APRIL 2026 | ISSUE 21

FLORIDA RX TIMES

In This Issue

Quarterly Newsletter from the Florida Society of Health-System Pharmacists (FSHP)

Message from the President

Madeline Camejo
PharmD, BCACP

Progress continues as we move further into the year, with a steady sense of momentum across both practice and policy. Recent legislative activity in Florida reflects meaningful steps forward in areas that directly impact patient care. The passage and signing of HB 697 addresses pharmacy benefit manager practices that have created challenges for both pharmacies and the patients they serve.

As patients transition between hospital and community settings, it is essential that they maintain access to a pharmacist and the care they need and deserve. In addition, the Governor's approval of funding for the Ryan White Part B AIDS Drug Assistance Program helps ensure continued access to essential medications for vulnerable populations across our state.

These developments matter because they support access, affordability, and continuity of care are closely connected; something pharmacists see every day. At the same time, the environment around us is changing quickly. Advances in therapy, including more targeted and in some cases curative treatments, continue to reshape how care is delivered. Alongside this, the way patients seek information is evolving. Many are now turning to digital tools, including artificial intelligence, to ask complex health-related questions and better understand their care.

Pharmacists are well positioned to help interpret information, provide clarity, and guide patients through decisions that are becoming increasingly complex. The need for clinical judgment, context, and evidence-based decision making has not changed, but the pace and volume of information surrounding patients has.

Message from the President

As we look ahead, this is also a time to begin preparing for the summer transition, when new graduates and residents enter practice. Research continues to show that diverse and multigenerational teams strengthen outcomes, bringing together experience, adaptability, and new ways of thinking. Many of our newer professionals bring strengths in navigating technology, diffusing information quickly, and approaching challenges with a different perspective. There is a great deal of value in all of that. The future of pharmacy will depend on our ability to integrate experience with evolving tools and new ideas, while continuing to stay grounded in patient care.

As we approach the 2026 Annual Meeting, I encourage you to stay engaged and connected. We cannot lose the momentum now. These moments allow us to learn from one another, share perspectives, and continue strengthening the role of pharmacists across all areas of care.

Our opportunity now is to continue building on that in a way that keeps patients at the center and the profession at the table.

CLINICAL PEARL

Implementation and Outcomes of a Pharmacist Led Community Outreach Medication Management Program

Jessica Bianco, PharmD, BCACP, CACP, CPh
Pharmacotherapy Specialist Coordinator
Tampa General Medical Group
Tampa General Hospital
Tampa, FL

Savannah Brannan, PharmD
Clinical Pharmacist
Tampa General Hospital
Tampa, FL

Isabel Matt, PharmD
PGY2 Ambulatory Care Pharmacy Resident
Tampa General Hospital
Tampa, FL

Introduction

Medication therapy management (MTM) is a comprehensive, individualized, pharmacist-led medication review and evaluation intended to improve therapeutic outcomes for patients with multiple chronic conditions, complex medication regimens, or polypharmacy. Evidence demonstrates that MTM improves medication use, enhances medication adherence, and potentially reduces direct and indirect healthcare expenditures[1]. Additionally, MTM has been associated with improvements in cardiovascular-related health outcomes, such as better blood pressure control and improved lipid panels, as well as enhancements in the quality of patient care and patient-reported quality of life.[1,2] Despite the ubiquitous availability of such services, a substantial proportion of adults in the United States lack adequate access to quality healthcare due to the influence of social determinants of health (SDOH). Barriers such as these may prevent patients from accessing pharmacist-led medication management services and realizing the potential benefits. Community-based outreach programs led by qualified pharmacists represent a potential strategy to address health disparities by increasing access to medication management services in underserved communities.

CLINICAL PEARL

The existing literature evaluating pharmacist-led community outreach services remains extremely sparse. A potential barrier noted is the lack of sustainable financial reimbursement, which may reduce institutional, stakeholder, and community support for implementation of these services. Although medication management services have demonstrated effectiveness in reimbursable clinical care models, community-based outreach programs that operate outside of traditional billing models lack robust outcomes data. While several colleges of pharmacy have implemented community outreach programs involving student pharmacists, measurable clinical outcomes from these initiatives remain infrequently reported in the literature.[3,4,5]

Tampa General Hospital (TGH) is a large, 982-bed academic health system in Tampa, FL, serving more than 4 million patients annually. In the hospital's 2024 Community Health Needs Assessment survey, healthcare access and quality of care were identified as the leading community health priorities. In Hillsborough County, approximately 13.1% of residents lack health insurance.[6] The county is also designated as a Health Professional Shortage Area (HPSA) for primary care, mental health, and dental services, reflecting an insufficient number of providers to effectively meet the healthcare needs of low-income residents.[7]

TGH primary care and specialty clinics extend the institution's footprint across 12 counties with more than 25 clinic locations in the state of Florida. The ambulatory pharmacy services team includes seven clinical pharmacy specialists, one pharmacy technician, and one postgraduate year two (PGY2) ambulatory care pharmacy resident. In December 2024, the ambulatory pharmacy team, in collaboration with TGH Community Health and Wellness, created the Tampa General Hospital Check Your Medication (CYM) program to address the identified gaps in equitable access to medication management services. The CYM program is a pharmacist-led community outreach initiative designed to provide accessible medication management services across various community settings, regardless of insurance status or ability to pay, demonstrating Tampa General Hospital's ongoing commitment to the community's health and wellness. The aim of the CYM pilot program was to evaluate the implementation and outcomes of a pharmacist-led community outreach medication management service in underserved communities.

