



Department of Commerce
Office of Professional Licensure Review

2026 Periodic Review

Pharmacist & Pharmacy Technician

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Executive Summary

Background

Pharmacists are important healthcare practitioners who are primarily engaged in dispensing, compounding, administering, and verifying prescription drugs. They also provide direct patient counseling regarding proper drug protocols, possible side effects, and potential drug interactions. Pharmacists work in a range of settings. In a retail or community pharmacy, in addition to dispensing medications, pharmacists may provide medication management services under collaborative practice agreements with physicians and may independently prescribe and administer certain medications. In hospitals, in addition to these collaborative practice agreements, pharmacists may treat patients directly and dictate pharmaceutical interventions.

Pharmacy technicians work under the general supervision of pharmacists, and typically assist pharmacists with dispensing and compounding.

Every state licenses pharmacists, and every state regulates pharmacy technicians in some manner. The requirements for pharmacist licensure are very similar nationwide, although the scope of practice can differ substantially between states.

Regulatory Model Recommendation: Maintain individual licensure for pharmacists and technicians

- The potential for harm from the activities of pharmacists and technicians is significant
- Holding individuals accountable through licensure is valuable, despite substantial existing federal and state regulation of pharmacies and pharmacy practices

Recommended Regulatory Adjustments: None

- Pharmacists and technicians work in a complex economic and regulatory landscape, leading to significant challenges for their professions
- Despite these factors, and given indications of safe practice, reasonable patient access, and ongoing updates to state regulations, OPLR does not recommend any adjustments

Additional Recommendations:

- *Better align the profession-specific and universal endorsement pathways*

Other Considerations:

OPLR considered, but ultimately decided against making formal recommendations related to:

- 1) Pharmacist independent prescribing authority
- 2) Tech-Check-Tech
- 3) Additional sterile compounding regulation

Context

Consistent with its legislative mandate, the Office of Professional Licensure Review (OPLR) reviewed Utah's regulatory laws for the pharmacy profession. The review evaluated how well current regulations:

1. Protect the public from present and consequential physical and financial harm
2. Balance public and practitioner access to the occupation
3. Limit the economic impact of regulation on consumers, practitioners, and the state¹

OPLR's research for this review included analysis of Utah's current laws and rules, licensing and complaint data from the Division of Professional Licensing (DOPL), academic literature, health workforce data, as well as laws and policies in other states. OPLR also conducted interviews with practitioners, industry representatives, business owners, employers, educators, and other subject-matter experts. See [Appendix 1.1](#) for more information.

Background

Profession Overview

Pharmacists play a key role in the healthcare ecosystem. Their role varies significantly depending on their work setting, but in general, pharmacists are primarily engaged in dispensing, compounding, administering, and verifying prescription drugs. They also provide direct patient counseling regarding proper drug protocols, possible side-effects, and potential drug interactions. In a retail or community setting, pharmacists may provide medication management services under collaborative practice agreements with physicians and may independently prescribe and administer certain medications. In hospitals, in addition to these collaborative practice agreements, pharmacists may treat patients directly and dictate pharmaceutical interventions.

Pharmacy technicians work under the general supervision of pharmacists, assisting pharmacists with dispensing and compounding. In addition to filling prescriptions for patients for final review by a pharmacist, technicians also help with administrative tasks, such as processing insurance claims, tracking inventory, and filing paperwork.² Technicians may also perform higher complexity work, such as sterile compounding, administering vaccines, and certain verification tasks.

Pharmacists work primarily in retail and clinical settings. According to a 2025 HWIC/DOPL pharmacist workforce survey, approximately 30% of Utah pharmacists work in retail chain pharmacies, including grocery and big-box stores, 35% in healthcare facilities (19% inpatient,

¹ Utah Code § 13-1b.

² Mayo Clinic College of Medicine and Science, "Pharmacy Technician Career Overview."

16% outpatient), approximately 10% in academic institutions and in independent pharmacies respectively, 2% in mail order pharmacies, and 12% in other settings (e.g., PBMs, regulatory agencies).³

Pharmacy technicians are more concentrated in retail settings. From a similar survey of technicians, nearly 60% work in retail (43% in retail chains, 14% in independent pharmacies), 5% work for mail-service pharmacies, nearly 25% work in healthcare facilities (13% inpatient, 10% outpatient), 2% in academic institutions, and 13% in other settings (e.g., PBMs, regulatory agencies).⁴

Profession in Utah

Utah currently has 4,212 pharmacists, 387 pharmacy interns, 6,462 pharmacy technicians, and 1,784 pharmacy technician trainees.⁵

To obtain a pharmacist license in Utah, an applicant must have graduated and received a doctoral-level degree (PharmD) from a pharmacy school accredited by the Accreditation Council for Pharmacy Education (ACPE), completed an internship of at least 1,740 hours that meets ACPE standards, passed a criminal background check, and passed both the national exam (North American Pharmacist Licensure Exam, or NAPLEX) and the Utah Multistate Pharmacy Jurisprudence Examination (MPJE).⁶

To obtain a license as a pharmacy technician in Utah, an applicant must complete a 400 hour pharmacy technician program accredited by the American Society of Health-System Pharmacists (ASHP), the Accrediting Bureau of Health Education Schools (ABHES), or equivalent, and successfully pass either the Pharmacy Technician Certification Board (PTCB) exam or the Exam for the Certification of Pharmacy Technicians (ExCPT). The pharmacy technician education program must require completion of at least 180 hours of practical training in a licensed pharmacy, directly supervised by a licensed pharmacist in good standing. All applicants must also pass a criminal background check and attest that they have no mental or physical condition that would prevent them from practicing competently.⁷

While this report solely addresses individual licenses given to pharmacists and pharmacy technicians, DOPL also licenses pharmacies. There are five types of pharmacies in Utah, labeled class A through E.⁸ In Utah, there are 500 class A (12% of total pharmacy licenses), 340

³OPLR's analysis of the 2025 Health Workforce Information Center (HWIC)/Division of Professional Licensing (DOPL) Pharmacist Workforce Survey (total response rate=63%)

⁴OPLR's analysis of the 2025 HWIC/DOPL Pharmacy Technician Workforce Survey (total response rate=50%)

⁵DOPL Licensee Active Count 2024 Data, accessed February 18, 2026

⁶Utah Code § 58-17b-303

⁷Utah Code § 58-17b-305

⁸Utah Code § 58-17b-102. A class A pharmacy is a Utah retail pharmacy authorized to compound or dispense drugs or dispense devices to the public under a prescription order. A class B pharmacy is a Utah pharmacy providing pharmaceutical care in an institutional setting, including closed-door, hospital, clinic, nuclear, and branch pharmacies. A class C pharmacy engages in the manufacture, production, wholesale, or distribution of drugs or devices in Utah. A class D pharmacy is a nonresident pharmacy, meaning one located outside Utah that sells to a person in Utah. A class E pharmacy is the residual category covering all other pharmacies.

class B (8%), 1,499 class C (37%), 947 class D (23%), and 816 class E (20%) licensed pharmacies.⁹

Class A, B, and D pharmacies, which operate in retail, institutional, and non-Utah settings, require a Pharmacist-in-Charge (PIC). This covers almost 45% of all licensed pharmacies in Utah. A PIC is a licensed pharmacist who is responsible for ensuring that the pharmacy meets all laws and rules relevant to pharmacy practice and distribution of drugs, and who is personally in charge of the pharmacy and all staff.

