BEYOND THE BELTWAY BULLETIN

POWER TO DECIDE

As of June 2026

Pharmacist Prescribing of Hormonal Contraceptives

Over the last decade, there has been a growing interest in expanding the authority of pharmacists to directly prescribe and dispense some hormonal birth control methods. This eliminates the need for patients to first get a prescription from a doctor before going to have it filled at a pharmacy. Currently, 36 states (including the District of Columbia) have enacted policies to allow pharmacists to prescribe or furnish self-administered hormonal methods (e.g., the pill, patch, ring, and shot). See the status of implementation in Table 1.

46% of pharmacies in Oregon prescribe contraception.

Allowing pharmacists to prescribe is not a new concept or limited to birth control. Many states provide pharmacists with varying levels of prescribing authority for certain products.[1] Some states allow collaborative practice agreements (CPAs), which require pharmacists to have a supervising physician. A plurality of states have statewide protocols specifically for prescribing hormonal contraception (among other drugs). Statewide protocols do not require agreements with physicians, as the authority comes directly from the state.

10% of new prescriptions for pills or patches were written by a pharmacist. **(Among Medicaid enrollees in Oregon)**

A few other states are using standing orders. A standing order could act like a CPA or a statewide protocol, depending on whether the authority is derived from a supervising physician the pharmacist has identified and entered into an agreement with (CPA), or the state department of health director who can grant authority to all pharmacists in the state (statewide protocol).

While there are some differences between these states' policies, there are several similarities. Pharmacists are required to undergo training and to refer patients at some point in the process to their primary care provider, or local providers for patients that do not already have one. Patients are required to complete a self-screening tool to identify risks.[2]

1. Adams, A.J. and Weaver, K.K. (2016). The Continuum of Pharmacist Prescriptive Authority. Annals of Pharmacotherapy, 50(9): 778-784 https://doi.org/10.1177/1060028016653608

2. Ibid.

States that have done well implementing pharmacist prescribing show the potential it has to increase access to some forms of contraception for some women. For instance, 46% of pharmacies in Oregon prescribe contraception. Among Medicaid enrollees in that state, 10% of new prescriptions for pills or patches were written by a pharmacist.[3] Additional research from Oregon and New Mexico shows that pharmacists in rural areas are similarly likely to prescribe birth control as pharmacists in urban areas.[4] Dr. Rebecca Stone, University of Georgia Pharmacist, has keenly noted, "Effective hormonal contraceptives have been safely used by women for more than 50 years, and pharmacists are well-trained to help women select and use their medications effectively."[5]

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Allowing pharmacists in more states to prescribe hormonal contraception could be especially useful for women without ready access to a doctor from whom they can get a prescription. Some 67% of women in a nationwide survey said that they would benefit from accessing contraception directly from a pharmacist without having to pay a fee to visit a physician or clinic.[6] As one consumer summarized the benefit of this service, "My prescription had sun out and I don't have a doctor to fill it. The pharmacist was just able to take care of it – super easy and convenient."[7] Some research suggests that pharmacists are helping to fill gaps; a 2019 study found women receiving contraception from a pharmacist were more likely to be younger, uninsured, and have less education than women seeing clinicians. [8]

However, as with any law, implementation is key. California, the first state to pass a law giving pharmacists this authority, has had a different experience with the roll-out of its law, where only 5% of pharmacies were prescribing contraception in the first year after implementation.[9] Other states looking into this policy option can learn from the lessons of these early adopter states. [10] [11]

"My prescription had run out and I don't have a doctor to fill it. The pharmacist was just able to take care of it – super easy and convenient."

3. Anderson L., Hartung, D.M., Middleton, L., Rodriguez, M.I. (2019). Pharmacist Provision of Hormonal Contraception in the Oregon Medicaid Population. Obstetrics and Gynecology, 133(6):1231-1237.https://doi.org/10.1097/AOG.0000000000003286

4. Rodriguez, M.I., Garg B., Williams, S.M., Souphanavong J., Schrote K., Darney, B.G. (2019). Availability of Pharmacist Prescription of Contraception in Rural Areas of Oregon and New Mexico. Contraception, 101(3):210-212. https://doi.org/10.1016/j.contraception.2019.11.005

5. R Street Institute. (April 14, 2020). Webinar: Bipartisan Solutions for Birth Control Access. https://www.youtube.com/watch?v=s3zoVbGCamg