CLINICAL PEARL

Program Description/Methods

The CYM program was initially piloted in conjunction with already established TGH-led community health screening events and offered exclusively on a walk-in basis. Following the pilot's initial success, the program partnered with the TGH Community Health and Wellness team to expand outreach and market an appointment-based service at stand-alone events throughout the Tampa Bay region. Event locations were selected to maximize program accessibility and enhance engagement with underserved and vulnerable populations through collaboration with community partners.

Attendees were scheduled in 30-minute appointment increments and were instructed to bring all their medication bottles or an updated medication list, including supplements, herbal products, and over-the-counter medications. Walk-in evaluations were accommodated between scheduled sessions, time permitting. Each patient encounter was conducted by a pharmacist or pharmacy learner and began with a comprehensive review of the patient's past medical history and current medication regimen. Pharmacists provided medication education, addressed patient questions and concerns, and evaluated medication appropriateness, adverse effects, dosing errors, and potential drug-drug interactions. At the conclusion of the visit, program attendees received a written summary of the pharmacist's recommendations to share with their primary care provider or specialist. Participants were also provided with relevant educational materials addressing chronic medical conditions (e.g., hypertension, diabetes, hyperlipidemia). Before leaving, attendees completed a brief, anonymous three-question survey about their experience and could provide additional written feedback used to improve future events. Additionally, clinical interventions were tracked during each visit and defined as pharmacist-identified medication-related problems (MRPs) requiring recommendations, education, or referral. Event staffing varied based on anticipated volume but generally consisted of one pharmacy resident (PGY1 or PGY2), one student pharmacist, and one to two board-certified ambulatory care pharmacists.

CLINICAL PEARL

Results

Across six CYM pilot events conducted between April 2025 and February 2026, 49 patients were evaluated, resulting in 58 pharmacist-led clinical interventions. Patient satisfaction was exceptionally high, with all survey respondents rating their experience with five stars (100%). Additionally, all written-in responses were equally positive.

Medication-related problems (MRPs) identified during encounters reflected a broad range of clinical issues (Table 1). The most frequently identified MRPs included potential adverse drug effects (n=14), untreated medical conditions (n=11), and medications used without a valid clinical indication (n=10). Additional MRPs included inappropriate medication selection based on age or comorbidities (n=7), drug interactions (n=4), improper medication administration (n=3), and patient education needs (n=4).

Table 1

Intervention	N
Inappropriate medication administration	3
Drug interaction	4
Education	4
Inappropriate dose	5
Inappropriate medication for condition or age	7
Medication without indication	10
Untreated medical condition	11
Potential adverse effect	14

Pharmacists enacted several high-impact clinical interventions since program initiation. Examples included identifying severe side effects in a patient receiving diazepam, prompting urgent prescriber follow-up and counseling on benzodiazepine withdrawal risks; recognition of multiple inappropriate aspirin regimens for primary prevention; identification of potentially inappropriate medications according to Beers criteria[8] (e.g., proton pump inhibitors, benzodiazepines, and anticholinergics); correction of improper inhaler technique; evaluation of inappropriate phentermine use in individuals with cardiovascular disease and anxiety disorders; and mitigation of high-risk over-the-counter or supplement use.

CLINICAL PEARL

Attendance patterns provided important operational insights and areas for program adjustment and improvement. Scheduled visits ranged from approximately 8 to nearly 30 appointments per event (Figure 1). Attendance peaked in November 2025, during a large event held in an affluent retirement community, which generated the strongest engagement. Events hosted in retirement communities demonstrated higher participation rates, whereas events paired with broader community gatherings garnered lower attendance. No-show rates followed a similar trend (Figure 2).

