Walmart

April 6, 2026

Lori Martinez
Board of Pharmacy
2720 Gateway Oaks Drive, Ste. 100
Sacramento, CA 95833

Submitted via electronic mail: PharmacyRulemaking@dca.ca.gov

Dear Ms. Martinez,

On behalf of Walmart Inc. (Walmart), we appreciate the opportunity to comment on the California Board of Pharmacy's (Board) proposed amended regulations governing central fill pharmacy operations. While Walmart wholeheartedly supports promotion of patient safety, we are concerned that the Board's proposed requirement limiting central fill pharmacies to facilities physically located within California is unnecessary, does not advance patient health or welfare, and would restrict access to lawful, efficient pharmacy services. As discussed below, this geographic limitation does not meaningfully improve oversight, ensure timely dispensing, or enhance patient protections, and instead risks undermining the operational flexibility that supports safe and effective pharmacy care.

The Board asserts that in-state location is essential to ensure timely prescription fulfillment and to avoid delays in therapy that could harm patient health, safety, or welfare.

This assertion is misguided. Central fill pharmacies are not used to dispense acute or urgent medications; rather, they support the dispensing of routine prescriptions and long-term or chronic medication refills, where timing is planned and predictable. In addition, the shared, real-time pharmacy management system utilized by both the retail and central fill locations ensures that the retail pharmacy retains full and immediate control over every prescription order. At any point prior to dispensing, a prescription transmitted to the central fill facility can be instantaneously retrieved and reassigned back to the retail pharmacy for on-site processing and dispensing. This capability allows the retail pharmacy to respond without delay if a patient presents earlier than expected, if therapy must begin immediately, or if clinical judgment determines that local dispensing is more appropriate.

Further, geographic proximity within California does not necessarily correlate to faster delivery times. For example, a central fill pharmacy located in Sacramento, CA serving an originating pharmacy in San Diego may take longer to return a filled prescription than a licensed nonresident central fill pharmacy located in a neighboring state, such as Nevada, with established distribution capabilities and logistics infrastructure.

As a result, central fill operations do not introduce barriers to timely care; rather, they provide operational flexibility while preserving the originating retail pharmacy's ability to intervene immediately when necessary. This seamless integration effectively eliminates any meaningful risk of delayed therapy attributable to central fill utilization. The retail pharmacy remains fully capable of ensuring prompt access to medications whenever clinical circumstances require it, thereby

maintaining patient health, safety, and welfare while also benefiting from the efficiency and accuracy enhancements that central fill services provide.

In the amended initial statement of reasons, the Board explains that requiring a central fill pharmacy to be located within California is intended to ensure compliance with California laws and regulations. But California law already provides the Board with all the powers it needs to ensure that relevant central fill pharmacies outside California comply with California laws and regulations.[1]

For these reasons, Walmart respectfully urges the Board to reconsider the proposed restriction and to permit Board-licensed nonresident pharmacies to provide central fill services for California pharmacies in a manner consistent with current law and the Board's broader regulatory objectives.

Sincerely,

Kevin Loscotoff

Kevin Loscotoff
Director, Public Affairs and State and Local Government Relations
Walmart

[1] CA BPC Section 4112 of the Business and Professions Code, effective July 1, 2026, expressly recognizes nonresident pharmacies and expressly vests the Board with extensive regulatory powers over such pharmacies. The statute provides that any pharmacy located outside of California that ships, mails, or delivers controlled substances, dangerous drugs, or dangerous devices into the state is considered a nonresident pharmacy and is subject to California licensure and compliance requirements.

RHS | PHARMACY ADVISORS

March 13, 2026

California State Board of Pharmacy
Attn: Lori Martinez
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Via Electronic Mail

Re: 16 CCR § 1707.4 – Comments on Modified Regulatory Text

Dear Honorable Members of the California State Board of Pharmacy,

Refined Health Solutions appreciates the Board's continued work on this rulemaking, and we are encouraged by the addition of subsection (e), the allowance for electronic patient notification, and the controlled substances provision. These changes reflect a commitment to preserving flexible pharmacy models.

We write to raise two concerns that remain unclear in the modified text:

1. The "located in California" requirement is inconsistent with AB 1503.

The Modified Initial Statement of Reasons states that the "located in California" requirement is necessary because "the Board must be able to inspect central fill facilities, which requires that the facilities be located within California." However, AB 1503 expressly provides that "the board *may* inspect a nonresident pharmacy licensed pursuant to this section." The Board already has inspection authority over California-licensed nonresident pharmacies. The stated rationale for the geographic restriction therefore does not hold, and we respectfully request that the Board reconcile this inconsistency.

2. Geography does not support a blanket in-state requirement.

The MISR further states that an in-state requirement is needed "to avoid any potential delays in therapy." This is not always accurate. A patient in Redlands, California, for example, is geographically closer to a central fill pharmacy in Phoenix than to one in Sacramento. Limiting central fill to in-state locations can create access barriers — particularly for Limited Distribution Drugs and patients in underserved or rural communities — rather than eliminating them.

Recommended Revisions

1. Remove the in-state location requirement.

We recommend removing "located in California and" from subsection (c), as this language is inconsistent with the Board's existing authority under AB 1503 and creates unnecessary access barriers as described above:

> **§ 1707.4(c)** — A central fill pharmacy ~~located in California and~~ licensed by the Board may process a request for ~~refill of~~ a prescription medication received by ~~a~~ another pharmacy ~~within this state~~, provided…

2. Allow direct-to-patient dispensing from a central fill pharmacy.

The current definitions in subsections (a) and (b) effectively require filled prescriptions to route back through the originating pharmacy before reaching the patient. We recommend removing this constraint. Allowing a California-licensed central fill pharmacy to ship directly to patients improves medication access, reduces time to therapy, and eliminates additional handling steps that introduce unnecessary risk of error or delay:

> **§ 1707.4(a)** — For purposes of this section, a central fill pharmacy is defined as a California-licensed pharmacy that, pursuant to a contract or on behalf of a pharmacy under common ownership, prepares and packages prescriptions for another pharmacy ~~to dispense to the patient~~.