Approaches in Other Jurisdictions

Every state licenses pharmacists, and every state regulates pharmacy technicians in some manner. The requirements for pharmacist licensure are very similar nationwide, although the scope of practice can differ substantially between states.

As in Utah, other states require pharmacists to complete a PharmD from an accredited pharmacy school, complete an internship, and pass the national exam and a jurisprudence exam.

Most often, the scope of practice for pharmacists in the United States includes compounding and dispensing medicines, immunization of some form, administration of naloxone, and some expanded forms of practice under collaborative practice agreements with physicians.¹⁰ States vary widely in how much independent authority they grant to pharmacists, meaning what a pharmacist can initiate without a prescriber involved. Six states grant broad independent prescriptive authority,¹¹ four of which adopt a standard-of-practice model.¹² The other states vary in their specific allowances. Common allowances for pharmacists include: prescription of contraception, HIV medication, tobacco cessation, and travel medications. Utah falls on the broader end of this range, allowing pharmacists to prescribe HIV medications, self-administered hormonal contraceptives, tobacco cessation, and naloxone.

Most states regulate technicians through registration. Thirty-three states register technicians, thirteen states license them, three states use certifications, and one, Delaware, requires no state credential at all.¹³ States that use registration typically set thin entry requirements (e.g., minimum age, high school diploma, criminal background check) and locate control of technicians in the workplace, chiefly through a numeric cap on technicians per pharmacist and increased responsibility for the PIC to attest to required training. States, like Utah, that use licensure typically also require a national certification (PTCB or ExCPT).

⁹ DOPL Licensee Active Count 2024 Data, accessed February 18, 2026.

¹⁰ 43 states authorize naloxone, all 50 authorize standard immunizations by some route, and 47 states authorize collaborative practice agreements in some form. OPLR Policy Scan, see [Appendix 1.3](#).

¹¹ These six states are California, Colorado, Idaho, Montana, New Mexico, and Oregon.

¹² These provide the broadest independent prescriptive authority where the pharmacist is constrained not by a formulary, statewide protocol, or collaborative practice agreement, but by generally applicable professional duties of demonstrated competence, a legitimate medical purpose within a patient-prescriber relationship, adequate patient assessment under the applicable standard of care, appropriate consultation and referral, and adequate documentation.

¹³ OPLR Policy Scan.

Scope of practice for technicians varies, and depends on the extent of a technician's training. Utah enumerates permitted tasks,¹⁴ while some states use a tiered system that allows technicians a broader scope if they have completed national certification. Others rely on a PIC to provide and attest to specific training of technicians in their pharmacy. Typically, technicians at the lowest tier of certification participate in product handling and data entry, while technicians in higher tiers can do things like accept a new prescription, clarify an order with the prescriber, or administer vaccines. In many states, with additional training or in specific acute settings, technicians can do some form of "tech-check-tech," the checking of a technician's order-filling accuracy by another technician rather than a pharmacist.

Regulatory Model Assessment & Recommendation

Framework

In an effort to standardize how appropriate regulatory models are determined for each profession (e.g. license, registry, or no regulation), OPLR developed a framework that incorporates its statutory review criteria.¹⁵ Appropriate models are determined principally by an evaluation of the potential for harm and related factors that may aggravate or mitigate the potential for harm. These factors include the availability of consumer choice, vulnerability of patients, and independence of practice. See [Appendix 2.1](#) for more information.

Recommendation

OPLR determined that licensing is an appropriate form of regulation for both pharmacists and pharmacy technicians despite heavy existing federal and state regulation of pharmacies. Significant considerations for this recommendation include: a risk of severe, permanent harm; the potential vulnerability of patients; information asymmetry; and the existence of independent practice.¹⁶

Potential for harm

Pharmacists occupy a distinct and important safety role in the prescription drug system. They act as the final check for prescribers by helping to determine the appropriateness of a drug regimen, verifying that the correct drug and quantity are dispensed to the correct patient, and educating patients on the proper use and side effects of prescriptions. In specific instances, they may also independently prescribe certain medications, structure and implement medication treatment plans, and administer drugs (e.g., vaccines).

¹⁴Utah pharmacy technicians can participate in compounding, prescription transfers, recorded telephonic intake, and delegated vaccine administration.

¹⁵Among other criteria, OPLR is required to evaluate "whether the regulation of the occupation is necessary to address a present, recognizable, and significant harm to the health, safety, or financial welfare of the public" and consider "potentially less burdensome alternatives to the... existing regulation". Utah Code § 13-1b-302.

¹⁶This is not a comprehensive list of all factors. Please see [Appendix 2.2](#) for more information on OPLR's analysis of the potential for harm related to pharmacy.

Pharmacy technicians perform much of the pharmacy work, although they do not determine the appropriateness of drugs or perform other work that requires advanced clinical knowledge. Technicians play a key role in preparing and verifying medications for patients.

Poor practice by either a pharmacist or technician can result in medication errors, which have the potential to result in severe and permanent patient harm, and even death.¹⁷

Pharmacists and technicians might also divert drugs for their own or others' use, which causes some financial harm to the pharmacy and may harm individuals in the community.

Compounding introduces additional risk. Pharmacists must ensure that the proper doses of the correct drug ingredients are combined in an appropriately sterile environment, and technicians perform much of the physical compounding. Incompetent compounding can result in medication errors or the introduction of bacteria or other contaminants into the medication. Failure to maintain proper sterility, especially for injectable drugs, has caused significant injury and death.¹⁸

Risk is exacerbated by the vulnerability of patients and the opacity of the dispensing process. While taking the wrong drug or receiving an excessive dose may not cause immediate or lasting harm to a person of average health, some individuals who take prescription drugs are vulnerable (e.g., chronically ill, pregnant, pediatric, or geriatric). Furthermore, there is information asymmetry between a pharmacist and a patient; dispensing and compounding occur without any patient oversight, and patients have few ways to verify that they are receiving the correct medication.¹⁹ Additionally, negative side effects can occur, especially for new medications and/or dosing, so a patient may not be able to determine whether they have the correct drug or dosage, even after taking it.

Related Harm Factors

Government and employer oversight mitigates some of the risks associated with pharmacy practice. Pharmacy technicians must work under the supervision of a pharmacist and, although pharmacists can operate independently, many in Utah work within large institutions (e.g., retail chains [~30%], hospitals and outpatient healthcare facilities [~35%] and universities [~10%]).²⁰ These institutions, particularly hospitals, may employ sophisticated technology, such as automated dispensing and barcode verification, or even AI medication therapy management systems, to provide additional guardrails or improve efficiency. These technologies have been shown to significantly reduce drug-related errors in these settings.²¹

¹⁷Tariq et al., "Medication Dispensing Errors"; Institute of Medicine, "Errors in Health Care."

¹⁸Kastango, "Lessons Learned from Compounding Tragedies."

¹⁹This mainly applies to prescriptions for new drugs or changes to existing prescriptions (e.g., new dose, moving to generic). There is less information asymmetry with refills; many patients can recognize whether a drug looks different from one they have been taking.

²⁰The 2025 HWIC/DOPL workforce survey administered by DOPL to pharmacists found that 84% of pharmacists do not work independently, and just ~10% work in an explicitly independent pharmacy.

²¹Agrawal, "Medication Errors"; Poon et al., "Effect of Bar-Code Technology."