Figure 1

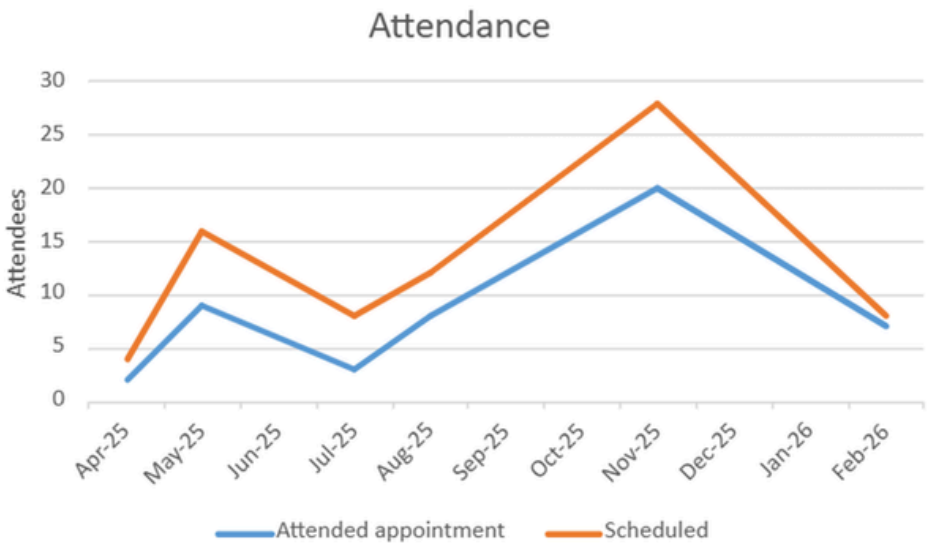
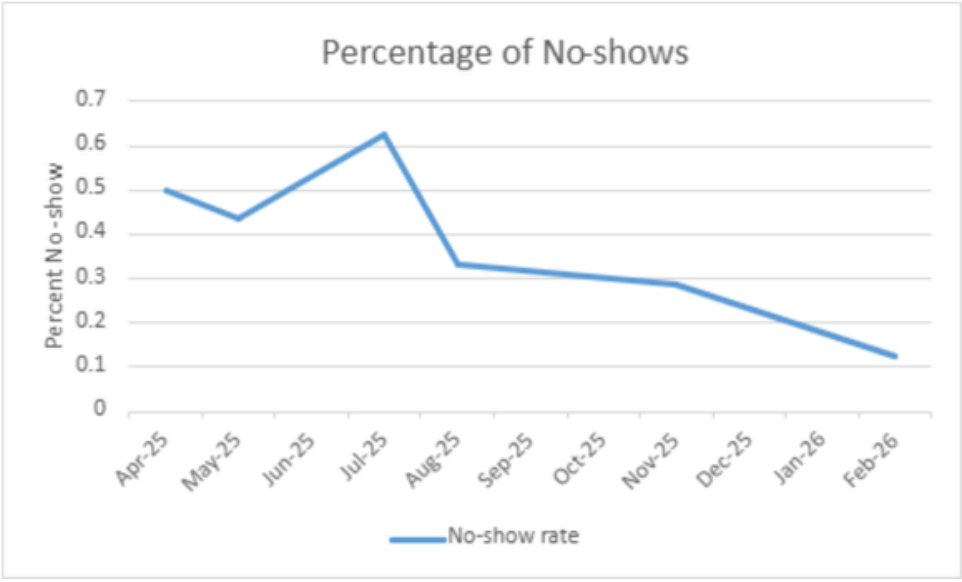


Figure 2



CLINICAL PEARL

Early events experienced higher no-show rates (approximately 50%), which declined substantially after the implementation of pre-event reminder calls. The lowest no-show rate occurred in February 2026 (13%), suggesting sustained benefit of this process improvement. These trends indicate that event setting and targeted communication strategies were associated with differences in attendance and participant engagement.

Conclusion

The Check Your Medication program demonstrated that pharmacist-led community outreach can identify clinically significant medication-related problems, deliver high-value interventions, and offer a well-received, impactful service to the community. Although the program was initially designed to target vulnerable populations with limited access to healthcare, early utilization was highest in more affluent retirement communities. This finding contrasts with the program's original aim and highlights the importance of understanding community-specific barriers to care and tailoring outreach strategies to better engage vulnerable populations.

While attendance generally improved throughout the program, barriers to patient participation will be an initiative that the service leaders continue to hone. It is well documented in existing literature that barriers to participation in community-based health promotion are multilevel and deeply tied to life complexities, such as lack of time, work conflicts, and transportation barriers.[9, 10]

Despite these challenges, the program will continue expanding into diverse community settings to reach individuals who may benefit most from medication management services. Planned enhancements to the program include follow-up calls to reinforce pharmacist recommendations and ensure communication with the patient's providers, as well as increased promotion of other pharmacist-led community resources, such as the diabetes self-management education (DSME) program.

CLINICAL PEARL

To further address access barriers, the program will explore telehealth-based medication management services. While reliance on computer or smartphone access may present limitations, telehealth may offer an additional pathway to expand the program's reach and promote equitable access to medication management services.

Overall, the CYM program underscores the critical role of ambulatory care pharmacists in optimizing medication safety, promoting patient education, and improving care coordination within the community, regardless of insurance status or ability to pay for services. Lessons learned from the program's initial events will guide its evolution and support the long-term sustainability of a model designed to advance health equity and optimize population health outcomes.