> **§ 1707.4(b)** — For the purposes of this section, the originating pharmacy is defined as the pharmacy that received the patient's initial prescription ~~and dispenses the medication to the patient~~.

Together, these revisions preserve all of the Board's safety and accountability requirements while removing restrictions that limit patient access and foreclose innovative models before they can develop. We also respectfully renew the request, made by multiple stakeholders, that if significant changes are finalized, pharmacies be given ample lead time to implement new systems and transition patients safely. Thank you for your time and for the opportunity to provide comments on this matter.

Sincerely,

Emily Haugh, PharmD
Principal Consultant
Refined Health Solutions

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

April 7, 2026

Debbie Damoth
Board of Pharmacy
2720 Gateway Oaks Drive, Ste. 100
Sacramento, CA 95833

Submitted via PharmacyRulemaking@dca.ca.gov

Re: Proposed Modifications to 16 CCR §1707.4; Central Fill Pharmacies

Dear Ms. Damoth,

On behalf of our members operating chain pharmacies throughout the state of California, the National Association of Chain Drug Stores (NACDS) thanks the Board of Pharmacy (Board) for the opportunity to comment on the proposed modifications to 16 CCR §1707.4 related to requirements for central fill pharmacies. We thank the Board for its recent work to convene pharmacy stakeholders and evaluate whether changes may be warranted to the over 20-year-old central fill rule, and for the Board's subsequent efforts to develop the proposed rule changes. Modernizing this rule can help California pharmacies to meet the dynamic and evolving healthcare needs of their patients across the state.

To enhance pharmacy operators' ability to safely and accurately deploy central fill operations and support their capacity to meet Californians' pharmacy care needs, NACDS asks the Board to make the following revisions to 16 CCR §1707.4 to provide clarity and allow for practical flexibilities that preserve patient safety while aligning with real-world pharmacy operations and supporting pharmacies' ability to meet patients' growing demand for pharmacy services:

1. **Strike the language in (c) that requires central fill pharmacies to be located in the state of California:**

   *(c) A central fill pharmacy ~~**located in California and**~~ licensed by the Board may process a request for prescription medication received by another pharmacy within this state, provided: …*

In proposing this geographic limitation, the Board asserts that the geographic limitations are needed "to avoid any potential delays in therapy … [and] ensure timely filling of the prescription medication" and to allow the Board to inspect central fill operations. Based on pharmacies' experiences implementing central fill operations across other states, these concerns are unfounded, as further detailed below.

Pharmacy operators typically deploy central fill operations to prepare routine, long-term, and chronic prescriptions where timing is planned and predictable, whereas local pharmacies will typically handle acute and urgent prescriptions. Moreover, retail pharmacies and central fill locations utilize a shared, real-time pharmacy management system, ensuring that local pharmacies retain full and immediate control over every prescription order. At any point prior to dispensing, a prescription transmitted to a central fill facility can be instantaneously retrieved and reassigned back to the retail pharmacy for on-site processing and dispensing, thereby allowing

the local pharmacy to respond without delay if a patient presents earlier than expected, if therapy must begin immediately, or if clinical judgment determines that local dispensing is more appropriate.

Notably, geographic proximity within California does not necessarily correlate to faster delivery times. For example, a central fill pharmacy located in Sacramento serving an originating pharmacy in San Diego may take longer to return a filled prescription than a licensed nonresident central fill pharmacy located in a neighboring state, such as Nevada, with established distribution capabilities and logistics infrastructure. Additionally, Section 4112 of the California Business and Professions Code as amended by AB 1503 (2025) now authorizes the Board to inspect nonresident pharmacies, which would extend to any central fill operation located in another state. For these reasons, the proposed geographic limitation for central fill operations to be located in the state of California are unwarranted and will only hinder the ability for central fill pharmacies to effectively serve California patients.

2. **Eliminate the ambiguity with respect to requirements for a prescription container under (c)(2)(B):**

   *(c)(2)(B) **~~as applicable,~~** clearly shows the name and address of the central fill pharmacy filling the medication or the name and address of the originating pharmacy. Nothing in this subsection should be interpreted as preventing inclusion of the name and address of both pharmacies. …*

In this particular paragraph, use of the phrase "as applicable" introduces unnecessary ambiguity and does not contribute meaningfully to the intent of the rule. Including this phrase could create unintended uncertainty about what information, in fact, is considered applicable and must be shown on the prescription container.

3. **Allow pharmacy operators to use an identifier to satisfy the recordkeeping requirements under (c)(4) related to filling and receipt of prescriptions from central fill operations:**

   (c)(4) Both pharmacies maintain complete and accurate records, including:
   *(A) the name of the pharmacist **or identifier of the pharmacist** who filled the prescription;*
   *(B) the name of the pharmacy **or identifier of the pharmacy** filling the prescription; and*
   *(C) the name of the pharmacy **or identifier of the pharmacy** that received the prescription.*

Allowing for the use of an identifier that is uniquely mapped to a specific pharmacist or permitted pharmacy location can reduce the risk of misspellings, name variations, or formatting inconsistencies that can occur with full names – especially in a high-volume central fill environment. As permitted under Section 4070 of the California Business and Professions Code, many California pharmacies already use identifiers to satisfy certain recordkeeping requirements for electronic prescriptions. Pharmacy operators should also be authorized to use this established, accurate identification method to track the filling and receipt of prescriptions from central fill operations.