6. Rafie, S., Richards, E., Rafie, S., Landau, S.C., and Wilkinson, T.A. (2019) Pharmacist Outlooks on Prescribing Hormonal Contraception Following Statewide Scope of Practice Expansion. Journal of Pharmacy Education and Practice, 7(3): 96 https://doi.org/10.3390/pharmacy7030096

7. Rodriguez, M.I. (2019) Unpublished research from the PEARL study https://www.ohsu.edu/womens-health/pearl-study

8. Rodriguez, M.I., Edelman, A.B., Skye, M., Anderson, L., Darney, B.G. (2020). Association of Pharmacist Prescription With Dispensed Duration of Hormonal Contraception. Obstetrics and Gynecology, 3(5):1-12. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766072

9. Batra P., Rafie S., Zhang Z., Singh A.V., Bird C.E., Sridhar A, Sullivan J.G. (2018). An Evaluation of the Implementation of Pharmacist-Prescribed Hormonal Contraceptives in California. Obstetrics and Gynecology, 131(5):850-855. https://doi.org/10.1097/AOG.0000000000002572

10. APhA. (2018, April 19). Pharmacist-prescribed contraception still hard to find. https://www.medscape.com/viewarticle/895334.

11. Manatt. (2021). Implementing Pharmacist Contraceptive Prescribing: A Playbook for States and Stakeholders. Retrieved from https://www.manatt.com/insights/newsletters/manatt-on-health/implementing-pharmacist-contraceptive-prescribing

12. Rafie S, Landau S. (2020). Opening New Doors to Birth Control: State Efforts to Expand Access to Contraception in Community Pharmacies. Birth Control Pharmacist. https://birthcontrolpharmacist.com/2021/04/08/updated-report/

13. Barber J.S., Ela E., Gatny H, Kusunoki Y, Fakih S., Batra, P., Farris K. (2019). Contraceptive Desert? Black-White Differences in Characteristics of Nearby Pharmacies. (2019). Journal of Racial and Ethnic Health Disparities 6:719-732. https://doi.org/10.1007/s40615-019-00570-3

As other states assess whether to pursue this policy option, there are a variety of factors to take into account. For example, there are concerns about whether pharmacies will be able to provide a private space for patient counseling and how to handle payment for that service provided by pharmacists.[12] States should also consider the financial burden counseling services may pose for uninsured customers. Other factors that could influence a patient's decision to use this service might include the availability of multilingual pharmacy staff, pharmacy hours, and distance to participating pharmacies.[13]

"Research from **Oregon** and **New Mexico** shows that pharmacists in rural areas are similarly likely to prescribe birth control as pharmacists in urban areas."

Contraceptive access remains challenging in the US, with more than 19 million women with low incomes living in contraceptive deserts, counties in which there is not reasonable access to a health center offering the full range of contraceptive methods.[14] Given this landscape, and ongoing federal policy challenges, interest in allowing pharmacists to prescribe hormonal contraception is likely to continue gaining traction in states. Many pharmacists are prescribing hormonal contraceptives, seeing it as an opportunity to practice at the top of their license.[15] Though pharmacist participation varies across states, advocacy within the pharmacy community for better implementation and reimbursement may increase pharmacist participation—and research has suggested pharmacist interest in states where they do not yet have the authority to prescribe contraception.[16] Like any policy option, pharmacist prescribing should not be considered a cure-all for barriers to contraceptive access. However, allowing and supporting more pharmacists to prescribe birth control provides another important access point for women, ensuring more have the power to decide if, when, and under what circumstances to get pregnant.

The table on the following page highlights key information from each state that has passed policies to allow pharmacists to prescribe or furnish contraception.

12. Rafie S, Landau S. (2020). Opening New Doors to Birth Control: State Efforts to Expand Access to Contraception in Community Pharmacies. Birth Control Pharmacist. https://birthcontrolpharmacist.com/2021/04/08/updated-report/

13. Barber J.S., Ela E., Gatny H, Kusunoki Y, Fakih S., Batra, P., Farris K. (2019). Contraceptive Desert? Black-White Differences in Characteristics of Nearby Pharmacies. (2019). Journal of Racial and Ethnic Health Disparities 6:719-732. https://doi.org/10.1007/s40615-019-00570-3

14. Birth Control Access. Power to Decide. https://powertodecide.org/what-we-do/access/birth-control-access

15. The Birth Control Pharmacist project provides education and training, implementation assistance, resources, and clinical updates to pharmacists prescribing contraception, and engages in advocacy, research and policy efforts to expand the role of pharmacists in family planning. Their Birth Control Pharmacies site helps people to find a pharmacy where they can obtain contraception directly from a pharmacist.