References

1. Centers for Medicare & Medicaid Services. Evidence Supporting Enhanced Medication Therapy Management. CMS; 2010. Accessed March 2026
2. Cazarim MS, Cruz-Cazarim ELC, Boyd K, Wu O, Nunes AA. Effect of Medication Therapy Management by pharmaceutical care on blood pressure and cardiovascular risk in hypertension: A systematic review, meta-analysis, and meta-regression. Pharmaceuticals. 2023;16(6):845.
3. Palombi LC, Bastianelli K, Fierke KK. Living an Educational Mission to Meet the Needs of Community and Public Health: Community Engagement in Pharmacy Education. Pedagogy in Health Promotion. 2017;3(4):265-269. doi:10.1177/2373379916667750
4. Abraham O, Torner C. Preparing Graduate Students for Community Engagement in Health Services Research. Innov Pharm. 2021;12(2):10.24926/iip.v12i2.3469. Published 2021 May 3. doi:10.24926/iip.v12i2.3469
5. DeRemer CE, VanLandingham J, Carswell J, Killough D. Pharmacy outreach education program in local community. Am J Pharm Educ. 2008;72(4):94.
6. Centers for Disease Control and Prevention. (2023, December 2). CDC - 2022 BRFSS survey data and Documentation. Centers for Disease Control and Prevention. https://www.cdc.gov/brfss/annual_data/annual_2022.html
7. Health Workforce Shortage Areas. (n.d.). https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard
8. American Geriatrics Society. (2023). Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults. J Am Geriatr Soc. DOI: 10.1111/jgs.18372.
9. Nagelhout GE, Abidi L, de Vries H. Reasons for (not) participating in a community-based health promotion program for low-income multi-problem households in the Netherlands: A qualitative study. Health Soc Care Community. 2021;29(1):241-249. doi:10.1111/hsc.13087
10. Zack RM, Rodríguez Bronico JV, Babbin M, et al. Facilitators and Barriers to Patient Attendance at a Free Health Center Produce Market. Am J Prev Med. 2022;63(3 Suppl 2):S131-S143. doi:10.1016/j.amepre.2022.03.034

SPECIAL INSIGHTS

Expanding Access and Excellence: Ambulatory Care Pharmacist Integration & Billing Under CPT 99211

Emilie Collongette, PharmD, CPh, BCMTMS & Daniela Luzardo, PharmD

The integration of pharmacists in the outpatient setting transforms healthcare delivery. Ambulatory care pharmacists can optimize medication regimens, expand access to care, and reduce administrative burden.[1] This collaborative model supports goals related to quality, safety, and value-based metrics.

In Florida, pharmacists may practice under a collaborative pharmacy practice agreement for designated chronic health conditions when certified by the Board[2], after completing the board-approved initial 20-hour course and meeting other requirements. In addition, a Consultant Pharmacist may provide medication management services within the framework of a written collaborative practice agreement in specified health care facilities.[3]

Understanding Incident to Billing and CPT 99211

The Centers for Medicare & Medicaid Services (CMS) defines incidentto services as those furnished by clinical staff under the supervision of a physician or qualified nonphysician practitioner, provided as part of a patient's established plan of care. To meet incidentto requirements, the referring provider(s) must see the patient and establish their plan of care, remain actively involved, and provide direct supervision.

Pharmacists are not recognized as Medicare Part B providers and may only bill under Current Procedural Terminology (CPT) 99211, the lowestlevel established patient Evaluation & Management (E/M) code. This limitation requires pharmacist-led visits to meet incidentto requirements. Per the E/M framework adopted by CMS, CPT 99211 is used for facetoface services by clinical staff, and medical decisionmaking is not applied at this level. Documentation must support medical necessity, include the reason for visit, assessment elements, and note the supervising provider.

SPECIAL INSIGHTS

Key Requirements to Bill CPT 99211

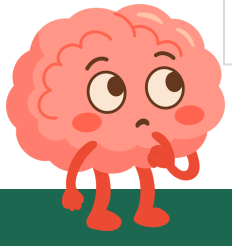
For pharmacistled incidentto visits, the following criteria must be met:

- Patient is established with the supervising provider, who initiated the plan of care
- Direct supervision: supervising provider must be physically present in the office suite
- Service is medically necessary, documented, and integral to the established plan of care
- The ambulatory care pharmacist is a direct expense to the clinic, meaning W2, leased, or contracted appropriately