4. **Clarify that central fill pharmacies may dispense finished prescriptions directly to the patient on behalf of local, retail pharmacies.**

While subsection (e) appears to permit direct-to-consumer dispensing through a mail-order pharmacy model, the language does not directly address a scenario where the central fill pharmacy might dispense a finished prescription to a patient on behalf of the patient's local retail pharmacy. Seemingly, there is no statutory or regulatory distinction that would preclude a central fill pharmacy from engaging in the same practice. However, we ask that the Board confirm that direct-to-consumer dispensing is authorized for central fill operations filling prescriptions on behalf of a local, retail pharmacy.

NACDS thanks the Board for considering our perspectives on this rulemaking. If you have any questions or need additional information, please contact NACDS's Sandra Guckian at SGuckian@nacds.org.

Sincerely,

Steven C. Anderson, FASAE, CAE, IOM
President and Chief Executive Officer
National Association of Chain Drug Stores

###

NACDS represents traditional drug stores, supermarkets and mass merchants with pharmacies. Chains operate over 40,000 pharmacies, and NACDS' member companies include regional chains, with a minimum of four stores, and national companies. Chains employ nearly 3 million individuals, including 155,000 pharmacists. They fill over 3 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 900 supplier partners and over 70 international members representing 21 countries. Please visit NACDS.org.

Lorri Walmsley, RPh., FAzPA
Vice President, Pharmacy Affairs
Walgreen Co.
200 Wilmot Rd.
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p: 602-214-6618
lorri.walmsley@walgreens.com

March 20, 2026
California State Board of Pharmacy
Attention: Anne Sodergren, Executive Director
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Via Email: PharmacyRulemaking@dca.ca.gov

RE: Recommended amendments to *§ 1707.4. Procedures for Central Fill Pharmacies*

Dear Executive Director Sodergren and members of the California Board of Pharmacy,

On behalf of all pharmacies owned and operated by Walgreens licensed in the State of California, we thank the Board for the opportunity to comment and provide full support on the amended sections of §1707.4 of Article 2 of Division 17 of Title 16 of the California Code of Regulations.

Walgreens expresses its sincere appreciation for the Board's willingness to consider and thoughtfully incorporate stakeholder feedback throughout the development of its central fill rulemaking. This collaborative approach has been essential in shaping a framework that will allow central fill pharmacies in California to operate effectively and deliver their full benefits to the residents of the state.

Walgreens respectfully requests clarification regarding Sections §1707.4(a) and (e), *Procedures for Central Fill Pharmacies*, specifically as they relate to direct-to-consumer dispensing. While subsection (e) appears to permit direct-to-consumer dispensing through a mail-order pharmacy model, we see no statutory or regulatory distinction that would preclude a central fill pharmacy from engaging in the same practice. We therefore seek the Board's confirmation that direct-to-consumer dispensing is permissible for central fill pharmacies under these provisions.

Walgreens respectfully recommends the following amendment to Section *§1707.4 (c)(2)(b) Procedures for Central Fill Pharmacies*

(B) ~~as applicable,~~ ~~c~~Clearly shows the name and address of the central fill pharmacy ~~re~~filling the ~~prescription~~ medication ~~and/~~or the name and address of the originating pharmacy ~~which receives the refilled prescription medication to dispense to the patient~~. Nothing in this subsection should be interpreted as preventing inclusion of the name and address of both pharmacies.

Rationale:
We believe that the phrase *"as applicable"* introduces unnecessary ambiguity and does not contribute meaningfully to the intent of the rule. Our concern is that its inclusion could create unintended uncertainty about what, in fact, is considered applicable. We further believe that the suggested amended language will eliminate this confusion and provide greater clarity to the rule overall.

Walgreens respectfully recommends the following amendment to Section *§1707.4 (c)(4) Procedures for Central Fill Pharmacies,* to bring the proposed rules into alignment with existing California law found within Business and Professions Code section 4070:

> *(4) Both pharmacies maintain complete and accurate records ~~of the refill~~, including:*
> *(A) the name of the pharmacist or identifier of the pharmacist who ~~re~~filled the prescription;*
> *(B) the name of the pharmacy or identifier of the pharmacy ~~re~~filling the prescription; and*
> *(C) the name of the pharmacy or identifier of the pharmacy that received the prescription ~~refill request~~.*

Rationale:

California law already permits the use of an identifier in place of a full name. Under Business and Professions Code section 4070 subdivision (b), electronic prescription records may show the name or identifier of the dispensing pharmacist. An example of a common identifier for a pharmacy would be a Store Number that is included in the name listed on the permit.

California Statute Business and Professions 4070 Reduction of oral or electronic prescription to writing:

> *(b) A pharmacy receiving an electronic transmission prescription shall not be required to reduce that prescription to writing or to hard copy form if, for three years from the last date of furnishing pursuant to that prescription or order, the pharmacy is able, upon request by the board, to immediately produce a hard copy report that includes for each date of dispensing of a dangerous drug or dangerous device pursuant to that prescription or order:*
>
> > *(1) all of the information described in subparagraphs (A) to (E), inclusive, of paragraph (1) of subdivision (a) of Section 4040, and*
> > *(2) **the name or identifier of the pharmacist** who dispensed the dangerous drug or dangerous device. This subdivision shall not apply to prescriptions for controlled substances classified in Schedule II, III, IV, or V, except as permitted pursuant to Section 11164.5 of the Health and Safety Code.*

Since the Board already relies on this approach in section 4070, we respectfully request that the same allowance be applied in section 1707.4. Using an identifier is consistent with existing law and provides accurate record keeping without adding unnecessary administrative burden.

Thank you for your time and consideration. Please feel free to contact me if you have any questions.