Although independent practice is a small portion of the pharmacy landscape (10% of licensed pharmacists in Utah practice independently), it is still a nontrivial portion and an important segment of Utah community pharmacies.

Beyond any institutional oversight, state and federal agencies enforce operational standards. Pharmacies must be licensed in the state in which they physically reside, and in states to which they distribute. In Utah, the Division of Professional Licensing (DOPL) proactively inspects physical pharmacies and investigates both violations from inspections and complaints. Federal entities regulate drug manufacturing through the FDA, controlled substances through the DEA, and compounding facilities and supply-chain security through the Drug Quality and Security Act, signed in 2013.²²

While facility-level and pharmacy practice oversight is important, it does not eliminate the need for individual professional licensure. Because drug manufacturing and distribution carry significant risks, it is useful to have a dual-regulatory model that can regulate both the entity and the individual practitioner. Some practice failures are strictly individual (e.g., drug diversion, impaired practice, or clinical incompetence), while others may be systemic (e.g., compromised cleanrooms, expired stock, or lack of standard operating procedures). Without both levels of regulation, accountability becomes unclear and potentially unfair.

Dual regulation is also better for patient access. It is less disruptive to patients to revoke the license of one pharmacist than to revoke a pharmacy license.

Regulatory Model Adjustments & Recommendations

Framework

After determining an appropriate regulatory model, OPLR's framework also evaluates whether adjustments should be made within a recommended model to address any material and existing safety and access issues affecting the Utah public and practitioners. Regulatory model adjustments may include changing entry qualifications, the scope of practice, unprofessional or unlawful conduct, and/or supervision and independence provisions (see [Appendix 3.1](#)).

Safety Issues

OPLR found that pharmacists and technicians are generally practicing safely in Utah; however, anecdotal evidence suggests that some pharmacies may be engaging in unsafe compounding practices.

²² To comply with the DQSA, a pharmacy must confirm that its trading partners (e.g., manufacturers, repackagers, wholesale distributors, third party logistics providers) are appropriately registered or licensed, receive and maintain product tracing documentation, and report suspect or illegitimate drug products. US Food and Drug Administration, "Utilize DSCSA Requirements."

OPLR analyzed DOPL complaint data from 2017 to 2022 and found that pharmacists had a relatively high rate of substantiated complaints during this period compared to other professions, while technicians had among the lowest rates.²³ Although the pharmacist rate was initially concerning, OPLR's further analysis of those complaints revealed a concentration of substantiated complaints within a single year, skewing the complaint rate upward.²⁴ DOPL investigators confirmed that an audit of continuing education (CE) hours caused the spike in complaints. After adjusting for these violations, the pharmacist substantiated complaint rate dropped by 34%, from 4.4 to 2.9 per 100 practitioners, which is much more in line with adjacent healthcare professions, such as physicians.²⁵ Although falsely attesting to continuing education hours does represent a violation of the practice act, OPLR does not consider this a significant threat to the health and safety of the public.

OPLR's analysis of substantiated complaints, excluding those from the CE audit, did not reveal any concerning patterns. OPLR found relatively few complaints related to medication errors or drug diversion, two areas of potentially great concern. DOPL investigators confirmed that they investigate relatively few cases of either complaint type and have no concerns regarding the frequency of cases.²⁶

Issues with sterile compounding in Utah are hard to gauge due to reliance on anecdotal evidence and the recency of concerns about this topic. A plurality of pharmacist complaints (~40%, or 67 complaints, excluding those from the CE audit) related to "pharmacy violations", which covered a wide range of violations. OPLR sampled 15%, or 10, of these 67 complaints and, of the sampled complaints, half involved violations of compounding standards.²⁷ However, these complaints were mainly compliance-related (managing expiry dates, documentation of training, etc.) and resulted from inspection, not from a complaint about consumer harm. At the same time, DOPL investigators and many stakeholders have expressed concern to OPLR about the growth of sterile compounding in Utah over the past several years, primarily due to widespread demand for GLP-1s and other injectable weight loss drugs. DOPL estimates that the number of sterile compounders in Utah has increased from approximately 20 to 100 in the last few years alone.²⁸ OPLR's analysis of compounding pharmacy inspection logs from December 2022 through July 2026 does not support these concerns. Of fourteen identified

²³Between 2017 and 2022, pharmacists received 4.4 substantiated complaints per 100 practitioners. Technicians received only 0.6. The 2017–2024 rates are 4.7 and 0.6, respectively. Although OPLR advises against making exact comparisons to other professions, the pharmacist complaint rate warranted further investigation as it was at least 1.5 points higher than all other professions except for chiropractic and naturopathic physicians.

²⁴The audit occurred in 2018, when DOPL closed 104 complaints. The average number of closed complaints per year across all other years between 2017 and 2024 was ~18, dramatically lower than 104. OPLR conservatively estimated that 66, or 63%, of the 2018 complaints were due to the audit. See [Appendix 3.2](#) for more information on OPLR's complaint analysis.

²⁵The substantiated complaint rate for physicians during this timeframe was 1.9 per 100 practitioners for MDs and 2.2 for DOs.

²⁶OPLR found that in the DOPL data, medication errors and drug diversion could be labelled in multiple categories. Still, OPLR found that a theoretical maximum of complaints concerning these topics would still be fairly low, around 18% concerning diversion and 9% concerning medication error. A theoretical minimum concerning these topics results in 11% of complaints labeled as drug diversion and 7% as medication errors.

²⁷Of the ten sampled complaints, five related to compounding, three covered disparate topics, and two concerned controlled-substance inventory and management of expiry dates.

²⁸These estimates come from DOPL pharmacy licensing data verified by DOPL Pharmacy Inspection staff and inspection logs.

inspection failures (i.e., involving multiple violations), only three related to sterile compounding. While DOPL investigators shared details of concerning practices, none have been connected conclusively to an incident of public harm. However, limitations in DOPL data make it hard to quantify the extent of this issue,²⁹ and more recent sterile compounding violations may be reflected in pending DOPL cases or investigations that OPLR is not able to analyze.

Access Issues

OPLR found that the pharmacy workforce is generally sufficient. However, there are some potential issues affecting pharmacists (e.g., low growth in number of licenses, anecdotal concerns about the challenges of operating a retail or community pharmacy, reduced pharmacy program enrollment) that may indicate future access issues, although data is unclear.

The U.S. Health Resources and Services Administration's (HRSA) state-level estimates of pharmacy practitioner supply, demand, and percent adequacy³⁰ suggest Utah has a sufficient pharmacy workforce.³¹ HRSA forecasts suggest that Utah will remain above 100% adequacy for pharmacists and technicians every year between 2024 and 2038. HRSA estimates rank Utah as fifth highest in the U.S. on average for adequacy of pharmacist supply and ninth highest on average for adequacy of technician supply.³²

Other data may indicate a slightly smaller pharmacy practitioner workforce. OPLR's rough estimate of the number of actively working licensees in Utah falls 10% short of HRSA's 2025 demand estimate for pharmacists but exceeds HRSA's demand estimate for technicians.³³ Between 2014 and 2024, the number of pharmacist licenses in Utah grew at an annualized rate of 3.2%, and the number of technician licenses increased at 2.3%, modestly outpacing the growth in Utah's population during this period (1.8%). However, recent annualized growth in the number of pharmacist licenses has dropped to 1.9% between 2020 and 2025.