Expanded Billing Opportunities Beyond CPT 99211 and Reimbursement

While reimbursement for CPT 99211 is modest ($15–$30), it enables ambulatory care pharmacists to account for workload, demonstrate value, and justify staffing through direct revenue capture and performance outcomes. Although CPT 99211 remains the foundation of pharmacist incident-to-billing, additional reimbursable services may be billed when they meet state scope of practice, additional accreditation standards, and supervision requirements. For example, the G0108 code may only be used for reimbursement when the service is provided under an accredited program recognized by an accrediting organization such as American Diabetes Association (ADA) or Association of Diabetes Care & Education Specialists (ADCES). Ambulatory care pharmacists currently leverage additional billing codes to increase reimbursement potential. These codes are commonly associated with advanced services such as diabetes education and continuous glucose monitoring (CGM):

Code	Average Reimbursement
Diabetes Self-Management Training G0108	$60 – $100
CGM Initiation & Training CPT 95249	$50 – $80
CGM Data Interpretation CPT 95251	$50 – $100



SPECIAL INSIGHTS

Pharmacists in ValueBased Care and Performance Metrics

Pharmacistled care improves performance in highimpact clinical metrics tied to payer contracts and sharedsavings programs. American Society of Health-System Pharmacists identifies key indicators influenced by ambulatory care pharmacist involvement such as:[4]

- A1C control in diabetes
- Hypertension management
- Medication adherence
- Reduction in hospital readmissions
- Completion of diseasestate monitoring and preventive health services

Value-Based Care Models increasingly rely on pharmacist interventions to improve Healthcare Effectiveness Data and Information Set, Medicare Star Ratings, and population health metrics, all areas where ambulatory care pharmacist involvement is strongly linked to financial incentives.[5]

Future Directions

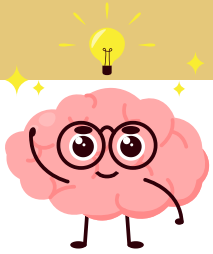
As pharmacists in Florida advocate for provider status and adopt payment pathways in Medicare, Medicaid, and commercial plans, opportunities will arise for billing, collaborative practice expansion, and telehealth services. The American Society of Health-System Pharmacists' Practice Advancement Initiative 2030 emphasizes the importance of credentialing, privileging, and payer contracting to ensure sustainable, compliant pharmacist billing models.[6]

SPECIAL INSIGHTS

Exploring these billing pathways ensures sustainability while maximizing the impact of ambulatory care pharmacist interventions on clinical outcomes and population health.

- Medication Therapy Management: Codes 99605–99607 for comprehensive medication reviews
- Chronic Care Management: Codes 99490, 99491, 99439 for non-face-to-face care coordination
- Transitional Care Management: Codes 99495, 99496 for post-discharge follow-up
- Annual Wellness Visits: Codes G0438, G0439 for preventive health assessments

Ambulatory care pharmacist integration enhances access, quality, and patient outcomes. Pharmacistled services create measurable clinical and financial benefits by enabling compliant incidentto billing, expanding billable service options, and strengthening valuebased care performance. The continued evolution of provider status expands opportunities for pharmacistled services and reinforces the essential role of pharmacists within interdisciplinary care teams.



References:

1. Dietrich, E., & Gums, J. G. (2018). Incident-to Billing for Pharmacists. Journal of managed care & specialty pharmacy, 24(12), 1273–1276.
2. REGULATION OF PROFESSIONS AND OCCUPATIONS, 465 PHARMACY U.S.C. § 1865 (2025).https://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0465/Sections/0465.1865.html
3. REGULATION OF PROFESSIONS AND OCCUPATIONS, 465 PHARMACY U.S.C. § 0125 (2025).https://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0465/Sections/0465.0125.html
4. American Society of Health-System Pharmacists. (2024). Advancing healthcare: Key steps to implementing pharmacist provider status. ASHP.
5. Clements, J. N., Emmons, R. P., Anderson, S. L., Chow, M., Coon, S., Irwin, A. N., Mukherjee, S. M., Sease, J. M., Thrasher, K., & Witek, S. R. (2021). Current and future state of quality metrics and performance indicators in comprehensive medication management for ambulatory care pharmacy practice. Journal of the American College of Clinical Pharmacy, 4(4), 390–405.
6. American Society of Health-System Pharmacists. (2020). Practice Advancement Initiative 2030: Recommendations for advancing pharmacy practice through the next decade. ASHP.

COMMENTARY

The Role of the Designated Person in charge of sterile compounding integrity and regulations

Jack Iskander, MBA, MHA, BCSCP
Jeff Cunningham, BS Pharm, PharmD, CPh, BCSCP
Vicki McConnell, BS Pharm, PharmD, CPh, BCSCP
Andrea Ledford, MBA, PharmD, CPh, BCSCP, BCOP, FASHP, FHOPA

The sterile and hazardous compounding areas of an inpatient pharmacy are one of the most regulated settings of any profession. The operations of these areas are guided by United States Pharmacopeia (USP) standards; the most popular of which are chapters <797> and <800>.These standards provide hundreds of best practices that should be followed to maintain the highest degree of safety for both our patients and employees. Due to the sheer number of regulations, the precision needed in the operations, and the negative consequences that could occur if these standards are not followed, it is a requirement in the state of Florida that healthcare facilities name a designated person to be responsible for these areas.The designated person of a pharmacy is the operational owner of sterile and/or hazardous drug compounding. The designated person is the accountable leader for making sure our compounding practices, environment, staff competency, and quality controls meet USP standards.

