australian pharmacy council®

Review of the Accreditation Standards for Pharmacist Prescriber Education Programs

Preliminary Consultation paper

24 April 2026

Acknowledgement of Country

We gratefully acknowledge the Ngunnawal people, the traditional owners of the land on which the APC is based. We pay our respects to the Ngunnawal people and recognise their deep connection to this incredible place we now share. We also pay our respects to the resilience, strength and wisdom of Aboriginal and Torres Strait Islander Elders, past and present across the nation.

We recognise First Nations people's vast knowledge in native plants and their uses. Indigenous Australians were our first pharmacists. Country has provided medicines and healing throughout history. We acknowledge this important connection to Country and the impacts colonisation continues to have on this integral practice.

Canberra means meeting place in Ngunnawal, and is a place where people have been meeting, living and learning for thousands of years. We hope to continue this tradition as we work toward our vision of collaborative, committed and safe pharmacy practice.

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Confidential – Preliminary Consultation paper

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Consultation Brief

1.1. Who we are

The Australian Pharmacy Council Ltd (APC) is the independent accreditation authority for pharmacy education and training programs in Australia.

The National Registration and Accreditation Scheme (the National Scheme) was created in 2010 under the Health Practitioner Regulation National Law Act (National Law).[1] The APC operates under assignment from the Pharmacy Board of Australia (the Board), who is responsible for the regulation of the pharmacy profession in Australia.

APC accreditation helps to protect the health and safety of the Australian community by establishing and maintaining high-quality standards for pharmacy education, training and assessment.

1.2. What we are doing

APC is releasing this confidential preliminary consultation paper to seek feedback on the proposed Draft Accreditation Standards for Pharmacist Prescriber Education Programs (the Standards).

At the Health Ministers' Meeting held in June 2025, Ministers noted that the jurisdictional expansion of community pharmacist's scope of practice was at differing stages and approaches, and that there were risks associated with states and territories progressing these trials independently. Following the outcomes of the meeting, the Pharmacy Board of Australia (the Board) began its work in September 2025 to progress an endorsement for scheduled medicines for pharmacists, with the intent to support a consistent, safe, and nationally coordinated approach to pharmacist prescribing.

To support this important initiative, the APC is undertaking a review of the Accreditation Standards for Pharmacist Prescriber Programs (the Standards) as requested by Health Ministers through the Board.

In April 2026, the Pharmacy Board of Australia commenced public consultation on a draft Endorsement for scheduled medicines for pharmacists following recommendation from Health Ministers' meeting in June 2025. The consultation documents include:[2]

i. draft Registration standard: Endorsement for scheduled medicines
ii. draft Guidelines: Endorsement for scheduled medicines

The final scope of the endorsement will inform the review of the Standards.

APC's accreditation standards and processes are critical for ensuring pharmacists are equipped with the education and competencies required to safely and effectively prescribe medicines under evolving legislative frameworks. National consistency in pharmacist prescribing will be underpinned by our work.

Please do not distribute this confidential information.

[1] Queensland Government. Health Practitioner Regulation National Law Act 2009 [Internet]. 2009 Accessed Apr 14, 2026.
[2] Pharmacy Board of Australia. Public consultation Endorsement for scheduled medicines for pharmacists. [Internet] 2026. Accessed April 21, 2026.

1.3. Purpose of preliminary consultation

The purpose of this preliminary consultation is to test the draft revised Standards with key stakeholders and refine them before public consultation. It also provides an opportunity for APC to gather further feedback about the consultation materials' form, expression and/or clarity.

This paper should be read in conjunction with the Literature Review and Environment Scan (Appendix A), the Accreditation Standards for Pharmacist Prescriber Education Programs draft version (Appendix B) and the Summary of Proposed Changes (Appendix C).

1.4. Providing feedback

We are sharing this document with you as a key stakeholder in the review of the Standards. We have arranged a meeting with your organisation to discuss the provision revisions and seek your feedback directly. You are also welcome to provide feedback by addressing the consultation questions and emailing your responses to us research.policy@pharmacycouncil.org.au (see the questions on page 6 of this consultation paper).

To align the collating of feedback, your written submission must be provided by close of business of 29 May 2026.

1.5. How your feedback will be treated

Your feedback will be used to prepare a revised version of the draft Standards for the public consultation phase.

APC will not publish the comments or feedback we receive in full. In the interest of transparency, we will publish a summary of the major themes derived from the comments and feedback we receive from stakeholders, along with our response to the matters raised from this consultation.

Material supplied in confidence, should be clearly marked 'IN CONFIDENCE' and be provided as a separate attachment to any non-confidential material or feedback you give us. Information we receive that is marked confidential or given in confidence will be treated as such.

1.6. Next steps

Feedback from this confidential preliminary consultation may be incorporated into the public consultation paper and/or its accompanying documents. Alternatively, APC may decide to test some proposals more widely and incorporate feedback after the public consultation process.

Questions for Preliminary Consultation

APC is seeking your feedback on the following questions in relation to the draft revised Standards:

1. Is the content and structure of the proposed draft revised standards clear and relevant?
    a. Y/N - if no, could you provide suggestions for improvement?

2. Are there any concepts missing from the proposed draft revised standards that should be included?
    a. Y/N - if no, could you provide suggestions for improvement?

3. Do the draft revised standards support the delivery of suitable training for pharmacists to be able to prescribe under legislation in your jurisdiction?

4. Criterion 2.1 specifies the requirements of education providers who deliver prescribing training and refers to allowing TEQSA (university) or ASQA (RTO) registered organisations. Does this align with your expectations for program design and delivery?

5. Would the draft Standards result in any potential negative or unintended consequences for Aboriginal and/or Torres Strait Islander Peoples?