State workforce survey and licensing data indicates moderate-to-high workforce engagement for pharmacists and technicians. Survey data indicates that 80% of pharmacists and 64% of technicians work more than 33 hours per week, 74% of pharmacists and 54% of technicians work 40 or more hours per week, and the vast majority of licensees plan to continue working or even increase their hours (96% pharmacists, 91% technicians).³⁴ Looming retirement is likely not an issue for pharmacists; the average age of the workforce is ~44 years old, an increase of

²⁹A few major limitations include: 1) missing data on inspection logs' pass/fail or other details, 2) DOPL is reliant on complaints to investigate concerning practices, and 3) DOPL may receive federal data that it cannot share with OPLR due to privacy concerns.

³⁰Percent adequacy is a measure of how well forecasted supply meets forecasted demand.

³¹HRSA estimates include a variety of workforce factors. Supply estimates include exam pass rates, 40-hour work week (which may lead to undercounting for roles working <40 hours), and workforce attrition, but do not account for new programs or program growth. Demand estimates include population growth and demographic projections, health risk factors, and provider ratios.

³²OPLR found the average percent adequacy across the time period 2024–2034 for each state. Health Resources and Services Administration, "Health Workforce Projections."

³³DOPL Licensee Active Count 2024 Data, accessed February 18, 2026.

³⁴OPLR's analysis of the 2025 DOPL Pharmacy Technician Workforce Survey; OPLR's analysis of the 2025 DOPL Pharmacist Workforce Survey.

only 2.5 years between 2014 and 2024. The upper percentiles of pharmacist age have barely increased during this time.³⁵

Turnover of licensed technicians is high, but this has not worsened over time. OPLR compared a cohort of licensed technicians that became inactive in 2014 to a cohort who became inactive in 2024 and found that 25% in both cohorts held their license for fewer than three years.³⁶ Turnover could be due to wages,³⁷ working conditions,³⁸ or an advancement ceiling due to the large educational gap between technician and pharmacist. Only 8% of technicians licensed in Utah advance to a pharmacist intern license,³⁹ and this group likely already planned (or quickly decided) on pharmacy as a career.⁴⁰

Technicians face limited barriers to entering that occupation. There are at least 16 accredited programs in Utah, and many employers offer training, which may be approved by DOPL.⁴¹ Programs in Utah range from four months to one year and typically cost between \$1,500 and \$3,000.⁴² Many programs allow high school students to attend, for whom education costs a negligible amount (\$0-\$500).⁴³ 77% of technician workforce survey respondents indicated that they graduated with no debt. This estimate increases to 84% when only respondents who graduated in the last ten years are considered.

Pharmacists face more significant barriers to entry, similar to those in many other doctorate-level healthcare professions. There are two pharmacist programs in Utah, with tuition ranging from roughly \$110,000 to \$205,000.⁴⁴ Although pharmacists earn far more than the median salary in Utah,⁴⁵ they also graduate with substantial debt. The median pharmacist surveyed reported education debt levels of \$60,000 to \$80,000 upon graduation, but pharmacists who graduated between 2015 and 2024 reported median debt levels of \$140,000–\$160,000.⁴⁶

Despite a fairly robust pharmacist and technician workforce in Utah, many pharmacies face

³⁵DOPL Licensee Active Count 2024 Data, accessed February 18, 2026, OPLR analysis.

³⁶ 2.7 years for those in 2014, 2.9 for those in 2024. DOPL Licensee Active Count 2024 Data, accessed February 18, 2026.

³⁷U.S. Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics Query System, 2024. Technicians in Utah earn \$22 per hour, although this is higher than reported national wages.

³⁸ A national survey of pharmacy technicians reported heavy workloads, low pay, and lack of time as top challenges in their day-to-day jobs. American Society of Health-System Pharmacists, Pharmacy Technician Shortage Survey.

³⁹Only 6.4% become licensed as a pharmacist in Utah.

⁴⁰ This group held their pharmacy technician licenses for an average of 3.8 years (median of 3.1 years) before obtaining a pharmacy intern license, implying that many became a technician during the first years of their undergraduate degree. DOPL Licensee Active Count 2024 Data, accessed February 18, 2026, OPLR analysis.

⁴¹ASHP Technician Program Directory.

⁴²Accreditation standards mean that programs must be at least 400 hours and occur over a period of at least eight weeks. These figures include both public and private programs.

⁴³ OPLR Pharmacy Technician Program Analysis.

⁴⁴Tuition estimates are from the program websites for the University of Utah and Roseman University of Health Sciences. The lower end of the tuition range reflects in-state tuition at the University of Utah while the higher end reflects out-of-state tuition. Roseman, a private university, costs roughly \$195,000. The University of Utah lowered the cost of tuition in 2023 by offering free full tuition for all students' first year.

⁴⁵The annual median salary for pharmacists in Utah is \$136,230, while the annual median salary in Utah is \$93,030. Utah Department of Workforce Services, "Annual Wages and Income by County."

⁴⁶OPLR's analysis of the 2025 DOPL Pharmacist Workforce Survey.

challenging economic forces. OPLR heard some anecdotal concerns about more limited hours at some community pharmacies,⁴⁷ and national and state data shows a slight decline in the number of pharmacies over the last 10-15 years.^{48,49} The national study found that, while the number of independent pharmacies increased over the study period, those pharmacies also experienced a high churn rate.⁵⁰ There are multiple economic factors at work, making it very hard to draw any conclusions about access. Some of these factors include insurer reimbursement practices creating financial pressure for independent pharmacies, consolidation within both the pharmacy and healthcare industries, shifts in consumer preferences toward e-commerce, and the establishment of direct-to-consumer online pharmacies.⁵¹

Enrollment in PharmD programs has dropped nationally, but this could also be in response to a range of factors.⁵² Enrollment has declined from a high of approximately 64,000 students in 2014 to approximately 42,000 in 2024, the lowest enrollment figure since 2002.⁵³ During this timeframe, the number of pharmacy intern licenses in Utah decreased 6.3% annually.⁵⁴

In contrast, enrollment in pharmacy technician programs does not appear to be an issue. For example, completion of Utah System of Higher Education (USHE) technician programs grew approximately 75% in total between 2020 and 2025.⁵⁵

Another possible access issue that OPLR considered is rural access. However, multiple statutory changes have already been made in Utah to address this concern. One recent geographic analysis of pharmacy deserts nationally found that 6.8% of the adult Utah population (~210,350 individuals) lives in a pharmacy desert, which is higher than the national median of 4.8%, but slightly lower than the median among mountain and north-west states (7.8%).^{56,57} Utah statute exempts pharmacies in designated areas of need from the requirement to have a supervising pharmacist physically in the facility, instead allowing the pharmacist to be available via telepharmacy for immediate contact with a pharmacy intern or technician. Additionally, Utah has specific classes of pharmacy for remote areas, namely, branch and remote dispensing

⁴⁷Stakeholders primarily expressed concern regarding severely reduced and/or inconsistent hours of availability for some stores within large retail chains due to the perceived inability of those businesses to properly staff certain pharmacies.

⁴⁸Nationally, the number of community pharmacies decreased slightly from 61,054 to 60,354 between 2010 and 2023. Mattingly, Sahu, and Anderson, "Community Pharmacy Turnover."

⁴⁹DOPL Pharmacy Location Data.

⁵⁰Churn is defined as the sum of pharmacy openings and closings during the time period divided by the total number of pharmacies at the beginning of the time period.