In this article we will outline:
1) Who is qualified to be a sterile compounding Designated Person
2) What this position is responsible for

I. What makes a person qualified to be in this position?

Individuals interested in the position of being a designated person over sterile compounding should not only have documented expertise in USP <797> and <800> but also have demonstrated mastery of compounding regulations and standards.They need to have role specific knowledge of aseptic processing, engineering and environmental controls, and personnel competency evaluation. A person in this position should be able to correctly interpret and apply USP standards, state board pharmacy requirements and related survey and accreditation expectations.

COMMENTARY

The designated person needs to have a proven ability to build and maintain a compliant quality system.Written and oral communication skills must be solid, as this position will need to oversee standard of procedure governance and corrective action planning when compounding practices deviate from regulatory expectations. They will also be responsible for maintaining the compounding records, which can be stored and retrieved in the electronic health record platform. It is imperative that the designated person has strong risk assessment capabilities and investigative judgment. They must be able to distinguish minor variations from detrimental ones, understand an isolated event from a systemic failure, and be capable of performing a root cause analysis to correctly identify the underlying reason for any problems occurring. The strength of a designated person will come not just from solving issues in the compounding area, but more importantly to help a health-system mitigate compounding related risks before they become potential problems.

A designated person must have strong verbal communication skills as well, because their credibility and influence will have to span across several professions and groups within a health-system. The designated person must be able to communicate not only with pharmacists and pharmacy technicians, but also with nursing, infection prevention, facilities, and environmental services. Many health-systems rely on environmental services for cleaning, and the designated person will be responsible for their training, documentation of training and ensuring the cleaning is done properly. The designated person will also be responsible for developing nursing education for proper immediate compounding practices. A technically strong person who cannot motivate good behavior, gain buy-in, or drive accountability, will struggle to make an impact in this role.

In terms of credentialing, it would be beneficial for a pharmacist who is named as the designated person to also be a Board Certified Sterile Compounding Pharmacist (BCSCP) through BPS. A pharmacy technician who wishes to pursue this position should obtain the Sterile Compounding certificate through ASHP or a similar organization.

COMMENTARY

II.What is this position responsible for?

Maintaining a state of control in your sterile compounding suite requires effective management of both facilities and personnel. While environmental controls are essential, people management is often one of the most challenging aspects of these responsibilities. USP <797> includes multiple sections related to personnel training, competency assessment, and revalidation. Determining who has access to clean rooms, and what level of training and competency they require, is typically defined by facility policy based on the minimum standards outlined in USP <797>.

Overall knowledge and competency requirements for compounding personnel are outlined in Section 2.1 of USP <797>. Demonstration of competency in garbing and hand hygiene, as well as aseptic manipulations, are addressed in Sections 2.2 and 2.3. Documentation of both didactic competencies and observed competencies is required. For Category 1 and Category 2 compounding, personnel must demonstrate competency at least every six months. For Category 3 compounding, competency demonstrations are required every three months. Didactic competencies are required at least annually. The designated person must maintain documentation of these competencies for possible inspection by regulators.

Those individuals who may not directly compound sterile preparations but still require access to the compounding suite may include: personnel who restock supplies or perform cleaning activities, those who conduct in-process checks or final verification of compounded sterile preparations (CSPs) without direct oversight of compounding staff, individuals who prepare immediate use CSPs, contractors, maintenance personnel, inspectors, surveyors, and other visitors.

The oversight of environmental monitoring is a major responsibility of the designated person.This includes ensuring that the facility has a compliant microbiological air and surface sampling program, with defined sampling locations, frequency, action levels, and response procedures.The designated person is responsible for reviewing all certification and recertification records. These records will show a range of findings including airflow concerns, pressure differentials, smoke studies, and any recommendations that affect compounding conditions. The designated person is expected to ensure that corrective action plans are implemented and confirm their effectiveness.

COMMENTARY

The designated person will also have oversight of master formulation records. This is to ensure that the compounding documentation system is accurate and complete. This entails more than just the recipes for the compounds. It includes assigned beyond use dates (BUDs), storage requirements, calculations, and the presence of references to support standardized preparations.

Having a designated person in a facility is a must-have, not just because it is stated by the Florida board of pharmacy. When it comes to compliance, there must be ownership. The designated person is the leader that any upper-level pharmacy leader will depend on to ensure successful regulatory surveys and the highest level of patient safety of their health-systems.

