

1.1 ..... moves to amend H.F. No. 2466 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. Minnesota Statutes 2023 Supplement, section 62Q.46, subdivision 1, is amended  
1.4 to read:

1.5 Subdivision 1. **Coverage for preventive items and services.** (a) "Preventive items and  
1.6 services" has the meaning specified in the Affordable Care Act. Preventive items and services  
1.7 includes:

1.8 (1) evidence-based items or services that have in effect a rating of A or B in the current  
1.9 recommendations of the United States Preventive Services Task Force with respect to the  
1.10 individual involved;

1.11 (2) immunizations for routine use in children, adolescents, and adults that have in effect  
1.12 a recommendation from the Advisory Committee on Immunization Practices of the Centers  
1.13 for Disease Control and Prevention with respect to the individual involved. For purposes  
1.14 of this clause, a recommendation from the Advisory Committee on Immunization Practices  
1.15 of the Centers for Disease Control and Prevention is considered in effect after the  
1.16 recommendation has been adopted by the Director of the Centers for Disease Control and  
1.17 Prevention, and a recommendation is considered to be for routine use if the recommendation  
1.18 is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;

1.19 (3) with respect to infants, children, and adolescents, evidence-informed preventive care  
1.20 and screenings provided for in comprehensive guidelines supported by the Health Resources  
1.21 and Services Administration;

1.22 (4) with respect to women, additional preventive care and screenings that are not listed  
1.23 with a rating of A or B by the United States Preventive Services Task Force but that are

2.1 provided for in comprehensive guidelines supported by the Health Resources and Services  
2.2 Administration;

2.3 (5) all contraceptive methods established in guidelines published by the United States  
2.4 Food and Drug Administration;

2.5 (6) screenings for human immunodeficiency virus for:

2.6 (i) all individuals at least 15 years of age but less than 65 years of age; and

2.7 (ii) all other individuals with increased risk of human immunodeficiency virus infection  
2.8 according to guidance from the Centers for Disease Control;

2.9 (7) all preexposure prophylaxis when used for the prevention or treatment of human  
2.10 immunodeficiency virus, including but not limited to all preexposure prophylaxis, as defined  
2.11 in any guidance by the United States Preventive Services Task Force or the Centers for  
2.12 Disease Control, including the June 11, 2019, Preexposure Prophylaxis for the Prevention  
2.13 of HIV Infection United States Preventive Services Task Force Recommendation Statement;  
2.14 and

2.15 (8) all postexposure prophylaxis when used for the prevention or treatment of human  
2.16 immunodeficiency virus, including but not limited to all postexposure prophylaxis as defined  
2.17 in any guidance by the United States Preventive Services Task Force or the Centers for  
2.18 Disease Control.

2.19 (b) A health plan company must provide coverage for preventive items and services at  
2.20 a participating provider without imposing cost-sharing requirements, including a deductible,  
2.21 coinsurance, or co-payment. Nothing in this section prohibits a health plan company that  
2.22 has a network of providers from excluding coverage or imposing cost-sharing requirements  
2.23 for preventive items or services that are delivered by an out-of-network provider.

2.24 (c) A health plan company is not required to provide coverage for any items or services  
2.25 specified in any recommendation or guideline described in paragraph (a) if the  
2.26 recommendation or guideline is no longer included as a preventive item or service as defined  
2.27 in paragraph (a). Annually, a health plan company must determine whether any additional  
2.28 items or services must be covered without cost-sharing requirements or whether any items  
2.29 or services are no longer required to be covered.

2.30 (d) Nothing in this section prevents a health plan company from using reasonable medical  
2.31 management techniques to determine the frequency, method, treatment, or setting for a  
2.32 preventive item or service to the extent not specified in the recommendation or guideline.