16. Stone R.H., Rafie S., Shealy K., Griffin B., Stein A.B. (2020). Pharmacist self-perception of readiness to prescribe hormonal contraception and additional training needs. Currents in Pharmacy Teaching and Learning 12(1):27-34. https://doi.org/10.1016/j.cptl.2019.10.005

Table 1 .

State	Bill/Guidance	Year passed (Date in Effect for Consumers)	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
Arizona	SB 1082 Regulations	2021 (2024)	Standing Order	pill, patch, ring	(-) Age restriction (18 and older)
Arkansas	ACT 408	2021 (2022)	Statewide Protocol	pill	(-) Cannot prescribe more than a 6-month supply to those without evidence of a primary care visit within the previous 6 months (-) Age restriction (18 and older)
California	SB 493 Regulations	2013 (2014)	Statewide Protocol	pill, patch, ring, injection	(+) Self-screening tool available in multiple languages[1] (+) Requires referral to a health care provider if these services are not available, if self-administered hormonal contraception is not recommended for patient, and after furnishing contraceptives to a patient
Colorado	SB 16-135 FAQs	2016 (2017)	Statewide Protocol	pill, patch	(-) Age restriction (18 or older) (-) Cannot continue to prescribe to patient beyond three years from initial Rx, if no evidence of a clinical visit
Connecticut	Substitute House Bill No. 6768 Regulations	2023 (TBD)	Statewide Protocol	pill, patch, ring, EC	(+) No age restriction
Delaware	SB 105	2021 (2023)	Standing Order	Contraceptives, defined as contraceptive medications approved by the FDA; injection	(+) No age restriction
District of Columbia	B 22-106 Proposed Regulations	2018 TBD	Statewide Protocol	pill, patch, ring	(+) Requires referral to a health care provider after contraceptives are furnished or if self administered hormonal contraception is not recommended

Table 1 continued

State	Bill/Guidance	Year passed (Date in Effect for Consumers)	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
Georgia	HB 1138	2026 TBD	TBD	self-administered contraceptive, injectable	N/A
Hawaii	SB 513	2017 (2017)	Statewide Protocol	pill, patch, ring, injection	(+) Requires referral to a health care provider after contraceptives are furnished
Idaho	HB 182	2019	Prescriptive Authority[2]	pill, patch, ring, injection	N/A
Illinois	HB 135	2021 (2023)	Standing Order	"Self-administered hormonal contraceptives"	N/A
Indiana	HB 1658	2023	Standing Order	"Hormonal contraceptive patch" and "self-administered hormonal contraception"	(-) Age restriction (18 and older)
Maine	PL 2023 Ch 115 (SP 158/LD 351) Draft Statewide Protocol (begins on page 52)	2023 TBD	Statewide Protocol	pill, patch, ring, shot	(+) No age restriction
Maryland	HB 613 Regulations	2018 (2019)	Statewide Protocol	pill, patch, ring	(+) Requires referral to a health care provider after contraceptives are furnished
Massachusetts	M.G.L. c. 94C, § 19F (FY 2024 Budget) 105 CMR, §700.004(B)(15)	2023 (2024)	Statewide Protocol	patch, pill	(+) No age restriction

Table 1 continued

State	Bill/Guidance	Year passed (Date in Effect for Consumers)	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
Michigan	Clarification of Regulations	2022[3]	Collaborative Practice Agreements	pill, patch, ring	N/A
Minnesota	SF 13	2020 (2020)	Statewide Protocol	pill, patch, ring	(-) Age restriction (18 and older, unless minor has existing Rx from licensed physician, physician assistant, or APRN) (-) Pharmacist who prescribes and dispenses and initial Rx cannot provide a refill if patient has no evidence of a clinical visit within preceding three years.
Montana	SB 112	2025	Prescriptive Authority[2]	Unknown	N/A
Nebraska	S 38-2867.03	2017	Collaborative Practice Agreements	Unknown	N/A
Nevada	SB 190 Regulations	2021 TBD	Statewide Protocol	pill, patch, ring, and any other self-administered hormonal method outlined in the protocol	(+) No age restriction (+) Up to 12-month prescription
New Hampshire	HB 1822 Protocol	2018 TBD	Statewide Protocol	pill, patch, ring	(+) Insurers that cover outpatient contraceptive services must cover initial screening at pharmacy