MEMBER SPOTLIGHT

Elizabeth M. Lewallen, CPhT, RPhT

For more than twenty two years, Elizabeth M. Lewallen has built a career defined by innovation, leadership, and unwavering dedication to advancing pharmacy practice in Florida. From her early beginnings as a technician at Eckerd's to her current role as Division Pharmacy Inventory & Automation Specialist for HealthTrust, Elizabeth has continually demonstrated her talent for elevating operations, empowering teams, and championing safety and quality across the continuum of care.

Elizabeth's career reflects a remarkable evolution through increasing responsibility and expertise. After earning her national certification from PTCB in 2005, she rose to Lead Technician at CVS, where she trained and mentored staff across multiple districts and played a pivotal role in the rollout of new technologies, including the RxConnect system. In 2012, she transitioned to HCA Florida North Florida Hospital as Technician Manager, overseeing largescale pharmacy operations, supervising a team of 30 technicians, and leading major projects such as a 14week USP <797>/<800>–compliant IV cleanroom renovation and multiple Pyxis technology upgrades. Her work encompassed inventory management, sterile compounding oversight, controlled substance diversion prevention, and development of staff competencies—laying the foundation for her future leadership in automation.

MEMBER SPOTLIGHT

In August 2021, Elizabeth began her current divisionlevel role, providing oversight of pharmacy automation for 15 facilities across the HCA North Florida Division. She manages complex initiatives involving Pyxis ES, SMART, RxMS, bed mapping, par optimization, and fleet modernization. Elizabeth develops education, policies, and datadriven insights that improve medication safety, efficiency, and accuracy. Her leadership in analytics, project coordination, inventory oversight, and system optimization has made her a trusted resource for pharmacy teams throughout the region.

Alongside her operational achievements, Elizabeth has made outstanding contributions to the Florida Society of HealthSystem Pharmacists (FSHP). A longtime member of the Technician Affairs Council since 2020, she served as Chair for 2024–2025 and steps into a new leadership role as a member of the FSHP Board of Directors beginning in 2025. She is also an active member of the Educational Affairs Council. Elizabeth has shared her expertise widely, presenting at both chapter events and statewide FSHP Annual Meetings on topics including medication safety, USP standards, and the technician's expanding role in modern pharmacy practice. Her commitment to the profession and to developing the technician workforce has been a defining aspect of her career.

Beyond her professional accomplishments, Elizabeth values creativity, balance, and connection. Outside of pharmacy, she enjoys baking and decorating cakes, practicing yoga, and spending cherished time with her family and friends. True to her grounded and humble nature, she says she has never had a specific "dream job"—instead, she focuses on being the best she can be in every role she holds. One of her favorite quotes, by Shel Silverstein, perfectly reflects that mindset: **"Maybe I'm not missing anything. Maybe I'm just… me."**

Elizabeth's career is a testament to dedication, curiosity, and constant growth. Whether advancing automation, shaping pharmacy operations, or uplifting the technician profession through FSHP, Elizabeth Lewallen continues to make a meaningful and lasting impact on the field.

LEGAL AND REGULATORY UPDATE

2026 Legislative Updates

Beatriz Jimenez-Cadilla, PharmD, BCACP, CDCES, CPh
Gray Robinson
Kathleen Baldwin, BS Pharm, MA, PharmD, BCPS, FFSHP, FASHP

Enrolled Bills

DRUG PRICES AND COVERAGE

HB 697 Representative Kincart Jonsson & SB 1760 Senator Brodeur
Effective: July 1, 2026; provisions relating to ADAP take effect upon the bill becoming a law

ACTION: Sent to the Governor for approval. Deadline to act: April 2, 2026.
The bill creates a non-statutory section of the Laws of Florida relating to the ADAP which takes effect upon the bill becoming a law. The bill provides funding for the Ryan White Part B AIDS Drug Assistance Program for the remainder of Fiscal Year 2025-2026. It appropriates $30,901,933 from the Grants and Donations Trust Fund to the DOH on a nonrecurring basis through June 30, 2026. Commencing April 1, 2026, the DOH must provide, monthly, detailed accounting reports for the ADAP to the Governor's Office of Policy and Budget, the chair of the Senate Appropriation Committee, and the chair of the House of Representatives Budget Committee, according to specified criteria.

The bill revises the definition of "pharmacy benefits plan or program" to exclude a plan which only serves beneficiaries of Program of All-Inclusive Care for the Elderly organizations. The bill revises the administrative appeal process for a pharmacy or pharmacist to contest the maximum allowable cost (MAC) pricing information and the reimbursement made by a PBM for a specific drug by allowing the pharmacy or pharmacist the option to submit an electronic spreadsheet containing a consolidated administrative appeal representing multiple adjudicated claims that share the same drug and day supply and have a date of service occurring within the same calendar month. The bill creates two new prohibited practices for a PBM. PBMs are prohibited from: (i) Prohibiting or restricting a pharmacy or pharmacist from declining to dispensing a drug if the reimbursement rate is less than the actual acquisition cost incurred or would be incurred by the pharmacy or pharmacist. (ii) Reimbursing a pharmacy or pharmacist less than the PBM reimburses an affiliated pharmacy or pharmacist, as those terms are defined in s. 626.8825(1), F.S.