3.1 (e) A health plan shall not require prior authorization or step therapy for pre-exposure  
3.2 prophylaxis, except as follows: if the United States Food and Drug Administration has  
3.3 approved one or more therapeutic equivalents of a drug, device, or product for the prevention  
3.4 of HIV, this paragraph does not require a health plan to cover all of the therapeutically  
3.5 equivalent versions without prior authorization or step therapy, if at least one therapeutically  
3.6 equivalent version is covered without prior authorization or step therapy.

3.7 ~~(e)~~ (f) This section does not apply to grandfathered plans.

3.8 ~~(f)~~ (g) This section does not apply to plans offered by the Minnesota Comprehensive  
3.9 Health Association.

3.10 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to health  
3.11 plans offered, issued, or renewed on or after that date.

3.12 Sec. 2. Minnesota Statutes 2022, section 151.01, subdivision 23, is amended to read:

3.13 Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed  
3.14 doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of  
3.15 dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed  
3.16 advanced practice registered nurse, or licensed physician assistant. For purposes of sections  
3.17 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision  
3.18 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to  
3.19 dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision  
3.20 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe  
3.21 self-administered hormonal contraceptives, nicotine replacement medications, or opiate  
3.22 antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs  
3.23 to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37,  
3.24 subdivision 17.

3.25 **EFFECTIVE DATE.** This section is effective January 1, 2026.

3.26 Sec. 3. Minnesota Statutes 2022, section 151.01, subdivision 27, is amended to read:

3.27 Subd. 27. **Practice of pharmacy.** "Practice of pharmacy" means:

3.28 (1) interpretation and evaluation of prescription drug orders;

3.29 (2) compounding, labeling, and dispensing drugs and devices (except labeling by a  
3.30 manufacturer or packager of nonprescription drugs or commercially packaged legend drugs  
3.31 and devices);

4.1 (3) participation in clinical interpretations and monitoring of drug therapy for assurance  
4.2 of safe and effective use of drugs, including the performance of laboratory tests that are  
4.3 waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code,  
4.4 title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory  
4.5 tests but may modify drug therapy only pursuant to a protocol or collaborative practice  
4.6 agreement;

4.7 (4) participation in drug and therapeutic device selection; drug administration for first  
4.8 dosage and medical emergencies; intramuscular and subcutaneous drug administration under  
4.9 a prescription drug order; drug regimen reviews; and drug or drug-related research;

4.10 (5) drug administration, through intramuscular and subcutaneous administration used  
4.11 to treat mental illnesses as permitted under the following conditions:

4.12 (i) upon the order of a prescriber and the prescriber is notified after administration is  
4.13 complete; or

4.14 (ii) pursuant to a protocol or collaborative practice agreement as defined by section  
4.15 151.01, subdivisions 27b and 27c, and participation in the initiation, management,  
4.16 modification, administration, and discontinuation of drug therapy is according to the protocol  
4.17 or collaborative practice agreement between the pharmacist and a dentist, optometrist,  
4.18 physician, physician assistant, podiatrist, or veterinarian, or an advanced practice registered  
4.19 nurse authorized to prescribe, dispense, and administer under section 148.235. Any changes  
4.20 in drug therapy or medication administration made pursuant to a protocol or collaborative  
4.21 practice agreement must be documented by the pharmacist in the patient's medical record  
4.22 or reported by the pharmacist to a practitioner responsible for the patient's care;

4.23 (6) participation in administration of influenza vaccines and vaccines approved by the  
4.24 United States Food and Drug Administration related to COVID-19 or SARS-CoV-2 to all  
4.25 eligible individuals six years of age and older and all other vaccines to patients 13 years of  
4.26 age and older by written protocol with a physician licensed under chapter 147, a physician  
4.27 assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered  
4.28 nurse authorized to prescribe drugs under section 148.235, provided that:

4.29 (i) the protocol includes, at a minimum:

4.30 (A) the name, dose, and route of each vaccine that may be given;

4.31 (B) the patient population for whom the vaccine may be given;

4.32 (C) contraindications and precautions to the vaccine;