⁵¹Mattingly, Sahu, and Anderson, "Community Pharmacy Turnover."

⁵²For example, in 2018 the Utah Medical Education Council's report on the pharmacy workforce suggested a potential over-supply of pharmacists in the workforce. Dropping enrollment could be a reflection of this oversupply correcting. Utah Medical Education Council, Utah's Pharmacist Workforce, 2018.

⁵³American Association of Colleges of Pharmacy (AACP) profile of pharmacy students.

⁵⁴DOPL Licensee Active Count 2024 Data, accessed February 18, 2026, OPLR analysis.

⁵⁵Utah System of Higher Education, "Institutional Data Resources."

⁵⁶Authors defined a pharmacy desert as both low income and low access, where low access means that at least one-third of the population is living 1, 5, or 10 miles from a pharmacy depending on urbanicity and low income means that the census tract has either (1) 20% or more of its population living below the federal poverty Level or (2) a median household income that is less than 80% of the median income of the nearest metropolitan area. Wittenauer et al., "Pharmacy Deserts in the United States."

⁵⁷OPLR included the following as mountain/north-west states: AZ, CO, ID, MT, NV, NM, UT, WY, OR, WA

pharmacies. Branch pharmacies are for rural or medically underserved areas and can be supervised by a pharmacist in another licensed pharmacy.⁵⁸ A remote dispensing pharmacy is only in an “area of need,” and is a site where patients receive telepharmacy services.

Discussion

Nationally, illegal or unsafe sterile compounding practices have garnered attention through FDA reports and warnings.⁵⁹ Despite hearing concern about sterile compounding violations, OPLR does not recommend statutory change at this time. This is because: 1) OPLR was unable to adequately verify the relative frequency and the severity of sterile compounding issues, 2) compounding violations tend to be entity/facility-level issues, not individual-level issues, which means they are somewhat outside OPLR’s scope of review, and 3) it appears that major compounding violations may be due to purposeful non-compliance rather than a lack of regulation given extensive federal and state law on this topic.⁶⁰ OPLR considered potential ways to improve DOPL’s ability to enforce sterile compounding regulations. See the Other Considerations section for this discussion.

Utah has a robust workforce, though the industry and workforce are changing rapidly. Given that data does not indicate current access issues in Utah, OPLR does not recommend changing licensure requirements for pharmacists or technicians. Instead, OPLR recommends that the state continue to monitor the pharmacy workforce.

Additional Recommendations

Better align the profession-specific and universal endorsement pathways

One avenue to licensure in Utah for pharmacists from other U.S. states is through a profession-specific endorsement pathway. Among other requirements, applicants must demonstrate they have worked under an pharmacist license for at least 2,000 hours in the four years immediately prior to their application.⁶¹

In 2020, the Utah Legislature approved a universal endorsement framework within DOPL, which allows out-of-state applicants to obtain licensure in Utah with at least one year of work in a similar scope of practice on a license that is in good standing.⁶²

OPLR recommends evaluating these pathways and bringing them into alignment as appropriate. This recommendation is consistent with other healthcare professions OPLR

⁵⁸ Utah Code § 58-17b-102(8), (11)(b)(i).11)(b)(i)

⁵⁹ US Food and Drug Administration, "Unapproved GLP-1 Drugs"; Williams, "Compounded GLP-1s."

⁶⁰ OPLR considers major compounding violations to be those with multiple, high-risk violations of compounding standards. Noncompliance with one or two small standards may be due to a lack of knowledge; noncompliance with nearly all major standards typically implies purposeful rejection of the laws.

⁶¹ Utah Code § 58-17b-303(3)

⁶² Utah Code § 58-1-302

reviewed in 2026 (e.g., physicians, naturopathic physicians, dentists and dental hygienists, and chiropractors).

Other Considerations

Independent Prescribing Authority

OPLR considered a recommendation to expand the scope of independent prescribing authority for pharmacists. This is an area in which some other states allow expanded and/or more flexible practice than Utah does. OPLR decided not to recommend any changes for several reasons related to existing flexibility in Utah law.

First, there is already a mechanism to expand pharmacist prescribing scope through DOPL rulemaking, albeit one that is deliberative and likely slow.⁶³ Second, increased public access to pharmacists' skill sets is constrained by the major time commitment that community dispensing requires, and the lack of current industry mechanisms to easily reimburse pharmacists for time spent counseling patients.

While a recent change in Utah statute requires insurers to treat pharmacists as providers when they provide patient consultations,⁶⁴ insurers currently lack reimbursement practices targeted to the retail setting of community pharmacy.⁶⁵

Further, Utah's collaborative practice agreement framework enables pharmacists to engage in a very broad scope of practice.⁶⁶ The pharmacists OPLR spoke with are positive about this framework, but also note that it may be challenging for some pharmacies to establish these collaborative agreements, making the framework less far-reaching.

Tech-Check-Tech

OPLR also considered recommending expansion of tech-check-tech (TCT) to retail/community settings, but ultimately decided against this despite a few states in the U.S. allowing the practice.

Current DOPL rule specifies that only technicians in class B hospital settings can verify medications prepared for distribution to an automated dispensing cabinet, cart fill, crash cart,

⁶³Utah Code § 58-17b-627 states that "The division shall make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to designate the prescription drugs or devices that may be prescribed by a pharmacist under this section, beginning with prescription drugs or devices that address a public health concern that is designated by the Department of Health and Human Services."

⁶⁴S.B. 312, 2025 Gen. Sess. (Utah 2025).

⁶⁵OPLR Stakeholder Series, see [Appendix 5.1](#).

⁶⁶Utah Code § 58-17b-102 (17). This enables the pharmacist to design, implement, and monitor a therapeutic drug plan which targets a specific patient's disease or symptoms.

medication tray, or unit dosing, if technicians are supported by sufficient automation or technology, such as barcode scanning, drug identification automation, checklists, or visual aids. to ensure accuracy.

Currently, seven states allow TCT in retail/community settings, but there is an absence of data showing evidence of safe practice.⁶⁷

One 2016 study conducted an analysis of the existing evidence on TCT safety in community settings. It found that TCT may be appropriate in retail or community settings that can meet the same standards as a hospital, so long as technicians are trained further, given increased risk from the length of patient prescriptions generally and the absence of additional checks.⁶⁸

Hospitals that authorize TCT must follow extensive protocols,⁶⁹ and it may not be feasible for a retail or community pharmacy to meet similar standards. TCT in hospital settings involves additional nurse checks before dispensing medication to the patient, and there is not a similar analog in community pharmacies.

Utah already has a broad scope of practice for technicians,⁷⁰ and pharmacist stakeholders with whom OPLR spoke did not believe that allowing TCT in community settings would meaningfully decrease pharmacists' workloads.⁷¹

Finally, state educators with whom OPLR spoke expressed hesitancy about this proposal given existing technician training and the difference in technology and operating practices between hospital and community settings.⁷²

Sterile Compounding Enforcement

OPLR considered the anecdotal concerns raised about sterile compounding practice in Utah and found that this issue arises despite considerable existing regulation on compounding practices and federal and state oversight of this issue.

DOPL currently requires pharmacies to disclose, upon license renewal every two years, whether they are participating in sterile compounding. DOPL also conducts random inspections of pharmacies and has the ability to cite them for violations. It is possible that DOPL's data-collection and enforcement practices could be tightened, or that more enforcement resources are needed; however, OPLR was unable to verify this.