Sincerely,

Lorri Walmsley, RPh, FAzPA
Vice President, Pharmacy Affairs

CALIFORNIA Kidney Care Alliance

1127 11th Street, Suite 820, Sacramento, CA 95814, Phone: (916) 446-2646

April 6, 2026

California State Board of Pharmacy
ATTN: Lori Martinez
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
PharmacyRulemaking@dca.ca.gov

Re: Comments on Proposed Amendments to 16 CCR § 1707.4 – Central Fill Pharmacies

Dear Members of the Board:

On behalf of the California Kidney Care Alliance (CKCA), representing dialysis providers throughout the State of California, we appreciate the opportunity to comment on the Board's proposed amendments to Title 16, California Code of Regulations (CCR) section 1707.4 regarding central fill pharmacy operations.

The CKCA—formerly the California Dialysis Council—has served since 1982 as the primary legislative voice for the state's End Stage Renal Disease (ESRD) community. We support the Board's mission to ensure safe, reliable, and equitable access to medications. However, we have significant concerns regarding the negative impacts the proposed in-state limitation on central fill pharmacies would have on ESRD patients. We respectfully submit the following comments.

Background

Effective January 1, 2025, the Centers for Medicare & Medicaid Services (CMS) incorporated oral-only phosphate binders into the ESRD Prospective Payment System (PPS) bundle, shifting these medications from Medicare Part D to Medicare Part B. This means that dialysis organizations, which serve a large Medicare patient population, are responsible for providing these medications to patients. CMS implemented a Transitional Drug Add-on Payment Adjustment (TDAPA) for at least two years to support this transition.

Key program changes for dialysis medications (2025–2026):

- **Included medications:** Sevelamer, sucroferric oxyhydroxide, lanthanum carbonate, ferric citrate, and calcium acetate.
- **Coverage shift:** Binders must now be supplied by dialysis facilities rather than retail pharmacies for Medicare Part B patients and certain patients with MA, Medicaid, and commercial insurance that reimburse similarly to CMS.
- **TDAPA:** Available through at least 2026 to offset the cost increase.
- **Future PPS impact:** Binder costs will be permanently incorporated into the base ESRD PPS rate after the TDAPA period.

This federal change substantially increases dialysis organization reliance on pharmacy partners—some of whom operate out of state or use central fill—to ensure timely access to these essential medications.

Concerns Regarding Proposed Amendments to § 1707.4

1. **Proposed restrictions conflict with federal ESRD policy changes and threaten continuity of care.**
   Because CMS now requires dialysis facilities to provide oral phosphate binders directly to patients, dialysis clinics depend on specialized kidney-care pharmacies—some of which utilize out-of-state central fill locations—to maintain consistent supply. These medications are clinically essential, and even short delays can have serious consequences for ESRD patients. Restricting a pharmacy's central fill operations to in-state facilities could:
   - Reduce availability of medications already susceptible to supply gaps in retail settings;
   - Disrupt federally driven workflows that rely on centralized dispensing; and
   - Restrict dialysis provider choice of qualified pharmacy partners during a period of significant operational transition.

The proposed Board of Pharmacy regulation is misaligned with the current federal payment and supply framework that governs ESRD medication delivery. Given that approximately 80% of ESRD patients rely on phosphate binders, this policy change poses a substantial risk to a highly vulnerable patient population, access to essential therapy, and could result in significant adverse healthcare outcomes.

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2. **Limiting central fill to California-based pharmacies will reduce access and increase delays**
   California's geography, transportation disparities, and ongoing pharmacy-access challenges create real risks for dialysis patients if central fill capacity is restricted. The proposed in-state requirement could overload local pharmacies and may unintentionally:
   - Reduce statewide dispensing capacity for high-acuity, chronically ill patients;
   - Increase delivery timelines, especially for rural or transportation-limited populations; &
   - Break existing relationships with specialized central-fill providers that have built the infrastructure needed to support ESKD patients.

Kidney-care pharmacies routinely provide direct-to-patient and direct-to-clinic delivery—ensuring reliable access regardless of distance or local pharmacy closures. Removing the option to utilize licensed out-of-state central fill partners would diminish this critical flexibility.

Conclusion

The proposed Board of Pharmacy regulation is fundamentally inconsistent with the federal payment and supply model that now governs ESRD medication distribution. Because phosphate binders are prescribed to approximately 80% of ESRD patients, the regulation would

disproportionately affect this high-risk population and could lead to significant disruptions in care and negative health outcomes.

For these reasons, the CKCA respectfully urges the Board to reconsider or revise the proposed in-state limitation in § 1707.4(c). A more flexible regulatory framework—consistent with statutory authority under BPC § 4112 and reflective of recent federal ESRD policy changes—would better protect medication access and continuity of care for California dialysis patients.

We appreciate the Board's thoughtful consideration of our comments and welcome the opportunity to discuss the operational and clinical impacts further.

Sincerely,

Maria Garcia

President, California Kidney Care Alliance

Cardinal Health
7000 Cardinal Place
Dublin, OH 43017
614.533.3970
Cardinalhealth.com

VIA Email: To: PharmacyRulemaking@dca.ca.gov

Lori Martinez
Board of Pharmacy
2720 Gateway Oaks Drive, Ste. 100
Sacramento, CA 95833
(916) 518-3100

RE: Amend Title 16, California Code of Regulations (CCR) section 1707.4

Dear Ms. Martinez:

I am writing regarding the Regulatory Proposal to amend Title 16, California Code of Regulation section 1707.4 on behalf of Cardinal Health, Inc. (NYSE: CAH) ("Cardinal Health").