4.33 (D) the procedure for handling an adverse reaction;

5.1 (E) the name, signature, and address of the physician, physician assistant, or advanced  
5.2 practice registered nurse;

5.3 (F) a telephone number at which the physician, physician assistant, or advanced practice  
5.4 registered nurse can be contacted; and

5.5 (G) the date and time period for which the protocol is valid;

5.6 (ii) the pharmacist has successfully completed a program approved by the Accreditation  
5.7 Council for Pharmacy Education specifically for the administration of immunizations or a  
5.8 program approved by the board;

5.9 (iii) the pharmacist utilizes the Minnesota Immunization Information Connection to  
5.10 assess the immunization status of individuals prior to the administration of vaccines, except  
5.11 when administering influenza vaccines to individuals age nine and older;

5.12 (iv) the pharmacist reports the administration of the immunization to the Minnesota  
5.13 Immunization Information Connection; and

5.14 (v) the pharmacist complies with guidelines for vaccines and immunizations established  
5.15 by the federal Advisory Committee on Immunization Practices, except that a pharmacist  
5.16 does not need to comply with those portions of the guidelines that establish immunization  
5.17 schedules when administering a vaccine pursuant to a valid, patient-specific order issued  
5.18 by a physician licensed under chapter 147, a physician assistant authorized to prescribe  
5.19 drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe  
5.20 drugs under section 148.235, provided that the order is consistent with the United States  
5.21 Food and Drug Administration approved labeling of the vaccine;

5.22 (7) participation in the initiation, management, modification, and discontinuation of  
5.23 drug therapy according to a written protocol or collaborative practice agreement between:

5.24 (i) one or more pharmacists and one or more dentists, optometrists, physicians, physician  
5.25 assistants, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more  
5.26 physician assistants authorized to prescribe, dispense, and administer under chapter 147A,  
5.27 or advanced practice registered nurses authorized to prescribe, dispense, and administer  
5.28 under section 148.235. Any changes in drug therapy made pursuant to a protocol or  
5.29 collaborative practice agreement must be documented by the pharmacist in the patient's  
5.30 medical record or reported by the pharmacist to a practitioner responsible for the patient's  
5.31 care;

5.32 (8) participation in the storage of drugs and the maintenance of records;

6.1 (9) patient counseling on therapeutic values, content, hazards, and uses of drugs and  
6.2 devices;

6.3 (10) offering or performing those acts, services, operations, or transactions necessary  
6.4 in the conduct, operation, management, and control of a pharmacy;

6.5 (11) participation in the initiation, management, modification, and discontinuation of  
6.6 therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:

6.7 (i) a written protocol as allowed under clause (7); or

6.8 (ii) a written protocol with a community health board medical consultant or a practitioner  
6.9 designated by the commissioner of health, as allowed under section 151.37, subdivision 13;

6.10 (12) prescribing self-administered hormonal contraceptives; nicotine replacement  
6.11 medications; and opiate antagonists for the treatment of an acute opiate overdose pursuant  
6.12 to section 151.37, subdivision 14, 15, or 16; ~~and~~

6.13 (13) participation in the placement of drug monitoring devices according to a prescription,  
6.14 protocol, or collaborative practice agreement;

6.15 (14) prescribing, dispensing, and administering drugs for preventing the acquisition of  
6.16 human immunodeficiency virus (HIV) if the pharmacist meets the requirements in section  
6.17 151.37, subdivision 17; and

6.18 (15) ordering, conducting, and interpreting laboratory tests necessary for therapies that  
6.19 use drugs for preventing the acquisition of human immunodeficiency virus (HIV), if the  
6.20 pharmacist meets the requirements in section 151.37, subdivision 17.

6.21 **EFFECTIVE DATE.** This section is effective January 1, 2026.