⁶⁷Those seven states are Iowa, Illinois, Missouri, Montana, Oregon, Vermont, and Wisconsin. OPLR Policy Scan.

⁶⁸Frost and Adams, "Tech-Check-Tech."

⁶⁹Utah Admin. Code R156-17b-601 This protocol includes documenting training and having specific technologies that have an error reporting system, process for maintaining a permanent log of unique initials, or having a description of the automation or technology used by the institution to augment the technician check.

⁷⁰Pharmacy Technician Society, "State Spotlight: Utah.", OPLR Policy Scan.

⁷¹OPLR Stakeholder Series.

⁷²OPLR Stakeholder Series.

The Legislature could add a study item directing DOPL to evaluate whether additional investigative resources are warranted. Any resulting needs could be included in the Department of Commerce's budget requests to the Governor's Office of Planning and Budget (GOPB) next year.

Rule Review

In accordance with Utah Code § 13-1b-203(5), OPLR conducted an in-depth review of DOPL's pharmacy rules, found in Utah Administrative Code R156-17b.

The rule review covered potential rule changes needed to:

1. address specific rules that may be overly burdensome (e.g., for individuals seeking to practice a profession or given the potential risk to public safety from a profession) or insufficient (e.g., to ensure safe practice);
2. address rules misaligned with statutory language;
3. clarify language, and correct references to statute or other rules; or
4. support OPLR's recommendations.

OPLR's review of R156-17b found:

1. One instance of a burdensome rule. R156-17b-621a(1)(b) requires long-acting injectable training from an ACPE-accredited provider, which excludes an equivalent hospital or manufacturer competency program regardless of content. OPLR recommends providing a way to approve another accreditor if needed.
2. Using DOPL's newly rewritten R156-17b,⁷³ OPLR found no rules misaligned with statutory language, no instances of unclear language, and seven incorrect references to statute or other rules, outlined in [Appendix 4](#).
3. No rules will be written to support OPLR's recommendations.

⁷³As of September 15, 2026, OPLR is using DOPL's rewritten rules, which are currently being filed.

Appendix

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1. Context

1.1 General Research Methodology

OPLR's methodology combines qualitative and quantitative methods with stakeholder engagement. Methods include:

- Analyzing data from workforce surveys administered by the Division of Professional Licensing (DOPL) as part of licensure renewal
- Conducting quantitative analysis of DOPL licensee and complaint data and publicly available data from other state and federal government entities (e.g., DWS, BLS) as well as relevant industry associations
- Reviewing academic literature and reports on a profession's practice, efficacy and safety
- Scanning education and credentialing requirements, programs and content
- Reviewing state occupational regulation policies across the U.S.
- Engaging with a wide range of stakeholders, including: Utah and other state governments and agencies, industry organizations, researchers, practitioners, and business owners and employers within a variety of settings

1.2 DOPL Pharmacy Renewal Survey

A. Survey Overview

OPLR used a Utah workforce survey available to pharmacists and technicians during their 2025 renewal period for information on the workforce in Utah. The survey was administered by DOPL for use by the Utah Health Workforce Information Center (HWIC) to inform legislators and the public about workforce trends and projections.⁷⁴

B. Survey Limitations

The survey was available to all licensed pharmacists and technicians during the license renewal process so results were not affected by sampling bias. Additionally, the response rate was high, around 63% for pharmacists and 50% for technicians. However, results still may be affected by non-response bias (e.g., if those who chose to respond to the survey shared characteristics not representative of the true population). This may be especially true for specific survey items, like primary practice location, for which only 75% of pharmacist survey respondents gave a legitimate response. As a result, the overall population represented for that item is roughly 48% and less likely to represent the population.

Other possible limitations include measurement error (which occurs when questions do not accurately measure the variable of interest due to errors in question design) and recall bias (which occurs when respondents misremember and inaccurately answer questions). For

⁷⁴ Utah Health Workforce Advisory Council, *Utah Pharmacist Workforce Survey*, Utah Health Workforce Advisory Council, *Utah Pharmacy Technician Workforce Survey*.

example, recall bias may impact the estimates of hours worked per week or debt at graduation. All of these potential errors may cause some variability or systematic bias.

OPLR uses this to provide background understanding of a profession, outline patterns, and identify general trends rather than to provide exact estimates. Therefore, the limitations articulated above should not unduly impact OPLR's findings or recommendations.

1.3 Pharmacy Policy Scan

To better understand the regulatory environment for pharmacists and pharmacy technicians, OPLR conducted a review of state occupational regulation in the U.S., which made use of industry resources, NotebookLM, Westlaw Advantage's AI Jurisdictional Survey tool, Vulcan's Justinian AI agent, and manual statute analysis. Results of the policy scans were used to both understand the regulatory landscape as well as to inform recommendations.

OPLR then used Westlaw's AI Jurisdictional Survey tool to engage in an in-depth review of the 50 states to understand the scope of practice, practice requirements and prescriptive authority. These results helped shape OPLR's initial research and primarily informed conclusions about the scope of practice.

The following prompts were used for Westlaw's AI tool:

- What are pharmacists allowed by rule or statute to prescribe in each state?
- What are the training and entry requirements for pharmacy technicians in each state, and what is their scope of practice?

OPLR also used Vulcan's Public Policy AI Justinian Agent to validate and construct more detailed policy scans on pharmacists and pharmacy technicians. This model provides extensive citations and sources, and limits its data to state law and statute. OPLR validated the sources from which Justinian derived policy scan information.

The following prompts were used for the Justinian tool:

- Make me a policy scan in a google sheets file that compares the scope of practice, training requirements, and licensure of pharmacy technicians in all 50 states. I also want to know how they differ from Utah specifically.
- I am looking for a 50-state policy scan on pharmacist scope of practice and where this differs among states. I'm less interested in requirements for licensure and more so scope of practice. I'm also interested in the states with a standard of practice model and a more expansive prescriptive authority. Make this scan in a csv format that I can export. Make sure to include sources in the statute.

This review does contain limitations related to normal human error. It is possible that there is slight misreporting of some data due to limited accessible state information, errors in data entry, or mistakes made by NotebookLM or Westlaw's AI tool that were not caught by OPLR's manual verification. This is an especially salient issue for specific policy scan prompts that asked

whether certain states had adopted a specific policy. Many states remain silent on issues of scope, and the Westlaw AI tool will exclude states in which it does not find any relevant information. It is therefore difficult to validate the “non-answers,” and it is possible that OPLR may have missed certain states that have adopted specific policies if Westlaw did not include them. States also take different enforcement approaches regarding “silent” issues; some may consider them out of scope while others might not. Therefore, certain numerical estimates may underestimate the true number of states that have adopted a specific policy. Still, potential bias or measurement error introduced by these limitations likely did not substantially alter any information.

2. Regulatory Model Assessment & Recommendations

2.1 Menu of Regulatory Models

Please see [this working document](#), OPLR’s *Occupational Regulation Framework*, for a more detailed explanation of OPLR’s approach to assessing occupational regulation and evaluating different regulatory models.⁷⁵

2.2 Model Assessment of Pharmacy

The following table summarizes OPLR’s analysis of pharmacy according to factors that OPLR determined should influence the appropriate regulatory model for an occupation. Factors that OPLR considered particularly determinative in its assessment are highlighted in bold.