About Cardinal Health

Cardinal Health is a publicly traded distributor of pharmaceuticals, a global manufacturer and distributor of medical and laboratory products, and a provider of performance and data solutions for health care facilities. With more than 50 years in business, operations in more than 30 countries and approximately 46,500 employees globally with 3,572 living in California. Cardinal Health is essential to care. We serve:

- roughly 90 percent of U.S. hospitals;
- more than 29,000 U.S. pharmacies;
- more than 3.4 million U.S. patients with more than 46,000 home healthcare products;
- more than 6,200 U.S. labs with nearly 51,000 laboratory products;
- more than 10,000 specialty physician offices and clinics.

Cardinal Health also serves approximately 1,600 patients a day in California through its subsidiary central fill pharmacy, RX E-Fill Solutions, located in Valencia, California.

Specific Comments to the Proposed Rule

Recognizing the Board likely wishes to proceed with the Proposed Amendment, Cardinal Health requests that the Board expressly codify within its regulations that central fill pharmacies are authorized to mail prescriptions directly to patients.

The Board staff's recommended addition below, which is in response to stakeholder comments is unclear. It appears to rely on Cal. Code Regs. Tit. 16, § 1717.1 to permit central fill pharmacies to mail prescriptions directly to patients. However, as written it may create confusion for future regulators and industry stakeholders and potentially impact patient care.

> *1707.4(e) Nothing in this section shall be construed as barring a pharmacy from also filling prescriptions through a mail order pharmacy model that fills prescriptions and delivers prescriptions directly to patients through any mail service, or from operating under the provisions of a common electronic file as established in section 1717.1 of this Article.*

To eliminate ambiguity and ensure uniform application of the Board's regulatory framework, we respectfully request that the Board revise the rule as follows:

16 CCR § 1707.4(a)-(b) (proposed rule). We suggest revising the rule as follows:[1]

> *(a) For purposes of this section, a central fill pharmacy is defined as a California licensed pharmacy that, pursuant to a contract or on behalf of a pharmacy under common ownership, prepares and packages prescriptions for another pharmacy,* ***and which either returns the dispensed prescription to the originating pharmacy or delivers the dispensed prescription directly to the patient or patient's agent.***
>
> *(b) For the purposes of this section, the originating pharmacy is defined as the pharmacy that received the patient's initial prescription.* ~~*and dispenses the medication to the patient.*~~

This revision will align California with other state boards of pharmacy that recognize the benefits of direct dispensing to patients in a central fill arrangement. Please refer to the following example regulations:

- **Oregon**: Or. Admin. Code § 855-041-3035(1) "A central fill pharmacy may deliver or mail medications to the primary pharmacy or patient. . . ."
- **Arizona**: Ariz. Admin. Code § R4-23-621(C)(2) (Requiring certain additional information to appear on the prescription container if an order is delivered directly to the patient by the filling pharmacy).
- **Texas**: 22 Tex. Admin. Code § 291.125(c)(2)(A)(ii) (Recognizing that non-controlled substance prescriptions may be delivered directly to the patient if certain additional information appears on the prescription container).

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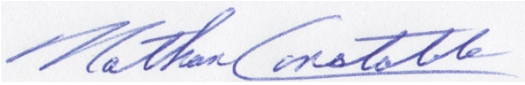
[1] Cardinal Health recognizes that under Drug Enforcement Administration ("DEA") regulations, controlled substance prescriptions may only be returned to the originating pharmacy. The requested revision would only apply to non-controlled substances as permitted by other state boards of pharmacy. *See* 21 CFR 1300.01(b).

- **Colorado:** 3 Colo. Code Regs.719-1-20.00.90(c) & 20.01.00(a)(2)(iv) (Describing the requirements of the fulfillment and originating pharmacies when the prescription is delivered directly to the patient).

Thank you for your consideration of Cardinal Health's comments. Should you have any questions, please feel free to contact me at nathan.constable@cardinalhealth.com.

Sincerely,



Nathan Constable
Director, Regulatory Affairs
Cardinal Health

April 9, 2026

California State Board of Pharmacy
Attn: Lori Martinez
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

Via Email: PharmacyRulemaking@dca.ca.gov

Re: Followup Comments to Staff Responses and Recommendations for Central Fill Pharmacies

To California State Board of Pharmacy Members and Executive Officer Sodgren,

The California Retailers Association appreciates the California Board of Pharmacy's continued work on the Central Fill Pharmacies rulemaking, and we are encouraged by the addition of subsection (e), the allowance for electronic patient notification, and the controlled substances provision. These changes reflect a commitment to preserving flexible pharmacy models.

We write to raise two concerns that remain unclear in the modified text.

1. The "located in California" requirement is inconsistent with AB 1503 (Berman – 2025) Board of Pharmacy Sunset review.

The Modified Initial Statement of Reasons states that the "located in California" requirement is necessary because "the Board must be able to inspect central fill facilities, which requires that the facilities be located within California." However, AB 1503 expressly provides that "the board *may* inspect a nonresident pharmacy licensed pursuant to this section." The Board already has inspection authority over California-licensed nonresident pharmacies. The stated rationale for the geographic restriction therefore does not hold, and we respectfully request that the Board reconcile this inconsistency.

2. In-State Requirements Fail to Account for Geographic and Patient Realities

The Modified Initial Statement of Reasons further states that an in-state requirement is needed "to avoid any potential delays in therapy." This is not always accurate. A patient in Redlands, California, for example, is geographically closer to a central fill pharmacy in Phoenix, Arizona than to one in Sacramento, California. Limiting central fill to in-state locations can create access barriers — particularly for Limited Distribution Drugs and patients in underserved or rural communities — rather than eliminating them.