LEGAL AND REGULATORY UPDATE

Bills That Did Not Pass

MEDICAL FREEDOM

SB 1756 Senator Yarborough & HB 917 Holcomb

SB 1756 aimed to expand what it described as "medical freedom" by placing new limits on vaccination policies and increasing flexibility for alternative treatments. The bill would have prohibited the state from requiring vaccinations during public health emergencies, restricted financial incentives tied to vaccine administration, and required additional disclosures and parental consent procedures before vaccinating minors. It also proposed expanding access to ivermectin by allowing broader prescribing protections for providers and authorizing pharmacists to dispense it without a prescription under certain conditions. Additionally, the bill revised school immunization exemption processes to make it easier to opt out based on religious or personal beliefs.

Supporters framed the bill as a way to protect individual choice and reduce coercion in medical decisions, particularly during emergencies. However, opposition raised significant public health concerns. Critics warned the bill could lower vaccination rates, increase the spread of preventable diseases, and put vulnerable populations, such as immunocompromised children, at greater risk. Others questioned provisions related to ivermectin and whether the bill aligned with established medical guidance, while some expressed concern that it disrupted the balance between personal choice and community health.

Despite advancing in the Senate, the bill ultimately died after the House declined to take it up, reflecting both policy concerns and a lack of agreement between the chambers on such a sweeping and controversial proposal.

CONSULTANT PHARMACISTS

HB 1425 Representative Booth & SB 1142 Senator Wright

The bill would allow a consultant pharmacist to provide medication management services at health care clinics that are owned by a hospital or at least one physician that is employed by or contracted with a hospital. The bill passed the House unanimously but did not advance in the Senate.

REGIONAL SOCIETY UPDATE

The Northeast Florida Society is a FSHP regional affiliate serving the surrounding areas of Jacksonville. had a busy fall hosting many events for the members of our region. We were proud to host our 2 day annual Fall meeting which offered over 13 hours of Consultant, General, and the required 2-hour Controlled Substance pharmacist CE along with Technician CE from various members from different health systems in the region. The large variety of topics covered during this event allowed our members to stay up to date on topics. Heart failure, anticoagulation reversal, pharmacogenomics, pharmacy team burnout, and zoonotic disease were just a few of our great selction of topics. Over 40 of our members joined us for this outstanding meeting showing our chapter's commitment to supporting and growing our regional chapter. Our local UF Jacksonville SSHP chapter also partnered with us during this event to provide volunteers to ensure the event ran smoothly.

We continue to offer virtual and live CE opportunities, along with drug sponsored dinners and socials. Our most recent virtual CE opportunity highlighted Dr. Anthony Casapao, Pharm.D., MPH, FIDSA, in his presentation, "Staph Showdown: Test Your Treatment Tactics." He led a great discussion with our members discussing new antibiotics along with new resistance patterns we should all be aware of and how to tackle those in clinical practice. Our members had many opportunities during the presentation to give their own personal experience with these treatments along with answer many questions posed during the discussion.

REGIONAL SOCIETY UPDATE

NEFSHP remains committed to delivering many great CE opportunities, networking socials, and community outreach events. We hope to continue to partner with our local UF Jacksonville SSHP chapter to provide guidance and collaboration with our local students. We thank all of our regional members that continue to show their dedication to advancing health-system pharmacy and have sustained engagement in our chapter. We look forward to seeing all of our regional members at our next event, April 25th, at UF Health Jacksonville, where we will offer 3 hours of General and Consultant Pharmacist and Technician CE. Our speakers will be presenting on various critical care topics. Please email us nefshpofficers@gmail.com for more information!

Jessica Andrews, Pharm.D., BCCCP
Cardiac Critical Care Clinical Pharmacist
Baptist Health | Department of Pharmacy
800 Prudential Drive, Jacksonville, FL 32207
C: 850-830-0140
Jessica.andrews@bmcjax.com

Pharm So Hard

Check out the Pharm So Hard podcast!

LinkedIn facebook twitter Instagram

@FSHPofficial

The FLORxIDA Times newsletter is published by the FSHP Communications Council.

Thank you to the following people for your contributions:

Beatriz Jimenez-Cadilla
Daniella Abi Kheir
Melody Blanchard
Kevin Taylor
Jessica Wendler
Jack Iskander
Vicki McConnell
Jeff Cunningham
Emilie Collongette
Daniela Luzardo
Jessica Bianco
Tamekia Bennett
Rachel Ross
Madeline Camejo

As always, a special thanks to the council liaisons and member submissions!

Contact us to get your content in our next newsletter: fshp@fshp.org