6. Are there any other regulatory impacts of the Standards that we should be aware of?

7. Are there any implementation issues the Board should be aware of for the final Standards?

Background information

2.1. Accreditation standards for pharmacist prescriber education programs

In 2023, to support national consistency in pharmacist prescriber education, the Board funded the APC to develop the Accreditation standards for pharmacist prescriber education programs (the Standards) and an accompanying Accreditation standards for pharmacist prescriber education programs Performance Outcomes Framework (the Performance Outcomes). The 2023 Performance Outcomes are aligned with the NPS MedicineWise Prescribing Competency Framework (2nd Edition) which describes the competencies that must be met by Australian prescribers regardless of profession.

The Standards and the accompanying Performance Outcomes and Evidence Guide for education providers were developed through APC's robust, transparent, and consultative approach that aligns with Ahpra's Procedures for the development of accreditation standards. The Standards were endorsed by the Board in 2023.

The Standards describe the requirements of the education provider and the program in relation to governance, resourcing, educational design, learner experience, outcomes and assessment. Assessment against the Standards also requires programs to demonstrate that the curriculum and assessment framework ensures all graduates will have achieved the defined Performance Outcomes.

2.2. Programs accredited against the 2023 Accreditation Standards

After the launch of the Standards in November 2023, the first Pharmacist Prescriber program was accredited against the Standards by APC in March 2024.

Accreditation of education programs follows established accreditation processes used to accredit pharmacy degree and intern training programs. Accreditation assessment is undertaken by a team of trained external assessors including people who have experience in educational design, are health care professionals who are authorised to prescribe, and/or practising pharmacists. This broad expertise allows all aspects of program design and delivery to be considered, prior to an accreditation decision being made by the APC Accreditation Committee (AC). The AC is a skills-based committee comprising of academics, practising pharmacists, accreditation experts, consumers, students and Aboriginal and Torres Strait Islander Peoples.

To date there have been multiple programs that have been granted accreditation, and more that are currently undergoing the accreditation process. All accredited programs include:

- work integrated learning
- observation/supervision by a designated prescriber and/or support from a prescriber mentor
- final assessment via an Objective Structured Clinical Exam (OSCE) or Oral assessment.

2.3. Request for early review of the Standards

State and territory regulators currently determine the requirements and scope for a pharmacist to be able to prescribe in their jurisdiction, including the training requirements.

Health Ministers' have asked the Pharmacy Board to commence a program of work exploring formal recognition of endorsed pharmacist prescribers, who can perform advanced clinical diagnosis and management in the National Registration and Accreditation Scheme.

Ministers specified that the work of the Board is to include establishment of practice, registration, and **accreditation standards** for this group of practitioners. Ministers also expect that patient history taking, examination, diagnostic investigation, electronic record keeping and referral as part of a

multidisciplinary team will be areas for national standardisation to ensure clinical appropriateness. These can be addressed in the revised Standards and specific program requirements.

In April 2026, the Pharmacy Board of Australia commenced public consultation on a draft Endorsement for scheduled medicines for pharmacists following recommendation from Health Ministers' meeting in June 2025. The consultation documents include:[1]

i. draft Registration standard: Endorsement for scheduled medicines
ii. draft Guidelines: Endorsement for scheduled medicines

This will inform the review of the 2023 Accreditation Standards for Pharmacist Prescriber Education Programs (the Standards).

To align with the work the Board has engaged APC to undertake a review of the Standards. The review includes an environmental scan and literature review looking at pharmacist and other health care professional prescribing in Australia and internationally, as well as identification of key changes in practice since the Standards were first developed.

Early discussions with key stakeholders have also identified areas that will be considered during the review, including:

- **Reducing duplication in the accreditation process**
  This is aligned with the findings of the independent review of complexity in the National Registration and Accreditation Scheme (the Dawson Review) report.

- **Inclusion of specific clinical training requirements**
  This has been requested by Health Ministers, states and territories, and the Board. The current APC Performance Outcomes are not explicit in the clinical skills required to prescribe. For example, the current Performance Outcomes make reference to a graduate outcome of being able to *"Apply current knowledge and use appropriate skills to assess the consumer"*. It could be presumed that 'appropriate skills' includes physical examination, but it is not explicitly included. APC understands that stakeholders are asking for this to be more explicit in the standards.

Our review process includes wide stakeholder consultation, including a public consultation. The feedback we receive will be used to inform the revisions we make. The revised standards, once approved, will replace the Accreditation Standards for Pharmacist Prescriber Education Programs 2023.

2.4. Alignment with the National Prescribing Competencies Framework

Currently, programs seeking accreditation against the 2023 standards are required to align their curriculum to the APC Pharmacist Prescriber Performance Outcomes Framework. During the initial process of review of the Performance Outcomes Framework, the environmental scan identified the National Prescribing Competencies Framework (now published in 3rd edition) as a recognised and accepted document used across other health professions.

APC proposes replacing the APC Performance Outcomes Framework 2023 with the National Prescribing Competencies Framework (3rd Edition). This allows for greater consistency and alignment in the education requirements between professions who undertake prescribing.

2.5. How the Standards fit in the pharmacy profession

The Standards will sit within a broader suite of Accreditation Standards developed by the APC. The APC accreditation standards collectively define the requirements for quality, safe and professional practice within the pharmacy sector.

Within this broader framework the Pharmacist Prescriber Standards play a critical role in ensuring that graduates are competent and qualified to prescribe medicines according to their scope of practice and

in line with specific state and territory legislation. The Standards are aligned with the National Prescribing Competencies Framework ensuring consistency with nationally recognised competencies for safe prescribing.

The review of the Standards will support the Board's work in strengthening safe prescribing through establishing an endorsement for scheduled medicines for pharmacists.

