The guideline also emphasizes the importance of including an angiotensin-converting enzyme (ACE) inhibitor, an angiotensin receptor blocker (ARB), or a combination angiotensin receptor and neprilysin inhibitor (ARNI) in the regimen of patients with chronic heart failure and reduced ejection fraction.

An ARNI is recommended as a replacement for an ACE inhibitor or ARB in patients who tolerate those medications and have chronic symptomatic New York Heart Association class II or III heart failure and reduced ejection fraction. According to the guideline, ARNI use may reduce the risks of hospitalization and death more than an ACE inhibitor or ARB in this patient population.

—Kate Traynor  
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Legislative year in Indiana ends with big wins for pharmacy

Five pharmacy bills, including 1 allowing partial fills of opioid prescriptions, progressed from the Indiana statehouse to the governor’s desk this year and became law on July 1.

Enactment of the 5 bills set a record for the Indiana Pharmacists Alliance, said John B. Hertig, cochair of the organization’s Legislative and Regulatory Task Force.

He credited the organization’s record year of legislative success to the staff, the task force, Pharmacy Legislative Day, and pharmacist-legislators Ron Grooms and Steven Davison.

Opioids. “One of the things we wanted to do in Indiana,” Hertig said of the 2017 legislative session, “was align our law with the Comprehensive Addiction and Recovery Act, or CARA, where now we’re afforded the opportunity to do . . . partial fills.”

Enacted in 2016 after the Indiana General Assembly had adjourned for the year, CARA allows a prescription for a Schedule II controlled substance to be partially filled if that action is not prohibited by state law. The partial fill must be requested by the patient or the prescribing healthcare practitioner.

Governor Eric J. Holcomb had identified Indiana’s “drug epidemic” as a major part of his “2017 Next Level Legislative Agenda.”

In addition to allowing partial fills of opioid prescriptions, recently enacted Senate bill 226 limits opioid prescriptions to a 7-day supply if the patient is younger than 18 years of age or is an adult for whom the prescriber is issuing a first-time opioid prescription. Exempted are prescriptions made when the patient has cancer, is receiving palliative care or medication-assisted treatment for a substance use disorder, or has a condition that the state medical board has deemed to warrant an exemption.

Suellyn Sorensen, director of clinical pharmacy services for St. Vincent Indianapolis, part of Ascension Health, said the new opioid law “will assist us in dispensing the amount that is appropriate for that patient and the specific situation of the patient. And it really helps also limit having unnecessary opioids out in the community that can . . . contribute to our opioid crisis.”
The new law also permits the state health commissioner to issue a statewide standing order, prescription, or protocol for pharmacists to administer or dispense a vaccine recommended by the federal Centers for Disease Control and Prevention Advisory Committee on Immunization Practices for people not younger than 11 years of age.

“We have pharmacists in our medication management services clinics that are readily available to provide those immunizations,” Sorensen said.

Those clinics already serve as the sites where employees of the company who provide housekeeping and food services for St. Vincent Indianapolis receive vaccine doses. That’s a patient population that Sorensen said typically has difficulty getting to their usual healthcare provider for vaccinations.

The health system also has contracts through which the clinic’s pharmacists vaccinate a company’s employees against a specific disease, such as influenza, she said.

Amy Harris, ambulatory care pharmacy manager at Deaconess Health System in Evansville, said her department is considering whether to start a vaccination program to serve patients sent by physicians in the integrated multispecialty group.

“Although I don’t know that this bill is going to have a huge impact on that, because we could have done a collaborative practice anyway,” Harris said.

The outpatient pharmacy at the flagship hospital cannot dispense to the general public, she explained. But, she added, the recently enacted bill would allow the department to start a vaccination program without spending time on the paperwork and committee approvals necessary for establishing collaborative drug therapy management protocols with the multispecialty group.

**Smoking-cessation products, other modernizations.**

Recently enacted House bill 1540, Sorensen said, will allow her department to transition its bedside tobacco-cessation counseling service for inpatients to the health system’s medication management services clinics and implement a protocol for smoking-cessation products.

Noting that smokers oftentimes must make multiple attempts to “quit for good,” she said having the statewide protocol and the products readily available for pharmacists to initiate will be key in helping more patients succeed.

“Our state health commissioner, Jerome Adams, is very much an advocate for utilizing pharmacists as the most accessible healthcare professional to help fight tobacco addiction,” Sorensen said.

Adams was keynote speaker at Pharmacy Legislative Day in February and on June 29 was nominated to be the next U.S. Surgeon General.

The Indiana Pharmacists Alliance had dubbed the bill the “Pharmacy Modernization Bill,” Hertig said. “We see it as modernizing much of the practice of pharmacy in the state of Indiana. . . . It’s essentially 7 bills in 1.”

House bill 1540 has 25 sections, including the section permitting standing orders for smoking-cessation products. Among the other sections are provisions that recognize telepharmacy and synchronized medication dispensing; change the eligibility requirements for members of the state pharmacy board; and increase penalties for pharmacy robberies involving controlled substances.

**Electronic prior authorization.**

Recently enacted Senate bill 73 requires health plans to accept and respond to electronically transmitted prior-authorization requests—a change that brought mixed reactions from Harris and Sorensen.

Deaconess Health System recently launched a specialty pharmacy and has had problems with electronic prior authorizations, Harris said. The transmissions from the health plan or pharmacy benefit company go to the office of the prescribing physician, not the specialty pharmacy.

“They think we’re dealing with it,” she said of a prior-authorization transmission personnel in the prescriber’s office, “so they don’t do anything with it. . . . In order for us to fill the script, they have to send us a new one.”

Sorensen said the new requirement will help the community pharmacies in her health system perform more efficiently, giving the patients who need those medications quicker access than has been the norm.

**Emergency medications in schools.**

Recently enacted Senate bill 392 adds albuterol and naloxone to the list of emergency medications that schools can obtain and store and allows schools to obtain injectable epinephrine, not just “auto-injectable epinephrine.” Also, the expiration date on the injectable epinephrine must not be less than 12 months from the date that the pharmacy dispenses the medication to the school or school corporation.

Hertig said the Indiana Pharmacists Alliance had wanted to rectify the problem of people paying a “really high price” for epinephrine autoinjectors and receiving product with a 3-month expiration date.

“We found by digging through that issue that we couldn’t really control as a state, at least, that particular issue as effectively as we wanted,” he said. “But we do have control over our public school systems in the state.”

—Cheryl A. Thompson

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**Correction**


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