differentials, or other incentives, to include particular drugs in a particular category or to promote the purchase of particular drugs.

e. Patients' compliance, therapeutic intervention, or generic substitution programs.

f. Disease management.

g. Drug use review, step-therapy protocol, or prior authorization.

h. Adjudication of appeals or grievances related to prescription drug coverage.

i. Contracts with network pharmacies.

j. Control of the cost of covered prescription drugs.

(2) A contract between a health insurer or payor and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health insurer or payor and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacy's or pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health insurer or payor and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring an insured to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5)(a) A pharmacy benefit manager has a fiduciary duty and obligation to the insureds and to the health insurer that uses pharmacy benefit management services or the payor. The pharmacy benefit manager must meet all the requirements of s. 465.203 and must perform pharmacy benefit management services with care, skill, prudence, diligence, and professionalism and for the best interests of the insureds and the health insurer or payor.

(b) A provision in a contract between a health insurer or payor and a pharmacy benefit manager is void and against the public policy of the state if the policy:

1. Limits or prohibits the fiduciary duty or obligation of the pharmacy benefit manager to the insureds and the health insurer or payor; or

2. Violates any provision of s. 465.203.

(c) All funds received by a pharmacy benefit manager in relation to providing pharmacy benefit management services shall be received by the pharmacy benefit manager in trust for the health insurer or payor and shall be used or distributed only for the benefit of the insureds or the health insurer or payor.

(6) A contract between a health insurer or payor and a pharmacy benefit manager must require the maximum allowable cost list to include:

(a) Average acquisition cost, including national average drug acquisition cost.

(b) Average manufacturer price.

(c) Average wholesale price.

(d) Brand effective rate or generic effective rate.

(e) Discount indexing.

(f) Federal upper limits.

(g) Wholesale acquisition cost.

(h) Any other item that a pharmacy benefit manager or a health insurer or payor may use to establish reimbursement rates to a pharmacist or pharmacy for filling prescriptions or providing other pharmacy services.

(7) A health insurer that uses pharmacy benefit management services or a payor shall have access to all financial and utilization records, data, and information used by the pharmacy benefit manager in relation to the pharmacy benefit management services provided to the health insurer or payor.

(8) A pharmacy benefit manager shall:

(a) Disclose in writing to the health insurer that uses pharmacy benefit management services or the payor any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager which directly or indirectly presents conflicts of interest with the pharmacy benefit manager's relationship with, or fiduciary duty or obligation to, the insureds and the health insurer or payor.

(b) Report quarterly to the health insurer or payor any income resulting from pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants,

chargebacks, reimbursements, or other financial benefits received by the pharmacy benefit manager from any person or entity. The pharmacy benefit manager shall ensure that such income and financial benefits are passed through in full, at least quarterly, to the health insurer or payor to reduce the cost of prescription drugs and pharmacy services to the insureds.

(9) The department shall investigate any alleged violation of this section.

(10)(a) A pharmacy benefit manager that violates any provision of this section is liable for a civil fine of $10,000 for each violation and may have its registration revoked by the department.

(b) A violation by a pharmacy benefit manager of any provision of this section which is committed or performed with such frequency as to indicate a general business practice is subject to the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(11) ~~(5)~~ This section applies to contracts entered into or renewed on or after January 1, 2021 ~~July 1, 2018~~.

Section 9. Section 641.314, Florida Statutes, is amended to read:

641.314 Pharmacy benefit manager contracts.—

(1) As used in this section, the term:

(a) "Maximum allowable cost" means the per-unit amount

that a pharmacy benefit manager reimburses a pharmacy or pharmacist for a generic drug, brand name drug, specialty drug, biological product, or other prescription drug, excluding dispensing fees, before ~~prior to~~ the application of copayments, coinsurance, and other cost-sharing charges, if any.

(b) "Maximum allowable cost list" means a listing of generic drugs, brand name drugs, specialty drugs, biological products, or other prescription drugs or other methodology used directly or indirectly by a pharmacy benefit manager to set the maximum allowable costs for the drugs.