Overall, the Standards will function as a key component of an evolving, nationally consistent system that supports expanded pharmacist roles while maintaining a strong emphasis on patient safety, quality use of medicines, and professional accountability.

Potential impacts of the Standards

The implementation of the Standards is expected to have an impact on pharmacy education programs and providers. Education providers will need to ensure their programs meet the revised Standards and meet the competencies in the National Prescribing Competencies Framework. This may result in the need for changes to governance, process and programs.

3.1. Benefits

The benefits of revising the Standards extend across the healthcare sector and the community. By ensuring the Standards remain contemporary and fit for purpose for the evolving healthcare environment pharmacists are working in, the APC are working towards the shared National Scheme goal of protecting public safety.

The revised Standards used together with the National Prescribing Competencies Framework will support setting relevant standards for pharmacist training to prescribe, provide formal recognition of endorsed pharmacist prescribers and allow greater national consistency in pharmacist prescribing.

3.2. Potential implementation costs & issues

APC is seeking feedback on potential impacts or implementation issues as part of this consultation through questions 5 – 7.

A patient health and safety impact statement has been developed and is included Appendix D.

Development of the draft Standards

The draft Standards have been developed in accordance with Ahpra Procedures for the development of accreditation Standards. APC's statement of assessment against the Ahpra procedures is included as Appendix E. To support the first draft of the revised Standards, discussions during the Pharmacy Board's forum on prescribing held in October 2025 and feedback from a follow-up consultation survey have been considered.

In addition, a literature review was undertaken. The review looks at reports on of systematic reviews from 2023 to October 2025, grey literature and models focused and relevant to pharmacist prescribing in the Australian context and internationally.

The Literature Review supporting the development of the draft Standards (Appendix A).

4.1. Literature Review Summary

The review synthesises and addresses three core topics:

a. **The evidence base for pharmacist prescribing reviews published between 2023 and 2025**

- *Accessibility:* Reviews consistently report that pharmacist prescribing improves timeliness and convenience of care, particularly in primary care and underserved settings. Models enabling same-day treatment and extended service hours were highlighted as important enablers of access.
- *Clinical Effectiveness:* Evidence indicates that pharmacist prescribing achieves outcomes comparable to medical practitioner-led care for common conditions, chronic disease management, improves adherence and supports guideline-based therapy.
- *Safety:* Reviews indicate that pharmacist prescribing supports safe practice through strong adherence to clinical guidelines. Effective safety outcomes were most evident when programs incorporated structured protocols and collaborative care models, reinforcing the importance of governance and team-based approaches.
- *Economic Impact:* Available evidence suggests pharmacist prescribing can deliver cost savings and efficiency gains, particularly in minor ailments, cardiovascular risk management, and hospital collaborative models.

b. Accreditation standards for non-medical prescriber programs in Australia

The grey literature review identified prescribing accreditation standards across midwifery, nursing, optometry, pharmacy, physiotherapy, and podiatry. Key observations:

- prescribing competencies are embedded in entry-level programs for optometry and podiatry but require postgraduate qualifications for pharmacy, nursing, midwifery, and physiotherapy
- all professions reference the National Prescribing Competencies Framework within their accreditation standards, ensuring potential alignment with national prescribing expectations
- accreditation domains commonly address program governance, curriculum design, learner experience, and assessment strategies. Pharmacy-specific standards emphasise safe, socially accountable practice, governance, and performance outcomes broadly aligned to the National Prescribing Competencies Framework.

c. International accreditation standards for pharmacist prescribing programs

International models reveal diverse approaches to embedding prescribing authority. Some examples of the prescribing models are as follows:

- integrating pharmacy prescribing into pharmacy education, enabling graduates to qualify as independent prescribers at registration
- offering accredited postgraduate prescriber program that is aligned with national competence standards
- embedding entry-level programs prescribing-related competencies but requiring additional jurisdiction-specific training for expanded scope
- pharmacist prescribing which occurs under state-level protocols or collaborative agreements.

International standards consistently emphasise diagnostic reasoning, clinical assessment, shared decision-making, and accountability. Supervised practice and competency-based assessment are universal requirements for prescribing authority.

In summary the review provides available evidence across the four key areas of accessibility, clinical effectiveness, safety, and economic impact, which collectively justify the need for rigorous accreditation requirements. These findings reinforce the standards' mandate for pharmacist prescriber education programs to be aligned with the National Prescribing Competencies Framework, ensuring consistency with prescribing expectations applied to other non-medical professions.

4.2. Scope of practice for pharmacist prescribers

The pharmacist role in medicines management and safety continually evolves to meet the needs of the public and includes prescribing.

The National Prescribing Competencies Framework (3rd Edition September 2025) defines prescribing for all prescribers in Australia as:

"A dynamic process involving the steps of information gathering, clinical and shared decision making, communication and evaluation which results in the initiation, continuation or cessation of a medicine"[3]

This definition highlights that a pharmacist's scope of practice comprises:

- Competence – based on education, training and professional experiences
- Authority – defined by federal and state/territory legislation and regulation and local systems and policies
- Accountability – articulated in applicable professional practice standards and competencies.

As the definition describes, a pharmacist's scope of practice changes with time, an important consideration relevant to all areas of practice, including prescribing.

Prescribing must be undertaken according to the parameters of the prescribing context. Factors such as the practice setting, service delivery model, contribution of other health practitioners within the multidisciplinary team, and the specific preferences and needs of the consumer influence prescribing. The demonstration of prescribing performance by learners must include consideration of, and an appropriate response to, these factors.

4.3. Managing conflicts of interest

Conflicts of interest (COI) should be identified, disclosed, and managed to ensure objectivity, integrity and transparency. Clear requirements need to be included for the identification and management of COI to support impartial decision making.