Model Assessment of Pharmacists and Pharmacy Technicians	
Harm Factors	
Mechanism of Harm	Medication errors (e.g. incorrect drug or dosing), unsanitary compounding, drug diversion, inappropriate prescribing by pharmacists.
Severity, Permanence, and Likelihood of Harm	High likelihood of severe injury if untrained; low likelihood of severe injury if trained. For technicians the likelihood is moderate if untrained, low if trained.
Consequence of Error ⁷⁶	96 for pharmacists, 75 for pharmacy technicians
Downstream Impact	High
Consumer & Setting Factors	

⁷⁵The document is also available on OPLR’s website in the “About OPLR” section, accessible here: <https://commerce.utah.gov/oplr/about/>

⁷⁶O*Net rates professions on a 100-point scale based on the seriousness of a consequence of making an error. OPLR has not been able to confirm the legitimacy of their methodology, so while this ranking is a consideration, OPLR does not consider it a deciding factor. National Center for O*NET Development, “Consequence of Error.”

Patient Vulnerability	Variable; treats all ages, conditions, and levels of acuity
Frequency of Physical Touch	Rare, only when administering drugs or tests
Frequency of Private Setting	Rare for pharmacists, likely only when engaging in 1:1 patient counseling. Technicians rarely treat patients in private settings.
Information Asymmetry	Very high. It may be difficult for a patient to ascertain whether they have been dispensed the correct drug or dosage (especially in cases of incorrect labeling) or to avoid inadvertent adverse drug interactions
Related Factors	
Level of Independence	Structural: Moderate. Although licensees primarily work within large institutions, roughly 10% work in independent pharmacies. Low for technicians, who must work under general supervision of a pharmacist. Clinical: High for pharmacists. Pharmacists serve as the final check for prescribers, independently evaluate the appropriateness of a drug, create compounded drugs, and may independently prescribe in some cases. In collaborative practice agreements, they structure and implement medication plans. Low for pharmacy technicians, although the scope of a technician is quite broad.
Patient Choice	Low to moderate. Patients may choose their retail pharmacy; ⁷⁷ they typically cannot choose the pharmacist or technician attending them.
Information Availability	Low to moderate. Patients can use online reviews and word of mouth in choosing their pharmacy, but there may be limited information on the pharmacists and/or technicians.
Level of Oversight	Employers: Moderate. The majority work within large institutions, while some work in independent pharmacies with little to no employer oversight. Employers can vary in complexity and sophistication of pharmacy practice. Government: High. State and federal government agencies oversee the regulation of pharmacies outside of DOPL, although federal enforcement resources are spread nationally. Private Bodies: Low to moderate. Few seek private certifications and there is little payor oversight due to lack of reimbursement, but

⁷⁷ This is not universally true. Some individuals may face insurance and/or geographical constraints that severely limit their ability to choose.

	there is oversight from PBMs and some physicians (e.g, in a collaborative practice agreement).
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3. Regulatory Model Adjustments & Recommendations

3.1 Possible Adjustments

Please see [this working document](#), OPLR’s Occupational Regulation Framework, for a more detailed explanation of how OPLR approaches whether adjustments should be made within a recommended regulatory model.⁷⁸

3.2 DOPL Complaint Data

The Division of Professional Licensing (DOPL) receives complaints from individuals, other state agencies, co-workers, professional associations, and licensing boards. DOPL is required to “investigate unlicensed practice in regulated professions, acts or practices inconsistent with recognized standards of conduct, allegations of gross negligence or incompetence, and patterns of gross negligence or incompetence”.⁷⁹ Violations that meet the criteria for investigation are then prioritized and assigned to an investigator. DOPL may resolve investigations in a variety of ways, including: closing an investigation due to a lack of evidence; referring the case to another agency or to law enforcement if appropriate; carrying out informal or formal administrative sanctions or stipulated agreements; issuing a citation; or denying, suspending, or revoking an individual’s license.

To analyze complaints sent to DOPL, OPLR used My License Office (MLO) and Salesforce to access closed complaints investigated by DOPL between 2017 and 2024. This data contains information on the license name, the complaint type, and the disposition of the complaint, among many other data fields not relevant to OPLR’s analysis. DOPL personnel helped code the complaint dispositions as substantiated, unsubstantiated, or no jurisdiction. Substantiated complaints are those in which a disposition includes some type of disciplinary action, whether formal or informal (e.g., letter of concern, verbal warning, surrender of license). Unsubstantiated complaints have dispositions without a disciplinary action (e.g., dismissed, lack of evidence, unfounded). ‘No jurisdiction’ complaints are complaints that may or may not have a basis, but DOPL was not able to take action on the cases.

OPLR filtered complaints to exclude any likely duplicates and then used substantiated complaints to calculate the number of complaints per license type or profession. OPLR estimated the complaint rate for each license type by dividing the number of substantiated complaints by the number of unique individuals who held that license type over the same period.

⁷⁸The document is also available on OPLR’s website in the “About OPLR” section, accessible here: <https://oplr.utah.gov/about-oplr/>

⁷⁹Utah Division of Occupational and Professional Licensing, Complaint Process.

Continuing Education Citation Adjustment

OPLR found that the spike in the number of substantiated pharmacist complaints occurred due to a continuing education audit in 2018. To adjust for these complaints, OPLR excluded any cases found highly likely to be related to continuing education in that year alone. Investigators explained that all CE cases were labeled as “ethical standards”, and OPLR found that nearly all “ethical standards” complaints were identical in both disposition and the length it took to resolve. Therefore, OPLR assumed that any ethical standards complaint from 2018 was related to the continuing education audit if it both: 1) resulted in a citation and 2) was resolved in less than one month.

Investigators confirmed the validity of OPLR’s approach,⁸⁰ and OPLR took a random sample of 6 of the cases (about 10%) and confirmed that all were related to the audit.

Complaint Case Notes Analysis

A more detailed analysis of historical case notes was conducted on a sample of pharmacist complaints closed between 2017-2024. A rough stratified random sample was drawn from all complaints categorized as substantiated, with stratification based on complaint type. Complaint types more likely to include client harm (i.e. medication error, drug diversion, incompetence/negligence) were oversampled, while all complaint types with 4 or fewer instances were excluded.⁸¹ OPLR analysts read through case notes from 36 complaints and for each complaint summarized the issue, noted whether or not client harm occurred or potentially occurred, and if harm was present, the type and severity.

Inspection Log Analysis

OPLR was provided with all inspection logs involving compounding pharmacies from 2023-2026. These logs included information on whether a pharmacy passed or failed their inspection, and any notes the investigator decided to leave. Not all fields were filled in for every inspection, and it is possible that more pharmacies failed inspection than were noted in the logs. The finding that three failed inspections involve sterile compounding is then a minimum number and could be higher. None of the logs included information on patient harm.

Limitations

There are significant limitations to these analyses, and the information collected should not be interpreted as a precise estimate of harm caused by pharmacy licensees. DOPL data likely underestimates true harm, as many instances of harm may be handled in other ways (e.g., directly by employers), reported to other entities, or may never be reported. Additionally, some

⁸⁰Investigators believed it was likely that all 73 ethical misconduct complaints were related to the CE audit, but OPLR took a slightly more conservative approach to only include those which shared nearly identical components (66).

⁸¹Examples of excluded categories include: failure to report to database, aiding unlicensed practice, prescription fraud, and probation violation. Probation violation technically had 5 instances, but OPLR felt it was unlikely to be related to patient harm and prioritized other complaints.

unsubstantiated complaints may have resulted in harm but the necessary evidence was not produced.