Recommended Revisions

1. Remove the in-state location requirement.

We recommend removing "located in California and" from subsection (c), as this language is inconsistent with the AB 1503 and creates unnecessary access barriers as described above:

§ 1707.4(c) — A central fill pharmacy ~~located in California and~~ licensed by the Board may process a request for ~~refill of~~ a prescription medication received by ~~a~~ another pharmacy ~~within this state~~, provided…

2. Allow direct-to-patient dispensing from a central fill pharmacy.

The current definitions in subsections (a) and (b) effectively require filled prescriptions to route back through the originating pharmacy before reaching the patient. We recommend removing this constraint. Allowing a California-licensed central fill pharmacy to ship directly to patients improves medication access, reduces time to therapy, and eliminates additional handling steps that introduce unnecessary risk of error or delay:

§ 1707.4(a) — For purposes of this section, a central fill pharmacy is defined as a California-licensed pharmacy that, pursuant to a contract or on behalf of a pharmacy under common ownership, prepares and packages prescriptions for another pharmacy ~~to dispense to the patient~~.

§ 1707.4(b) — For the purposes of this section, the originating pharmacy is defined as the pharmacy that received the patient's initial prescription ~~and dispenses the medication to the patient~~.

Together, these revisions preserve all of the Board's safety and accountability requirements while removing restrictions that limit patient access and innovation in the pharmacy space. We also respectfully renew the request, made by multiple stakeholders, that if significant changes are finalized, pharmacies be given ample lead time to implement new systems and transition patients safely.

Thank you for taking our followup comments on Central Fill Pharmacies into consideration. Please do not hesitate to contact me at sarah@calretailers.com if you have any questions.

Sincerely,

Sarah Pollo Moo
Vice President
California Retailers Association

cc: Seung Oh, PharmD, President Board of Pharmacy
Anne Sodergren, Executive Officer, Board of Pharmacy
Julie Ansel, Assistant Executive Officer

Rob Geddes, PharmD, MBA
Executive Director,
Pharmacy Advocacy and Regulatory Affairs

One CVS Drive
Woonsocket, RI 02895

c 208-860-5342

Robert.Geddes@CVSHealth.com

April 3, 2026

Lori Martinez
Board of Pharmacy
2720 Gateway Oaks Dr, Ste. 100
Sacramento, CA 95833
PharmacyRulemaking@DCA.CA.gov

Dear Ms. Martinez,

Re: Proposed Rules 1707.4 Procedures for Central Fill Pharmacies

On behalf of CVS Health, I want to express appreciation for the Board's recent revisions to the proposed rule and reaffirm our commitment to providing high-quality, accessible healthcare. Our pharmacists and technicians are integral to supporting community health, and we are dedicated to ensuring patients have reliable access to vital medications at both our community and specialty pharmacy locations across the state. The Board's modifications, particularly those clarifying dual-purpose pharmacies and allowing direct shipment from central fill to patients, have addressed several prior concerns and improved operational clarity.

While these revisions are welcomed, the purpose of this letter is to strongly urge the Board Members remove the phrase "located in California" from the proposed language in 1707.4 (c) to avoid creating unnecessary barriers for patients seeking to obtain their medications in California.

(c) A central fill pharmacy ~~located in California and~~ licensed by the B~~b~~oard may process a request for ~~refill of a~~ prescription medication received by ~~a~~ another pharmacy ~~within this state~~, provided:

1707.4 (c)

The phrase "located in California" within section 1707.4 (c) creates an undue and potentially harmful barrier for central fill models by restricting participation to entities within the state. Specifically, to pharmacies that leverage central fill to accommodate complex, high-touch disease states, this residency requirement jeopardizes patient access to critical specialty medications. Some manufacturers often restrict their product to dispensing only by pharmacies within their limited distribution drug (LDD) networks often referred to as specialty pharmacies. This results in only a small number of select pharmacies, sometimes outside California, being authorized to dispense critical drugs that require specialized handling. Manufacturers assign LDD designations to products for management of complex disease states, adherence to REMS programs, and other specialized requirements. Such designation limits distribution of those medications to a very small number of pharmacies capable of meeting rigorous manufacturer-defined criteria. Along with dispensing these drugs, these

pharmacies are expected to perform comprehensive care coordination to reduce adverse events, complete detailed prior authorization processes, dispense appropriate administration equipment, provide on-call support for patients including REMS monitoring, and take other intensive measures that prioritize patient safety.

The specialty pharmacy industries, approach focuses on maximizing patient access to critical therapies through a collaborative model. Collectively, these pharmacies satisfy both manufacturer-defined criteria and patient care needs. Under current central fill regulations, the intake center serves as the originating pharmacy, with the dispensing pharmacy—usually mailing the medication directly to the patient—considered the central fill pharmacy. The operational intent is always to utilize the dispensing pharmacy closest to the patient to minimize transit times. Nonetheless, due to the structure of manufacturer-designed LDD networks, situations arise where a California-based pharmacy cannot dispense a particular drug, though another qualified pharmacy within our national network can. Because of the manufacturer-driven distribution model for specialty medications, the proposed residency limitation would gravely impact patient access to specialty medications from any specialty pharmacy in California and would introduce potential for patient harm.

Another consideration is that the limitation unnecessarily burdens pharmacies seeking to improve timely patient access to refill medications through efficient central fill processes. Board staff have previously stated that this provision intends to prevent delays caused when patients receive medications filled by out-of-state providers. However, such reasoning does not correspond with common industry practices for central fill implementation within traditional community pharmacy settings. Central fill operations utilize advanced systems to fulfill prescriptions to drive continuity of care for patients' anticipated needs.

Given the sophistication of central fill processes and their use of automation to ensure originating pharmacies can timely meet patient medication needs, maintaining this restriction will effectively impede operational efficiencies for pharmacies and increase the likelihood of patient delays.