Ahpra suggests *"an actual, potential or perceived Conflict of Interest (COI) exists [when a practitioner is] influenced by a personal interest in the course of performing [their] professional duties under the National Law. A COI could arise through a range of personal interests or connections including family, friends and associates, or as a result of financial, employment and/or community or political interests or activities"*.

The Pharmaceutical Society of Australia's (PSA) Code of Ethics defines a COI as *"...a particular relationship or practice leads to risk that professional judgements or actions regarding a primary interest (e.g. the responsibilities of a pharmacist). [is] unduly influenced by a secondary interest (e.g. financial gain)."*[4]

The PSA Code of Ethics [5](currently under review) clarifies pharmacists' obligations when conflicts of interest arise. Integrity Principle 1 includes a disclosure position: *"disclosing and managing actual, potential or perceived conflicts of interest ensures professional decisions are not (and nor are they perceived to be) improperly impacted by other pecuniary or non-pecuniary interests."*[6]

The College of Physicians and Surgeons of Ontario (CPSO) also have a disclosure position, *"where avoidance of conflicts of interest is not possible, it may be appropriately managed through disclosure to patients, making them aware of alternatives, and offering reassurance that the patient's choice of an alternative will not affect the quality of care"*.[7]

In pharmacy practice in Australia, pharmacist dispensing of medication prescribed by non-pharmacist prescribers allows for separation of prescribing and dispensing. Where a pharmacist prescribes a medication, it is important to acknowledge the conflict of interest that results if the pharmacist

[3] Department of Health, Disability and Ageing. National Prescribing Competencies Framework- Embedding quality use of medicines into practice (3rd edition). September 2025. [Internet] Accessed April 8, 2026.
[4] Ahpra & National Boards. Code of conduct PC011. 2020. [Internet] Accessed April 13, 2026.
[5] Pharmaceutical Society of Australia. Code of Ethics for Pharmacists 2017 (Draft). 2017.[Internet] Accessed April 14, 2026.
[6] Pharmaceutical Society of Australia. Code of Ethics for Pharmacists 2026 (Draft). 2026.[Internet] Accessed April 9, 2026.
[7] The College of Physicians and Surgeons of Ontario. Advice to the Profession: Conflicts of Interest and Industry Relationships. Published online 2024. [Internet] Accessed April 10, 2026.

prescriber is also in the position of being the only person able to dispense the medication. It is noted that this is not always the case but may occur in remote areas or after hours.

The primary interest of a pharmacist requires professional judgement and action that is not unduly influenced by secondary interests such as vertically integrated models.[8] The National Prescribing Competencies Framework [competency area 7.6 (f)] requires disclosure of conflicts of interest to minimise the impact on prescribing decisions and ensure transparency.[9] Ongoing monitoring and reporting structures enable regulatory action by Ahpra against individual practitioners where required.[10]

The UK Royal Pharmaceutical Society has released a position statement that *"where there is a risk assessment in place and in the best interests of the patient, the same healthcare professional can be responsible for the prescribing and dispensing/supply/administration of medicines."*[11]

APC has incorporated the management of conflict of interest into the draft revised Standards as a necessary step to reflect the role of pharmacists in Australia's healthcare system, ensuring that prescribing pharmacists have the competencies to identify, disclose and manage conflict of interest, ensuring the safety of the public and reinforcing safe and effective prescribing.

4.4. Learner cohort

The 2023 Standards refer to "The Standards have been developed with the intention that learners will be pharmacists with general registration." All programs accredited against these standards have been unable to enrol pharmacy students and interns into their program to date. The Pharmacy Board commenced public consultation on a draft Endorsement for scheduled medicines for pharmacists, in April, and is proposing that applicants for general registration would also be able to apply for endorsement. As a result, the draft Standards have removed the wording used in the 2023 Standards in relation to learner cohort.

Consultation Process and Timeframes

The consultation approach for the revision of the Standards aligns with Ahpra's Procedures for the development of accreditation standards and Consultation process of National Boards as follows:

Figure 1 Ahpra & National Boards - Consultation process of National Boards

In line with Ahpra's consultation processes, a range of opportunities for stakeholders, the public and the profession to provide input into the development of the Standards is available. Feedback and input from stakeholders is being gathered through:

- one-on-one interviews
- targeted stakeholder meetings
- written submissions via email (preliminary consultation)

[8] Pharmaceutical Society of Australia. Code of Ethics for Pharmacists 2026 (Draft). 2026.[Internet] Accessed April 9, 2026.
[9] Department of Health, Disability and Ageing. National Prescribing Competencies Framework- Embedding quality use of medicines into practice (3rd edition). September 2025. [Internet] Accessed April 8, 2026.
[10] Ahpra & National Boards. Immediate action. 2023. [Internet] Accessed April 13, 2026.
[11] Royal Pharmaceutical Society. Prescribing and dispensing / supply / administration by the same healthcare professional. 2024. [Internet] Accessed April 10, 2026.

- written submissions via an online form (public consultation)

5.1. Consultation timelines

The phases of consultations are as follows:

Preliminary Consultation (28 April – 29 May)

- This consultation paper forms part of this preliminary consultation.

Public Consultation (22 June – 3 August)

- The public round will be offered via written response format and will be open for 6 weeks. An online form will be published on APC website with other consultation materials when public consultation phase opens.