There could also be latent factors correlated with both the likelihood of complaint and the profession, systematically biasing the comparisons across professions. This is especially true in healthcare, as certain professions, by their nature, include a greater potential for harm and may generate more complaints.

Furthermore, OPLR had limited access to complaint information. Any detail not included in the investigator's final summary could not be considered here and missing context can lead to incorrect categorizations of the nature of harm.

For these reasons, OPLR uses DOPL complaint data as directionally informative, but typically avoids direct comparisons across professions wherever possible.

3.3 DOPL Licensee Data

OPLR used DOPL licensee data queried in October of 2025 to conduct analyses on the number of licensees per year. The dataset included individuals first licensed after 1970 to those actively licensed as of January 2026. Each row in this dataset is a unique combination of individual and license type and contains information regarding when the license was issued, the status of the license, the date the status was last updated, and the sex and year of birth of the individual. OPLR estimated the number of licensees in each year by summing the number of unique individuals whose licenses were active during any point in each year. Additionally, OPLR excluded any individual with a null or incorrect value for their license issue date and license expiration date, as OPLR could not determine how long or for what years they were actively licensed. License counts may slightly underestimate the true number of licensees due to this, but the effect is fairly negligible given OPLR's use of the data to determine trends over time rather than estimate with precision for specific dates.

OPLR also used the licensing data to conduct additional analyses. To perform the pharmacist age analysis, OPLR found the age of each licensee who was active in a given year, according to that year and the birth date on their license. OPLR then grouped the data by year and found descriptive statistics for the age of licensees actively practicing in each year. Licensees without a birth date or with unreasonably high ages were excluded from the analysis.

Pharmacy Technician Turnover Analysis

OPLR's analysis of pharmacy technician turnover used DOPL pharmacy licensing records to understand how long pharmacy technicians kept their licenses active. OPLR divided exit years into two-year blocks that matched the biennial renewal cycle so that turnover could be compared across cohorts over time. The reported results are a median technician tenure of about 5.3 years, with roughly a quarter of departing technicians leaving before 3 years. A comparison of the 2014-2015 and 2024-2025 exit cohorts show that early attrition has not accelerated.

There are limitations of this analysis. License status is only a proxy for employment, so a lapse cannot distinguish leaving the occupation from retiring, relocating, or continuing to work without renewing.

4. Rule Review

OPLR identified the following incorrect references in the Pharmacy Practice Act Rule (R156-17b):

Rule	Incorrect Reference	Correct Reference
R156-17b-102(75)	Subsection 58-17b-608.1(7)	58-17b-608.2(7)
R156-17b-402, Table 1	Duplicate citation (R156-17b-502(5)). Two consecutive rows cite the same subsection but set different penalties (\$100-\$200 / \$200-\$500 and \$500-\$1,000 / \$2,000-\$10,000). R156-17b-502(5) has no lettered subparts, so the two rows cannot both be correct.	DOPL should decide which penalty level is correct.
R156-17b-614a(2)(b)(ii)	Title 26B, Chapter 21, Part 2, Health Care Facility Licensing and Inspection	Title 26B, Chapter 2, Part 2
R156-17b-615(15)	Subsections R156-17b-102(20)(c) and R156-17b-615	Indeterminate, perhaps R156-17b-102(21)
R156-17b-625(1)	Subsections 26B-4-510(2)(c) and (d)	26B-4-510(3)(c) and (3)(d)
R156-17b-625(5)	Subsection 26B-4-510(2)(d)	26B-4-510(3)(d)
R156-17b-1005	58-37-1	Title 58, Chapter 37 (no successor section)

5. Stakeholder Outreach

5.1 OPLR Stakeholder Series

OPLR relied heavily on stakeholder engagement and qualitative interview data, combined with OPLR's other analysis, to conduct this review and develop recommendations. OPLR engaged with practitioners, industry associations, employers, and Utah and other state regulators. OPLR prioritized diversity of perspective and relevance to the industry in selecting stakeholders.

Interviews were conducted via video conferencing using semi-structured interview methods; they were conducted one-on-one and with multiple members. Extensive notes were taken for all interviews.

OPLR conducted initial interviews to understand the pharmacy profession, determine potential issues related to safety and access, and identify potential areas for change. OPLR engaged with stakeholders later in its review to test initial findings from analysis and preliminary recommendations. OPLR reflected on and synthesized feedback across multiple discussion sessions to develop clear and achievable evidence-based recommendations.

Limitations

This interview sample was not randomly selected and, therefore, is not completely representative. OPLR spoke to individuals most likely to represent the broad aims and concerns of their groups. Additionally, OPLR did not contact pharmacist patients, so their perspectives were not incorporated into this review. Thus, the stakeholder engagement and findings from these interviews should not be understood to be fully representative of the views of all Utahns, DCs, or any other person, group, or population.

Note that stakeholders' views are not always reflected in OPLR's recommendations. OPLR is directed by Utah Code 13-1b-302 to apply specific review criteria. These can and do lead to recommendations that diverge from stakeholder preferences. A stakeholder's appearance here is not an endorsement of OPLR's recommendations as such.

5.2 Stakeholder Engagement Summary

Stakeholder Engagement Summary	
Government Stakeholders	
Utah Department of Commerce	Deborah Blackburn , Assistant Division Director, Division of Professional Licensing Travis Drebing , Lead Pharmacy Investigator, Division of Professional Licensing Jim Garfield , Bureau Manager, Division of Professional Licensing Lauren Harvey , Legal Analyst, Division of Professional Licensing Maddy Holt , Pharmacy Program Specialist, Division of Professional Licensing Lisa Martin , Bureau Manager, Division of Professional Licensing Mark Steinagel , Deputy Commissioner, Department of Commerce & Director, Division of Professional Licensing
DOPL Board Members	Chris Cox , DOPL Advisory Committee Chair, Owner and Pharmacist at Smith Rexall Drug Karen Gunning , DOPL Board Member, Professor of Pharmacotherapy, Residency Program Director, Clinical Pharmacist at the University of Utah Gary Hale , DOPL Board Vice Chair Matthew Higley , DOPL Board Chair, Chief Pharmacy Officer, Intermountain Health Chris Sheard , Past DOPL Board Chair, VP of Pharmacy, Associated Food Store
Other State Governmental Agencies & Members	Thomas Davies , Pharmacy Director, Utah Medicaid Ngan Huynh , Assistant Pharmacy Director, Utah Department of Health and Human Services Jason Stewart , Director of Operations, MMIS and Project Management Office at the State of Utah Evan J. Vickers , Utah Senator and Pharmacist, District 28
Industry Stakeholders	
Industry Associations	Jennifer Bishop , Past President, Utah Society of Health-System Pharmacists Richard Bishop , President Elect, Utah Pharmacy Association Jeff Gatzemeier , President, Utah Pharmacy Association Conor Hanrahan , President, Utah Society of Health-System Pharmacists Adam Jones , Executive Director, Utah Pharmacy Association
Subject-Matter Experts	
Academics, Researchers, & Clinicians	Carrie Dunford , Chief Pharmacy Officer & VP Clinical Services, Intermountain Healthcare Mandi Connelly , Senior Program Coordinator of Pharmacy Technicians, Mountainland Technical College Dave Young , Professor of Pharmacy, University of Utah

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