(c) "Payor" means a health plan, a health plan sponsor, a health plan provider, or any other payor that uses pharmacy benefit management services in this state.

(d) ~~(b)~~ "Pharmacy benefit manager" means an ~~a person or~~ entity that performs pharmacy benefit management services for ~~doing business in this state which contracts to administer or manage prescription drug benefits on behalf of~~ a health maintenance organization or payor ~~to residents of this state~~. The term does not include a provider as defined in s. 641.19, a physician as defined in s. 458.305, or an osteopathic physician as defined in s. 459.003.

(e) "Pharmacy benefit management services" means services that:

1. Are provided, directly or through another entity, to a health maintenance organization or payor, regardless of whether

the services provider and the health maintenance organization or payor are related or associated by ownership, common ownership, organization, or otherwise.

2. Include the procurement of prescription drugs to be dispensed to patients and the administration or management of prescription drug benefits, including, but not limited to, any of the following:

a. Mail service pharmacy or specialty pharmacy.

b. Claims processing, retail network management, or payment of claims to pharmacies for dispensing drugs.

c. Clinical or other formulary or preferred-drug-list development or management.

d. Negotiation, administration, or receipt of rebates, discounts, payment differentials, or other incentives, to include particular drugs in a particular category or to promote the purchase of particular drugs.

e. Patients' compliance, therapeutic intervention, or generic substitution programs.

f. Disease management.

g. Drug use review, step-therapy protocol, or prior authorization.

h. Adjudication of appeals or grievances related to prescription drug coverage.

i. Contracts with network pharmacies.

j. Control of the cost of covered prescription drugs.

(2) A contract between a health maintenance organization or payor and a pharmacy benefit manager must require that the pharmacy benefit manager:

(a) Update maximum allowable cost pricing information at least every 7 calendar days.

(b) Maintain a process that will, in a timely manner, eliminate drugs from maximum allowable cost lists or modify drug prices to remain consistent with changes in pricing data used in formulating maximum allowable cost prices and product availability.

(3) A contract between a health maintenance organization or payor and a pharmacy benefit manager must prohibit the pharmacy benefit manager from limiting a pharmacy's or pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug, and the availability of a more affordable alternative drug, pursuant to s. 465.0244.

(4) A contract between a health maintenance organization or payor and a pharmacy benefit manager must prohibit the pharmacy benefit manager from requiring a subscriber to make a payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(a) The applicable cost-sharing amount; or

(b) The retail price of the drug in the absence of prescription drug coverage.

(5)(a) A pharmacy benefit manager has a fiduciary duty and obligation to the subscribers and to the health maintenance organization that uses pharmacy benefit management services or a payor. The pharmacy benefit manager must meet all the requirements of s. 465.203 and must perform pharmacy benefit management services with care, skill, prudence, diligence, and professionalism and for the best interests of the subscribers and the health maintenance organization or payor.

(b) A provision in a contract between a health maintenance organization or payor and a pharmacy benefit manager is void and against the public policy of this state if the policy:

1. Limits or prohibits the fiduciary duty or obligation of the pharmacy benefit manager to the insureds and the health maintenance organization or payor; or

2. Violates any provision of s. 465.203.

(c) All funds received by a pharmacy benefit manager in relation to providing pharmacy benefit management services shall be received by the pharmacy benefit manager in trust for the health maintenance organization or payor and shall be used or distributed only for the benefit of the insureds or the health maintenance organization or payor.

(6) A contract between a health maintenance organization or payor and a pharmacy benefit manager must require the maximum allowable cost list to include:

(a) Average acquisition cost, including national average

drug acquisition cost.

(b) Average manufacturer price.

(c) Average wholesale price.

(d) Brand effective rate or generic effective rate.

(e) Discount indexing.

(f) Federal upper limits.

(g) Wholesale acquisition cost.

(h) Any other item that a pharmacy benefit manager or a health maintenance organization or payor may use to establish reimbursement rates to a pharmacist or pharmacy for filling prescriptions or providing other pharmacy services.