Need more information

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Key contact person

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Appendices

Appendix A: Accreditation standards for pharmacist prescriber education programs - Environmental scan and literature review

Appendix B: Accreditation Standards for Pharmacist Prescriber Education Programs draft version 0.2

Appendix C: Summary of proposed changes to Pharmacist Prescriber Standards

Appendix D: Statement of Health Impact

Appendix E: Statement of assessment against Ahpra's Principles - Accreditation Standards

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Accreditation standards for pharmacist prescriber education programs

Environmental scan and literature review

April 2026

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- The Pharmacy Board of Australia (a NRAS National Board), as the sponsor of the pharmacist prescriber accreditation standards project
- Members of the APC Governance Group

Australian Pharmacy Council Ltd

(ACN 126629 785)

The Australian Pharmacy Council (APC) is the national accreditation authority for pharmacy education and training. We do this under the National Registration and Accreditation Scheme (NRAS) working with the Pharmacy Board of Australia and Ahpra.

We're an independent, not-for-profit company. Our work protects public health by setting and maintaining high standards of pharmacy education.

We help pharmacists deliver effective health care to meet our community's changing needs. We do this through skills assessments and accreditation of programs and providers.

Contents

Executive Summary

The Australian Pharmacy Council (APC) commissioned this literature review and environmental scan to inform the update of accreditation standards for pharmacist prescriber education programs. The review synthesises and addresses three core areas: (1) the evidence base for pharmacist prescribing reviews published between 2023 and 2025, (2) accreditation standards for non-medical prescriber programs in Australia, and (3) international accreditation standards for pharmacist prescribing programs.

Context and Rationale

Pharmacist prescribing has evolved globally as a response to health system pressures, including ageing populations, chronic disease burden, and workforce shortages in primary care. While pharmacists in Australia are not currently authorised to independently prescribe Schedule 4 medicines under national legislation, state-based reforms now permit prescribing for defined conditions following completion of accredited training. In April 2026, the Pharmacy Board of Australia commenced a public consultation on a draft Endorsement for scheduled medicines for pharmacists following recommendation from Health Ministers' meeting in June 2025.[1] The Board's work will inform the review of the APC's Accreditation standards for pharmacist prescriber education programs.[2]

Internationally, two dominant models exist: independent prescribing, where pharmacists assume full responsibility for diagnosis and prescribing within their competence, and collaborative prescribing, which operates under shared governance arrangements. Jurisdictions such as the United Kingdom and Canada have demonstrated mature implementation of independent prescribing, supported by competency frameworks and structured education pathways.

Part A: Evidence from Literature (2023-2025)

A review of 19 systematic and scoping reviews covering 758 studies provide the available evidence for safety, efficacy, and accessibility of pharmacist prescribing across diverse settings. Searches were conducted across databases (PubMed, CINAHL, Scopus) and Google Scholar using pharmacist prescribing-related terms. Reviews were screened and assessed using PRISMA principles, with systematic reviews generally applying formal bias and quality appraisal tools, while scoping reviews focused on mapping emerging practices. Data extraction was review-level rather than study-level, and findings were synthesised narratively due to heterogeneity in prescribing models and outcome measures.

Key themes identified across the evidence base include:

- **Accessibility:** Reviews consistently report that pharmacist prescribing improves timeliness and convenience of care, particularly in primary care and underserved settings. Models enabling same-day treatment and extended service hours were highlighted as important enablers of access.
- **Clinical Effectiveness:** Evidence indicates that pharmacist prescribing achieves outcomes comparable to physician-led care for common conditions and chronic disease management. Reviews also note its role in improving adherence and supporting guideline-based therapy.
- **Safety:** Reviews indicate that pharmacist prescribing supports safe practice through strong adherence to clinical guidelines. Effective safety outcomes were most evident when programs incorporated structured protocols and collaborative care models, reinforcing the importance of governance and team-based approaches.
- **Economic Impact:** While economic evaluations remain limited, available evidence suggests pharmacist prescribing can deliver cost savings and efficiency gains, particularly in minor ailments, cardiovascular risk management, and hospital collaborative models.

Part B: Accreditation Standards for Australian Non-Medical Prescribers

The grey literature review identified prescribing accreditation standards across midwifery, nursing, optometry, pharmacy, physiotherapy, and podiatry. Key observations:

- Prescribing competencies are embedded in entry-level programs for optometry and podiatry but require postgraduate qualifications for pharmacy, nursing, midwifery, and physiotherapy.
- All professions reference the National Prescribing Competency Framework 3rd Edition September 2025[3] or the NPS Medicinewise Prescribing Competencies Framework 2nd edition,[4] (either framework will be henceforth referred to as the National Prescribing Competency Framework or NPCF within this document) within their accreditation standards, ensuring potential alignment with national prescribing expectations.
- Accreditation domains commonly address program governance, curriculum design, learner experience, and assessment strategies. Pharmacy-specific standards emphasise safe, socially accountable practice, governance, and performance outcomes broadly aligned to the National Prescribing Competency Framework.

Part C: International Accreditation Standards

International models reveal diverse approaches to embedding prescribing authority:

- **United Kingdom:** From 2026, prescribing will be integrated into initial pharmacy education, enabling graduates to qualify as independent prescribers at registration. Current pharmacists require a postgraduate prescribing course comprising 26 days of structured learning and 90 hours of supervised practice.
- **New Zealand:** Pharmacists must complete an accredited postgraduate prescriber program (~600 hours, including clinical placements) aligned with national competence standards.
- **Canada:** Prescribing authority is regulated provincially; while entry-level programs embed prescribing-related competencies, additional jurisdiction-specific training is required for expanded scope.
- **United States:** Prescribing occurs under state-level protocols or collaborative agreements; ACPE accreditation standards ensure graduates possess baseline competencies for therapeutic decision-making and prescribing within team-based care.

International standards consistently emphasise diagnostic reasoning, clinical assessment, shared decision-making, and accountability. Supervised practice and competency-based assessment are universal requirements for prescribing authority.