6.22 Sec. 4. Minnesota Statutes 2022, section 151.37, is amended by adding a subdivision to  
6.23 read:

6.24 **Subd. 17. Drugs for preventing the acquisition of HIV.** (a) A pharmacist is authorized  
6.25 to prescribe and administer drugs to prevent the acquisition of human immunodeficiency  
6.26 virus (HIV) in accordance with this subdivision.

6.27 (b) By January 1, 2025, the Board of Pharmacy shall develop a standardized protocol  
6.28 for a pharmacist to follow in prescribing the drugs described in paragraph (a). In developing  
6.29 the protocol, the board may consult with community health advocacy groups, the Board of  
6.30 Medical Practice, the Board of Nursing, the commissioner of health, professional pharmacy  
6.31 associations, and professional associations for physicians, physician assistants, and advanced  
6.32 practice registered nurses.

7.1 (c) Before a pharmacist is authorized to prescribe a drug described in paragraph (a), the  
7.2 pharmacist must successfully complete a training program specifically developed for  
7.3 prescribing drugs for preventing the acquisition of HIV that is offered by a college of  
7.4 pharmacy, a continuing education provider that is accredited by the Accreditation Council  
7.5 for Pharmacy Education, or a program approved by the board. To maintain authorization  
7.6 to prescribe, the pharmacist shall complete continuing education requirements as specified  
7.7 by the board.

7.8 (d) Before prescribing a drug described in paragraph (a), the pharmacist shall follow the  
7.9 appropriate standardized protocol developed under paragraph (b) and, if appropriate, may  
7.10 dispense to a patient a drug described in paragraph (a).

7.11 (e) Before dispensing a drug described in paragraph (a) that is prescribed by the  
7.12 pharmacist, the pharmacist must provide counseling to the patient on the use of the drugs  
7.13 and must provide the patient with a fact sheet that includes the indications and  
7.14 contraindications for the use of these drugs, the appropriate method for using these drugs,  
7.15 the need for medical follow up, and any additional information listed in Minnesota Rules,  
7.16 part 6800.0910, subpart 2, that is required to be provided to a patient during the counseling  
7.17 process.

7.18 (f) A pharmacist is prohibited from delegating the prescribing authority provided under  
7.19 this subdivision to any other person. A pharmacist intern registered under section 151.101  
7.20 may prepare the prescription, but before the prescription is processed or dispensed, a  
7.21 pharmacist authorized to prescribe under this subdivision must review, approve, and sign  
7.22 the prescription.

7.23 (g) Nothing in this subdivision prohibits a pharmacist from participating in the initiation,  
7.24 management, modification, and discontinuation of drug therapy according to a protocol as  
7.25 authorized in this section and in section 151.01, subdivision 27.

7.26 **EFFECTIVE DATE.** This section is effective January 1, 2026, except that paragraph  
7.27 (b) is effective the day following final enactment.

7.28 Sec. 5. Minnesota Statutes 2023 Supplement, section 256B.0625, subdivision 13f, is  
7.29 amended to read:

7.30 Subd. 13f. **Prior authorization.** (a) The Formulary Committee shall review and  
7.31 recommend drugs which require prior authorization. The Formulary Committee shall  
7.32 establish general criteria to be used for the prior authorization of brand-name drugs for

8.1 which generically equivalent drugs are available, but the committee is not required to review  
8.2 each brand-name drug for which a generically equivalent drug is available.

8.3 (b) Prior authorization may be required by the commissioner before certain formulary  
8.4 drugs are eligible for payment. The Formulary Committee may recommend drugs for prior  
8.5 authorization directly to the commissioner. The commissioner may also request that the  
8.6 Formulary Committee review a drug for prior authorization. Before the commissioner may  
8.7 require prior authorization for a drug:

8.8 (1) the commissioner must provide information to the Formulary Committee on the  
8.9 impact that placing the drug on prior authorization may have on the quality of patient care  
8.10 and on program costs, information regarding whether the drug is subject to clinical abuse  
8.11 or misuse, and relevant data from the state Medicaid program if such data is available;

8.12 (2) the Formulary Committee must review the drug, taking into account medical and  
8.13 clinical data and the information provided by the commissioner; and

8.14 (3) the Formulary Committee must hold a public forum and receive public comment for  
8.15 an additional 15 days.