(7) A health maintenance organization that uses pharmacy benefit management services or a payor shall have access to all financial and utilization records, data, and information used by the pharmacy benefit manager in relation to the pharmacy benefit management services provided to the health maintenance organization or payor.

(8) A pharmacy benefit manager shall:

(a) Disclose in writing to the maintenance organization that uses pharmacy benefit management services or the payor any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager which directly or indirectly presents conflicts of interest with the pharmacy benefit manager's relationship with, or fiduciary duty or obligation to, the subscribers and the health maintenance organization or payor.

(b) Report quarterly to the health maintenance organization or payor any income resulting from pricing discounts, rebates of any kind, inflationary payments, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other financial benefits received by the pharmacy benefit manager from any person or entity. The pharmacy benefit manager shall ensure that such income and financial benefits are passed through in full, at least quarterly, to the health maintenance organization or payor to reduce the cost of prescription drugs and pharmacy services to the subscribers.

(9) The department shall investigate any alleged violation of this section.

(10)(a) A pharmacy benefit manager that violates any provision of this section is liable for a civil fine of $10,000 for each violation and may have its registration revoked by the department.

(b) A violation of any provision of this section which is committed or performed with such frequency as to indicate a general business practice is subject to the Florida Deceptive and Unfair Trade Practices Act under part II of chapter 501.

(11)~~(5)~~ This section applies to contracts entered into or renewed on or after January 1, 2021 ~~July 1, 2018~~.

Section 10. Paragraph (a) of subsection (1) of section 409.9201, Florida Statutes, is amended to read:

409.9201 Medicaid fraud.—

(1) As used in this section, the term:

(a) "Prescription drug" means any drug, including, but not limited to, finished dosage forms or active ingredients that are subject to, defined in, or described in s. 503(b) of the Federal Food, Drug, and Cosmetic Act or in s. 465.003(14) ~~465.003(8)~~, s. 499.003(17), s. 499.007(13), or s. 499.82(10).

The value of individual items of the legend drugs or goods or services involved in distinct transactions committed during a single scheme or course of conduct, whether involving a single person or several persons, may be aggregated when determining the punishment for the offense.

Section 11. Paragraph (pp) of subsection (1) of section 458.331, Florida Statutes, is amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(pp) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or

causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a

communication that purports to be a prescription as defined in s. 465.003 ~~465.003(14)~~ or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 458.3265(3).

Section 12. Paragraph (rr) of subsection (1) of section 459.015, Florida Statutes, is amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(rr) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq.,

the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003 ~~465.003(14)~~ or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient

relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 459.0137(3).

Section 13. Subsection (1) of section 465.014, Florida Statutes, is amended to read:

465.014 Pharmacy technician.—

(1) A person other than a licensed pharmacist or pharmacy intern may not engage in the practice of the profession of pharmacy, except that a licensed pharmacist may delegate to pharmacy technicians who are registered pursuant to this section those duties, tasks, and functions that do not fall within the purview of s. 465.003(23) ~~465.003(13)~~. All such delegated acts must be performed under the direct supervision of a licensed pharmacist who is responsible for all such acts performed by persons under his or her supervision. A registered pharmacy technician, under the supervision of a pharmacist, may initiate or receive communications with a practitioner or his or her agent, on behalf of a patient, regarding refill authorization requests. A licensed pharmacist may not supervise more than one registered pharmacy technician unless otherwise permitted by the guidelines adopted by the board. The board shall establish guidelines to be followed by licensees or permittees in determining the circumstances under which a licensed pharmacist may supervise more than one pharmacy technician.

Section 14. Paragraph (c) of subsection (2) of section 465.015, Florida Statutes, is amended to read:

465.015 Violations and penalties.—

(2) It is unlawful for any person:

(c) To sell or dispense drugs as defined in s. 465.003(14) ~~465.003(8)~~ without first being furnished with a prescription.

Section 15. Subsection (9) of section 465.0156, Florida Statutes, is amended to read:

465.0156 Registration of nonresident pharmacies.—

(9) Notwithstanding s. 465.003(18) ~~465.003(10)~~, for purposes of this section, the registered pharmacy and the pharmacist designated by the registered pharmacy as the prescription department manager or the equivalent must be licensed in the state of location in order to dispense into this state.