Implications for Australian Accreditation standards for pharmacist prescriber education programs

The environmental scan and literature review provides available evidence across four key areas - accessibility, clinical effectiveness, safety, and economic impact - which collectively justify the need for rigorous accreditation requirements. These findings reinforce the standards' mandate for pharmacist prescriber programs to be aligned with the National Prescribing Competencies Framework, ensuring consistency with prescribing expectations applied to other non-medical professions.

Introduction

Within this context, Australia's prescribing workforce currently consists of several health professions, including dental practitioners, medical practitioners, endorsed midwives, nurse practitioners, endorsed optometrists and endorsed podiatrists. For some professions, the authority to prescribe medicines is granted upon initial registration, while others are required to undertake additional education and training beyond the entry-level program to achieve endorsement to prescribe scheduled medicines.

Pharmacists are not currently authorised under national legislation to independently prescribe Schedule 4 medicines; however, several jurisdictions now permit pharmacist prescribing for defined low-acuity health conditions where pharmacists have completed an accredited prescribing course and meet jurisdictional authorisation requirements.[5] In addition to these state-based reforms, pharmacists continue to play a central role in selection and supply of medicines included in Schedules 2 (Pharmacy Only) and schedule 3 (Pharmacist Only) of the Poisons Standard.[6] This requires the pharmacist to understand the consumer's needs, make a clinical decision regarding optimal therapy (which may or may not include medicines), and communicate that decision with the consumer. This process includes three of the four stages in the prescribing process, according to the Australian definition.[7]

Pharmacist prescribing is defined as the authority of pharmacists to initiate, modify, or discontinue medicines. Pharmacist prescribing has expanded substantially over the past two decades, reflecting broader health system reforms aimed at improving access, safety, and efficiency in medication use.[8–10] Pressures from aging populations, multimorbidity, and workforce constraints in primary care have catalysed the redistribution of prescribing tasks across professions, including pharmacy, to maintain quality and responsiveness of care.[11] Across jurisdictions, this evolution has been accompanied by competency frameworks, regulatory adjustments, and growing evidence of clinical effectiveness and patient acceptability.[10]

The global picture is heterogeneous, shaped by statutory authority, professional education pathways, funding mechanisms, and health system integration. Broadly, two predominant models of pharmacist prescribing exist internationally: independent prescribing (IP) and dependent or collaborative prescribing. In IP, pharmacists assess, diagnose, and prescribe autonomously within their competence, typically following completion of accredited postgraduate training and supervised practice.[12] The United Kingdom represents a mature implementation, where pharmacist independent prescribers are legally recognised and supported by an interprofessional competency framework that sets expectations for safe, patient centred prescribing across all prescribing professions.[13,14] In contrast, dependent/collaborative models (e.g., Collaborative Drug Therapy Management) delegate prescribing functions via written protocols and physician agreements; this is common in the United States, where pharmacists adjust therapy, order tests, and manage ongoing pharmacotherapy under a shared governance arrangement.[8,15] In Canada, provincial regulations permit a spectrum of activities, from adapting and renewing prescriptions to initiating therapy for defined minor ailments, underpinned by competency and training requirements; evidence syntheses indicate safe and acceptable prescribing with positive impacts on access and antimicrobial stewardship in community settings.[11,15]

In Australia and New Zealand, prescribing is framed more narrowly and often linked to protocols or specific services, though scope expansions continue to be debated within broader non-medical prescribing policies.[8] Several European countries (e.g., Denmark, Poland) have introduced or piloted forms of pharmacist prescribing, typically coupling legal authority with structured education and explicit professional accountability.[15] Earlier literature also described variable experiences in South Africa and other settings, illustrating that adoption is sensitive to national policy environments and can be transient when governance or funding is uncertain.[8,16] The evidence base although not fully matured, comprises of systematic reviews, umbrella reviews, and scoping reviews, consistently suggests that pharmacist prescribing is safe, effective, and patient centred when embedded within robust regulatory frameworks and supported by appropriate training, supervision, and access to clinical information.[15,17] Syntheses report benefits in access (reduced wait times, improved convenience), quality (guideline consistent prescribing, de-prescribing where appropriate), and antimicrobial stewardship (appropriate selection and duration for common infections), alongside high patient satisfaction.[11,15]

Nevertheless, successful implementation depends on system integration: clear scopes of practice, shared records, defined referral pathways, and funding models that recognize clinical consultation time and responsibility.[17] A crucial enabler is the competency architecture underpinning pharmacist prescribing. For example, The Royal Pharmaceutical Society's Competency Framework for All Prescribers is widely cited and adopted across professions in the UK; it articulates domains spanning patient centred consultation, shared decision making, clinical assessment and diagnostic reasoning, prescribing governance, and reflective practice.[13] Contemporary reviews extend these competencies with granular "micro skills" (e.g., applying guidelines, risk stratification, communication techniques) and "macro capabilities" (e.g., clinical judgment, accountability, and reflective practice), providing a blueprint for curricula and continuous professional development.[15] This competency led approach addresses historic concerns raised in early international reviews, such as training sufficiency, liability, documentation, and reimbursement, by standardising expectations and fostering interprofessional trust.[8,16]

Pharmacist prescribing has transitioned from isolated initiatives to a mainstream, albeit variably implemented, component of modern healthcare systems. The accumulating international evidence supports its clinical safety and system value, contingent on regulation, training, and integration. As jurisdictions continue to expand scope, particularly for minor ailments, chronic disease optimisation, and antimicrobial stewardship, the policy emphasis has shifted from "*if*" to "*how*" best to implement and scale: ensuring equitable access, avoiding care fragmentation, and aligning payment and information infrastructures to enable pharmacists to practice at the top of their license.[15,17]