Thank you for taking into consideration these important concerns. If you have any questions, please reach out to me at Robert.Geddes@CVSHealth.com or 208-860-5342.

Sincerely,

Rob Geddes, PharmD, MBA

March 25, 2026

Lori Martinez
California State Board of Pharmacy
2720 Gateway Oaks Drive, Ste 100
Sacramento, CA 95834

Re: Proposed Regulatory Action Concerning Central Fill Pharmacies

Ms. Martinez,

The Kroger Co. appreciates the opportunity to submit additional comments regarding the California Board of Pharmacy's proposed amendments to Section 1707.4 of Title 16, Division 17, Article 2 of the California Code of Regulations, which would require central fill pharmacies to be located within the State of California.

In the Board's AMENDED INITIAL STATEMENT OF REASONS, there are two reasons stated as to why the board believes it is necessary for central fill pharmacies to be located within the state of California:

1. To ensure compliance with California laws and regulations, and to do so, the Board must be able to inspect central fill facilities, which requires that the facilities be located within California.
2. To avoid any potential delays in therapy that would harm the health, safety, and welfare of Californians, it is essential that the central fill pharmacy be located within California to ensure timely filling of the prescription medication and return to the originating pharmacy for dispensing.

California Board of Pharmacy currently requires all nonresident pharmacies shipping prescriptions into the state of California to licensed and comply with all applicable California laws and regulations including the recently enacted Business and Professions Code Chapter 9, Division 2 Section 4112 (k), which goes into effect July 1st, 2026 and states that "the board may inspect a nonresident pharmacy licensed pursuant to this section."

Concerns regarding potential delays in therapy related to prescription processing and return to the originating pharmacy are mitigated by the routine use of common carriers offering overnight delivery. Nonresident central fill pharmacies utilize established carriers such as FedEx, UPS, and USPS to deliver dispensed prescriptions to the originating pharmacy, often within 24 hours, thereby supporting timely prescription fulfillment and delivery. Pharmacies utilizing central fill pharmacies generally have the ability to recall prescriptions to the originating pharmacy during

the dispensing and shipping process, when necessary, to support timely access to therapy in response to urgent patient needs or unanticipated processing and shipping delays.

For these reasons, we respectfully urge the Board to reconsider excluding California-licensed nonresident pharmacies from providing central fill services to pharmacies within the state.

In conclusion, The Kroger Co. stands ready to work with the Board to address its concerns on this and other issues in a manner that best supports pharmacies, pharmacists, and the patients they serve.

Sincerely,

Camille Tackett Pharm.D, RPh.
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From: Bill Hartig <billh@prescript.net>
Sent: Thursday, March 5, 2026 6:34 PM
To: PharmacyRulemaking@DCA <PharmacyRulemaking@dca.ca.gov>
Subject: Title 16 CCR Sections 1707.4 Related to Central Fill Pharmacies COMMENT

To whom it may concern,

WITH RESPECT TO 1707.5

I am submitting the following in response to the Boards request for comments regarding the proposed changes. I am not certain why this regulations includes reference to automated dispensing devices. Central-fill pharmacies may already operate under common ownership. There are separate regulations for ADDS/APDS already. This vagueness of these changes seem to allow central-fill pharmacies to take on a contract manufacturing role. It should be stated in the regulation that nothing in this regulation allows a central-fill pharmacy to distribute non-patient specific prescriptions outside of its own registered facility.

"A pharmacist shall not be required to perform final product verification where product verification by a pharmacist is performed at the time of stocking the automated dispensing device, if the dispensing device is not further accessed by pharmacy personnel, and the medication is dispensed into a labeled container (with a label that meets the requirements set forth in section 1707.5 of this Article)." The purpose of this addition is to establish an exemption from product inspection. This exemption is necessary to prevent duplicative product verification that would be unnecessary given that the product was previously verified and dispensed by an automated device without human intervention.

COMMENT 1: Automated Dispensing Device can be broadly interpreted and current Board Regulations define ADDS, APDS (which require registration of each device) so it would seem appropriate to articulate the phrase AUTOMATED DISPENSING DEVICE in the proposed regulation for consistency.

1. Current regulations limit the number of ADDS/APDS that may be operated from a single pharmacy to ten as I recall. Will there be the same limitation on Central Fill pharmacies? If not, why not?

2. Current regulations allow human handling (retrieval) from dispensing devices (not all are fully automated). Who confirms that the correct medication is removed and dispensed if the pharmacist only needs to perform product verification at time of stocking?

3. Current regulations limit central fill operations for hospital pharmacies to 75 miles from facility. Will the same 75 mile restriction apply to central fill for retail pharmacies? If not, why not?

4. Are medications that are not picked up from the automated dispensing device returned to the contracted central-fill site or to the pharmacy (since they must be patient specific)?

5. How are expirations dates affected by un-collected prescriptions.

COMMENT 2: Pharmacies are already required to license ADDS/APDS and are already allowed to supply up to ten sites from the main pharmacy.

1. Is it the intention of the Board to allow a Central Fill Pharmacy to oversee and stock Automated Dispensing Devices registered to the originating pharmacy? If so, who will register the ADDS/APDS?

2. Can a central-fill pharmacy register their own Automated Dispensing devices? Are they restricted to ten units. Are they restricted to a 75 mile radius like hospital central fill?

Who is performing the inspection at time of stocking? When does the originating pharmacy (contracting services with a Central Fill Pharmacy) perform any inspection?

Per the Board's legislative intent, A central fill facility prepares and packages prescriptions for other pharmacies to dispense to patients. The change is necessary to ensure the type of prescription (new or refill) a central fill pharmacy can fill is not restricted, provided the other requirements of the regulation are met.