Section 16. Paragraph (s) of subsection (1) of section 465.016, Florida Statutes, is amended to read:

465.016 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(s) Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in ~~by~~ s. 465.003 ~~465.003(14)~~ or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship.

Section 17. Subsection (4) of section 465.0197, Florida Statutes, is amended to read:

465.0197 Internet pharmacy permits.—

(4) Notwithstanding s. 465.003(18) ~~465.003(10)~~, for purposes of this section, the Internet pharmacy and the pharmacist designated by the Internet pharmacy as the prescription department manager or the equivalent must be licensed in the state of location in order to dispense into this state.

Section 18. Paragraph (j) of subsection (5) of section 465.022, Florida Statutes, is amended to read:

465.022 Pharmacies; general requirements; fees.—

(5) The department or board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

(j) Has dispensed any medicinal drug based upon a communication that purports to be a prescription as defined in ~~by~~ s. 465.003 ~~465.003(14)~~ or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459,

chapter 461, chapter 463, chapter 464, or chapter 466.

For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall deny the application if upon final resolution of the case the licensee has failed to successfully complete the program.

Section 19. Paragraph (h) of subsection (1) of section 465.023, Florida Statutes, is amended to read:

465.023 Pharmacy permittee; disciplinary action.—

(1) The department or the board may revoke or suspend the permit of any pharmacy permittee, and may fine, place on probation, or otherwise discipline any pharmacy permittee if the permittee, or any affiliated person, partner, officer, director, or agent of the permittee, including a person fingerprinted under s. 465.022(3), has:

(h) Dispensed any medicinal drug based upon a communication that purports to be a prescription as defined in ~~by~~ s. 465.003 ~~465.003(14)~~ or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459,

chapter 461, chapter 463, chapter 464, or chapter 466.

Section 20. Section 465.1901, Florida Statutes, is amended to read:

465.1901 Practice of orthotics and pedorthics.—The provisions of chapter 468 relating to orthotics or pedorthics do not apply to any licensed pharmacist or to any person acting under the supervision of a licensed pharmacist. The practice of orthotics or pedorthics by a pharmacist or any of the pharmacist's employees acting under the supervision of a pharmacist shall be construed to be within the meaning of the term "practice of the profession of pharmacy" as defined ~~set forth~~ in s. 465.003 ~~465.003(13)~~, and shall be subject to regulation in the same manner as any other pharmacy practice. The Board of Pharmacy shall develop rules regarding the practice of orthotics and pedorthics by a pharmacist. Any pharmacist or person under the supervision of a pharmacist engaged in the practice of orthotics or pedorthics is not precluded from continuing that practice pending adoption of these rules.

Section 21. Subsection (40) of section 499.003, Florida Statutes, is amended to read:

499.003 Definitions of terms used in this part.—As used in this part, the term:

(40) "Prescription drug" means a prescription, medicinal, or legend drug, including, but not limited to, finished dosage forms or active pharmaceutical ingredients subject to, defined

by, or described by s. 503(b) of the federal act or s. 465.003(14) ~~465.003(8)~~, s. 499.007(13), subsection (31), or subsection (47), except that an active pharmaceutical ingredient is a prescription drug only if substantially all finished dosage forms in which it may be lawfully dispensed or administered in this state are also prescription drugs.

Section 22. Paragraph (c) of subsection (24) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(24) "Prescription" includes any order for drugs or medicinal supplies which is written or transmitted by any means of communication by a licensed practitioner authorized by the laws of this state to prescribe such drugs or medicinal supplies, is issued in good faith and in the course of professional practice, is intended to be dispensed by a person authorized by the laws of this state to do so, and meets the requirements of s. 893.04.

(c) A prescription for a controlled substance may not be issued on the same prescription blank with another prescription for a controlled substance that is named or described in a different schedule or with another prescription for a medicinal drug, as defined in s. 465.003 ~~465.003(8)~~, that is not a controlled substance.

Section 23. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 24. This act shall take effect January 1, 2021.