In Australia as the population ages, demand for health services increases and so does the burden of chronic diseases management.[18,19] Use of medicine is a core intervention of healthcare, and it is the healthcare professional's responsibility to ensure safe use of medicine while providing patient centered care with consideration to cultural safety.[3] Prescribing in Australia has been defined as "a dynamic process involving the steps of information gathering, clinical and shared decision making, communication and evaluation which results in the initiation, continuation, or cessation of a medicine".[3] Prescribing is accepted as a multifaceted process, requiring significant expertise through its multiple components. The NPCF further describes these components as "Prescribing process: Understanding the Person and their need; Understanding the managing options; Explore, discuss and decide on a plan for medicines; Prescribe medicines and communicate the agreed treatment decision; Prescribe medicines and communicate the agreed treatment decision; Monitor and review the outcomes of treatment; Prescribe safely and effectively; Prescribe professionally.[3] Prescribing is "exclusively permitted for authorised health practitioners who must "Have completed accredited prescribing education and training that is consistent with their scope of practice; be registered with the national board for their specialty, be approved under the National Health Act 1953 for prescriptions of PBS or RPBS medicines, be approved under relevant state and territory legislation and regulation".[3]

Review aims and focus

The debate currently focuses on the type of model to be endorsed at national level, its educational and training requirements and the legislative framework surrounding the practice. This review aims to contribute through using a previously undertaken environmental scan and conducing grey and published literature reviews from 2023 to 2025.

The review is presented in three parts:

Part A: Reports on a literature review of systematic reviews from 2023 to October 2025 focused and relevant to pharmacist prescribing internationally and nationally in Australia.

Part B: Consists of a review of the grey literature including websites which summarises and compares standards applicable to Australian non-medical prescribing professions

Part C: Comprises an environmental scan of international accreditation standards applicable that permit pharmacists to register as pharmacist prescribers according to relevant jurisdiction regulation, legislation and professional practice requirements.

Part A: Review of the literature relevant to pharmacist prescribing

Aim

This section reports on a literature review of systematic reviews from 2023 to October 2025 focused and relevant to pharmacist prescribing internationally and in the Australian context.

Methods

The same search terms and databases used in the previous report published by the APC were utilised[7] (Table 1) with the addition of Google Scholar from 2023 to 2025. The search was restricted by using type of articles (all type of literature reviews) and date (2023 to 2025) as filters. The previous environmental scan report did not explicitly state inclusion and exclusion criteria; therefore, a broad and over-inclusive approach was followed throughout the process for the selection of articles. Since the literature on pharmacist prescribing has grown substantially since 2023, this review was pragmatically focused on the numerous reviews published during this period. The Cochrane methodology for reviews of systematic reviews was used[20]

Table 1 Search terms used to identify literature

Database	Search Terms & Combinations
PubMed	Pharmacist, prescrib*, Australia
	'minor ailment'
	Pharmacist AND prescrib* AND Australia
	Pharmacist AND 'minor ailment'
	Pharmacist AND prescrib* AND safety
	Pharmacist AND prescrib* AND outcome
	Pharmacist AND prescrib* AND effective*
CINAHL	Pharmacist, prescrib*, Australia
	'minor ailment'
	Pharmacist AND prescrib* AND Australia
	Pharmacist AND 'minor ailment'
	Pharmacist AND prescrib* AND safety
	'Pharmacist prescribing' AND safety
	'Pharmacist prescribing' AND effectiv*
Scopus	Pharmacist, prescrib*, Australia
	'minor ailment'
	Pharmacist AND prescrib* AND Australia
	Pharmacist AND 'minor ailment'
Google Scholar	Pharmacist prescribing
	Safety of pharmacist prescribing
	Effectiveness of pharmacist prescribing

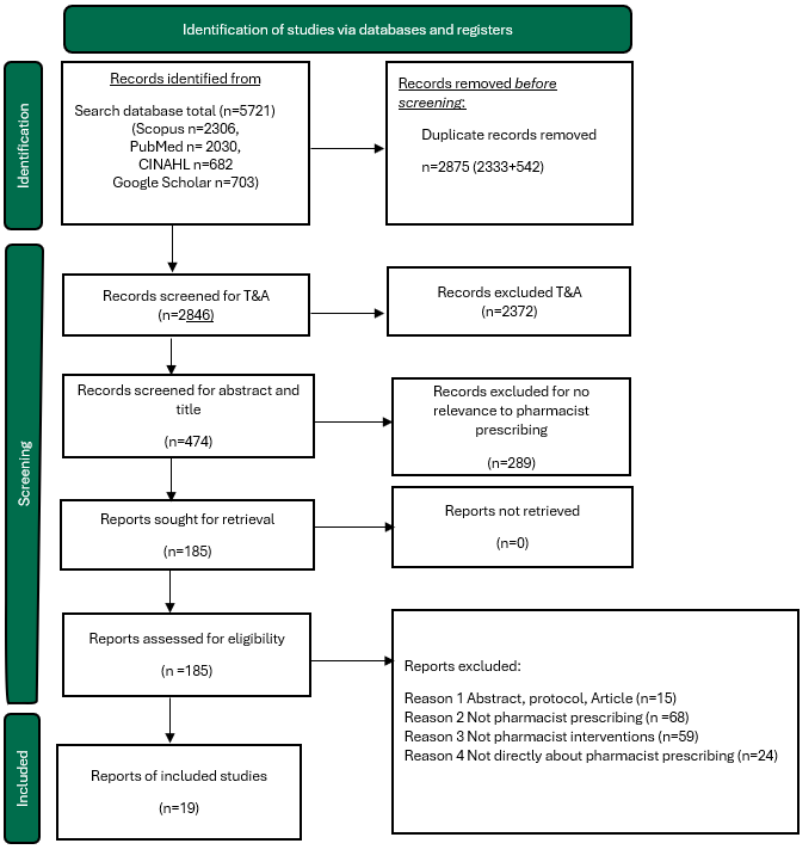
Initial article selection was undertaken by screening titles and abstracts by two reviewers. The full text articles were also reviewed by two reviewers. At all stages, disagreements were resolved by consensus. Data were extracted from the systematic reviews rather than the original reference papers. Data extraction

was undertaken by a single reviewer with a second reviewer assessing the quality of content and extraction.