1. If it is the intent to prepare prescriptions for other pharmacies to dispense, does the intended regulation authorize central fill pharmacies to directly ship products to patients or is shipment limited to the originating pharmacy or automated dispensing devices licensed to the originating pharmacy. The regulation is broad and extremely vague. In fact, per the stated intent, "ensuring that a central-fill pharmacy is not restricted on the type of prescription it may fill" (especially if not under common ownership) seems to have significant impact on small pharmacy operations.

2. The largest pharmacy entities who can afford automated dispensing devices will certainly seize the opportunity to gain market share.

3. Current regulations require inclusion of the patient's name on the final prescription label. Changing the wording to "dispensed medication" from "prescription" (a well-defined legal term) could circumvent the very specific labeling requirements for

"prescriptions" dispensed, especially from unattended Automated Dispensing Devices. Nothing in the regulations should allow pharmacies (originating or central fill) to prepare in advance or stock dispensing devices with non-patient specific "prescriptions". To do so would constitute "manufacturing", and as such would require a Dept. of Health Services (Food and Drug Branch) manufacturing license. Has the Department of Health Services (Food and Drug Branch) weighed in on the proposed changes?

4. Current State regulations already provide a legal avenue for supplying pre-packaged "non-patient specific" unit-of-use containers to legally authorized dispensers under Department of Health Services (Food and Drug Branch). Since prescriptions dispensed from a pharmacy MUST be patient specific, it should be clarified in the proposed changes, that nothing in the proposed change(s) authorizes a central-fill pharmacy to supply such medications absent a legal "patient specific" prescription.

I believe the economic impact assessment fails. These changes without similar restrictions to hospital central-fill for unit dose (common ownership and 75 mile radius) will have a very significant impact on independent pharmacies. Since the number of prescriptions actually filled will remain the same, whatever prescriptions move to central-fill must move away from retail-fill. What economic assessment studies, if any, have been made in this regard? If prescriptions are moving to automated dispensing devices, likewise they will move away from retail-fill. If this proposed change extens the geographical limitations for ADDS/APDS oversight, the regulation goes beyond clarification of existing rules.

In particular, while the economic impact assessment states, The Board has determined that this proposal will not:

(1) create jobs within California;
(2) eliminate jobs within California;
(3) create new businesses within California;
(4) eliminate existing businesses within California;
(5) expand businesses currently doing business in the State of California.

COMMENT 3: Regarding the ability for central-fill pharmacies to package for entities that are NOT under common ownership in fact does create a new business. Large corporations who have the wherewithal to deploy hundreds of remote dispensing devices, will quickly change the landscape of the profession. Perhaps it is the large corporation(s) who have lobbied for these changes especially in light of the concurrent new rule-making that allows a pharmacist to work outside of the licensed pharmacy. Similar to mega-PBMs destroying small businesses by controlling mail-order, the central-fill model can simply hire an outside pharmacist to manage numerous automated dispensing devices (as the new

regulation does not establish a limitation). This sounds like a recipe to destroy small independent businesses, who already struggle daily with PBM's that the Board has historically failed to challenge. This change will clearly have an economic impact! Great for big stakeholders. Horrible for small independent pharmacies and stakeholders.
The Proposed regulations fail to articulate the nature of "contract" arrangements with central-fill pharmacies that are NOT under common ownership. The option to engage in contract services NOT under common ownership not only creates a new business model but opens the door for anti-kickback and Stark violations that are simply not addressed in the proposed modification. Pharmacies are covered entities under Stark and Antikickback regulations (Federal as well as State). If NOT under common ownership, the only incentive must be financial benefit (direct or indirect) to one or both parties for "steering" production / processing toward a single solution. Steering production in and of itself is a violation. This lack of clarification opens up an entire regulatory loophole similar to big pharma PBM's who used vague regulatory language to create an entire industry that has devastated small independent pharmacies. When PBM's controlled the claims process for all pharmacies, it didn't take long to direct "steer" business to their own mail order solutions. Boards of Pharmacy have failed the profession with respect to PBM's oversight and now, allowing central-fill outside of commonly owned entities opens up the same scenario that allowed mega PBM's to control our industry.

The inclusion of entities that are not under common ownership does more than simply clarify rules, it in fact creates a new business model, contrary to your economic impact declaration. Have there been any evaluations as to the nature of contracts with entities that are not under common ownership? Who will evaluate those contracts with respect to Stark and anti-kickback regulations? Does the Board review those contracts as part of the licensure process? Are those contracts available for public review? PBM's have long refused to be transparent about their contracts. Without transparency, this vague rulemaking will simply turn into PBM's 2.0! The regulations should prohibit contracts outside of common ownership and if not, minimally should certainly require submission and review of contracts with any entity not under common ownership.

OF GENERAL CONCERN:

From the outside looking in, these changes seem to favor only the largest and wealthiest stakeholders who can afford to deploy expensive automated dispensing devices to the detriment of small stakeholders and to the profession. It is the largest stakeholders that have currently demonstrated the highest prescription error rates per the Boards own latest report. Current time frame for inspection of a ADDS application is supposed to be 30 days, however according the a recent inquiry, this is currently taking 3-6 months. When I asked if a ADDS can be pre-certified, the Board's answer was no. Does the Board intend to pre-

certify Automated Dispensing Devices for large scale deployment by the largest central-fill entities? The regulation changes appear conspicuous and they WILL have a substantial impact on the profession. Prescriptions moving to central-fill have to come from “somewhere”. The “somewhere” will certainly be affected economically. To suggest that there will be no economic impact simply can’t be true. The Boards duty is to all stakeholders in the profession, not just the largest.

Respectfully submitted,

Very small stakeholder!

William Hartig, president

Prescript Pharmaceuticals Inc.

Pleasanton CA 94566