Table 1 continued

State	Bill/Guidance	Year passed (Date in Effect for Consumers)	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
New Jersey	S 275 Regulations	2023 (2024)	Standing Order	TBD by	(+) No age restriction (+) Includes a provision allowing the Commissioner of Health to establish a public awareness campaign about the availability of the service.
New Mexico	16.19.26.24 NMAC	2017 (2017)	Statewide Protocol	pill, patch, ring, injection	(+) Requires referral to health care provider if hormonal contraception is not recommended, desired method is not available or if patient experiences side effects
New York	Public Health Law § 267-a (SB 1043A)	2023 (2024)	Standing Order	pill, patch, ring	(+) No age restriction
North Carolina	HB 96	2021 (2022)	Standing Order	pill, patch	(-) Age restriction (18 and older)
Oregon	HB 2527 (expanded authority) HB 2879 (only applied to pills and the patch) Regulations	2017 2015 2016	Statewide Protocol	pill, patch, ring, injection	(+) Self-screening tool also available in Spanish[1] (+) Referral to a health care provider required if hormonal contraception is not recommended (+) Age restriction (18 and older) removed as of January 2020 (-) Cannot continue to prescribe to patient beyond three years from initial Rx, without evidence of a clinical visit
Rhode Island	R.I.Gen. Laws § 5-19.1-36 (SB 103)	2023 TBD	Statewide Protocol	pill, patch, ring, shot	(+) No age restriction (+) Legislation directs pharmacies to display signs in stores and on websites indicating the availability of the service. (-) Limits an initial prescription issued by a pharmacist to a three month supply.
South Carolina	S 477	2026	Standing Order or Joint Written Protocol	pill, patch, ring, shot	(-) Age restriction (18 and older), unless there's evidence of a previous prescription from a practitioner.
	S 628 Protocol	2022 (2022)	Standing Order (each pharmacy must secure their own)		

Table 1 continued

State	Bill/Guidance	Year passed (Date in Effect for Consumers)	Type of Authority	Methods Pharmacist can Prescribe	Other Limits (-) or Features (+)
South Dakota	S.D.§ 36-11-19.1 (6)	1997	Collaborative Practice Agreements	Unknown	N/A
Tennessee	SB 1677 Rule 1140-15	2016 (2019)	Collaborative Practice Agreements	pill, patch, ring, injection	(-) Age restriction (18 and older unless an emancipated minor) (-) Pharmacists may charge an annual administrative fee, except insured patients are not required to pay it
Utah	SB 184 Rule R433-200	2018 (2019)	Standing Order	pill, patch, ring	(+) Self-screening tool also available in Spanish[1] (-) Age restriction (18 and older), regardless of whether patient has an existing Rx (+) Referral to a health care provider is required if hormonal contraception is not recommended (-) Cannot continue to prescribe to a patient more than 2 years after initial Rx, without evidence of consultation with a primary care provider (-) Not covered by insurance
Vermont	S 220	2020 (2021)	Statewide Protocol	pill, patch, ring	(+) H 663 ensures that existing health insurance coverage requirements for contraceptives will also apply to self-administered hormonal contraceptives prescribed by a pharmacist
Virginia	HB 1506	2020 (2021)	Statewide Protocol	pill, patch, ring, shot	(-) Age restriction (18 and older)
Washington[4]	Chapter 90, 1979 laws	1979 (1998)	Collaborative Practice Agreements	...	(-) Age restriction (18 and older)
West Virginia	HB 2583 Protocol	2019 (2020)	Standing Order	pill, patch, ring	(+) Referral to a health care provider required if hormonal contraception is not recommended (-) Cannot continue to prescribe to a patient more than 12 months after initial Rx, w/out evidence of consultation w/ a health care practitioner (-) Age restriction (18 and older)
Wisconsin	Wis. Stat. Ann. § 450.033	2013	Collaborative Practice Agreements	Unknown	N/A

Table 1 notes

***Several studies have shown that while these services may theoretically be available, consumers in some states can find it hard to access these services.**

1. All states with prescribing authority require self-screening tools, but they may not be available in languages other than English.

2. In Idaho and Montana, pharmacists have general prescriptive authority that allows them to prescribe under limited conditions and that are generally minor conditions that do not require a new diagnosis.

3. In 2022, Gov. Whitmer announced the issuance of an interpretive statement from Licensing and Regulatory Affairs that indicates the Michigan Public Health Code allows a physician licensed in Michigan to delegate limited prescriptive authority to a Michigan-licensed pharmacist with a PharmD degree to prescribe self-administered, hormonal contraceptives. Even before this CVS was leveraging collaborative practice agreements for several years.

4. While Washington has allowed pharmacists to enter into CPAs for several decades, up-take among pharmacies has been slow.