8.16 The commissioner must provide a 15-day notice period before implementing the prior  
8.17 authorization.

8.18 (c) Except as provided in subdivision 13j, prior authorization shall not be required or  
8.19 utilized for any atypical antipsychotic drug prescribed for the treatment of mental illness  
8.20 if:

8.21 (1) there is no generically equivalent drug available; and

8.22 (2) the drug was initially prescribed for the recipient prior to July 1, 2003; or

8.23 (3) the drug is part of the recipient's current course of treatment.

8.24 This paragraph applies to any multistate preferred drug list or supplemental drug rebate  
8.25 program established or administered by the commissioner. Prior authorization shall  
8.26 automatically be granted for 60 days for brand name drugs prescribed for treatment of mental  
8.27 illness within 60 days of when a generically equivalent drug becomes available, provided  
8.28 that the brand name drug was part of the recipient's course of treatment at the time the  
8.29 generically equivalent drug became available.

8.30 (d) Prior authorization must not be required for liquid methadone if only one version of  
8.31 liquid methadone is available. If more than one version of liquid methadone is available,

9.1 the commissioner shall ensure that at least one version of liquid methadone is available  
9.2 without prior authorization.

9.3 (e) Prior authorization may be required for an oral liquid form of a drug, except as  
9.4 described in paragraph (d). A prior authorization request under this paragraph must be  
9.5 automatically approved within 24 hours if the drug is being prescribed for a Food and Drug  
9.6 Administration-approved condition for a patient who utilizes an enteral tube for feedings  
9.7 or medication administration, even if the patient has current or prior claims for pills for that  
9.8 condition. If more than one version of the oral liquid form of a drug is available, the  
9.9 commissioner may select the version that is able to be approved for a Food and Drug  
9.10 Administration-approved condition for a patient who utilizes an enteral tube for feedings  
9.11 or medication administration. This paragraph applies to any multistate preferred drug list  
9.12 or supplemental drug rebate program established or administered by the commissioner. The  
9.13 commissioner shall design and implement a streamlined prior authorization form for patients  
9.14 who utilize an enteral tube for feedings or medication administration and are prescribed an  
9.15 oral liquid form of a drug. The commissioner may require prior authorization for brand  
9.16 name drugs whenever a generically equivalent product is available, even if the prescriber  
9.17 specifically indicates "dispense as written-brand necessary" on the prescription as required  
9.18 by section 151.21, subdivision 2.

9.19 (f) Notwithstanding this subdivision, the commissioner may automatically require prior  
9.20 authorization, for a period not to exceed 180 days, for any drug that is approved by the  
9.21 United States Food and Drug Administration on or after July 1, 2005. The 180-day period  
9.22 begins no later than the first day that a drug is available for shipment to pharmacies within  
9.23 the state. The Formulary Committee shall recommend to the commissioner general criteria  
9.24 to be used for the prior authorization of the drugs, but the committee is not required to  
9.25 review each individual drug. In order to continue prior authorizations for a drug after the  
9.26 180-day period has expired, the commissioner must follow the provisions of this subdivision.

9.27 (g) Prior authorization under this subdivision shall comply with section 62Q.184.

9.28 (h) Any step therapy protocol requirements established by the commissioner must comply  
9.29 with section 62Q.1841.

9.30 (i) Notwithstanding any law to the contrary, prior authorization or step therapy shall not  
9.31 be required or utilized for any class of drugs that is approved by the United States Food and  
9.32 Drug Administration for the treatment or prevention of HIV/AIDS.

9.33 **EFFECTIVE DATE.** This section is effective January 1, 2026."

9.34 Amend the title accordingly