Results and Discussion

The literature provided 19 reviews; 10 scoping, eight systematic, and one rapid review from several international authors (Appendix 1). 758 studies were covered by the reviews, although some studies were covered in more than one review (Figure 1).

Figure 1 PRISMA diagram



A comprehensive summary of the characteristics of included reviews examining pharmacist prescribing is provided in Appendix 1. The reviews encompass a range of objectives, methodologies, and prescribing models, reflecting the evolving role of pharmacists. The included reviews span from 2023 to 2025, indicating a recent surge of scholarly interest in pharmacist prescribing. The number of studies varies substantially, from nine studies to as many as ninety-two suggesting heterogeneities in evidence bases. Systematic reviews generally include larger datasets compared to scoping reviews, which tend to prioritise breadth over depth. Specialised domains include mental health,[21,22] cancer services,[23] and emergency departments,[24] while broader lenses address community pharmacy practice and non-medical prescribing.[12,25]

Models of pharmacist prescribing

Prescribing models are predominantly categorised as mixed, encompassing both independent and collaborative approaches. Independent prescribing features prominently in reviews addressing community pharmacy settings,[11,12,25] whereas collaborative models are emphasised in hospital contexts.[26] Protocol-driven prescribing, such as structured protocols for urinary tract infection (UTI) management, illustrates

policy-driven implementation for specific conditions.[27,28] Well-defined models of care provide clarity and consistency for the services providers and consumers, and the wider healthcare workforce, which assist in adoption of these models including pharmacist prescribing.[15,29] Prescribing definitions varied greatly across these studies, alongside the pharmacists' responsibilities of the prescribing role.[29] Research has called for unity in defining prescribing roles and responsibilities.[11,29] Standard terminology is essential to formulate the best evidence nationally and to be able to compare it to international evidence, and to guarantee mutual understanding and expectations between stakeholders.[29] Independent prescribing: A prescribing model that allows pharmacists to prescribe autonomously without the need of previous agreement with a physician,[12] and pharmacists in this model take full responsibility and accountability for assessment, diagnosing and prescribing.[28] Independent prescribing is well placed to fit into patient-centered care rather than; legislation and restrictions centered care. As it focusses on the patients' need, symptoms rather than protocol or formularies limitations.[29] Independent prescribing has been established in the UK and Alberta Canada,[12] while formulary prescribing is unique to Idaho, US.[29] Government protocol is an "independent prescribing model for pharmacists, containing specific conditions and/or drugs pharmacists can prescribe for".[12] Dependent prescribing; A prescribing model that allows pharmacists to prescribe under the supervision of another health care professional, through a practice agreement with a physician.[12] That agreement or protocol outlines "parameters of how, when, and what may be prescribed".[28] Standing orders and statewide protocols are forms of dependent prescribing.[28] Collaborative prescribing; is when "prescribers enter into an agreement outlining the authorities delegated, and the roles and responsibilities of each party in the process of prescribing.[28] Standard of care is an "independent prescribing model for pharmacists, without specific conditions and/or drugs pharmacists can prescribe for, guided by accepted medical guideline".[12] That model is clearly defined in the UK.[11] Prescriptive authority (PA): is defined as "A regulatory framework that depending on the jurisdiction allows pharmacists to initiate, continue, or discontinue medications following a patient assessment".[12]

Several reviews aim to map existing evidence and terminology,[21,23] while others evaluate clinical and economic outcomes.[27,30] Systematic reviews such as Akintunde et al.[31] and Atey et al.[24] examine health-related outcomes and quality use of medicines, employing rigorous synthesis methods. Reviews addressing mental health services[22] and cardiovascular disease prevention[32] expand pharmacist-led interventions into public health and chronic disease management.[32,33]

Scoping reviews frequently employ the Arksey and O'Malley framework, often supplemented by enhancements from Levac, Colquhoun, and O'Brien, and methodologies from the Joanna Briggs Institute (JBI).[21,23] Systematic reviews adhere to PRISMA or PRISMA-ScR guidelines.[12,15] The integration of theoretical lenses, such as the Consolidated Framework for Implementation Research,[11] and the Theoretical Framework of Acceptability,[34] supports conceptual clarity and structured interpretation of findings. In specialised contexts, access to regulatory body information informs national assessments of prescribing competence.[35]

Quality appraisal practices vary. Systematic reviews commonly use Cochrane RoB 2, ROBINS-I, and GRADE to assess bias and evidence of certainty.[24,31] Other tools include MMAT,[22] CASP,[15] QuADS,[28] MERSQI,[35] and JBI checklists for diverse study designs.[27,32] By contrast, several scoping reviews do not report formal quality appraisal, reflecting the exploratory nature of scoping methodology while signaling a need for consistency.[21,23]

Three patterns are notable. First, the predominance of mixed models suggests ongoing negotiation between independent and collaborative roles for pharmacists as scopes of practice evolve.[28,29] Second, systematic reviews demonstrate stronger methodological rigor, whereas scoping reviews often omit formal appraisal, limiting comparability.[15,31] Third, economic evaluations remain sparse; while some evidence addresses costs and value for money,[27,30] more comprehensive analyses are required to inform sustainable policy decisions. Stakeholder perspectives, including patient acceptability and professional readiness, are underexplored outside specific contexts such as sexually transmitted infection services[34] and naloxone provision beyond community settings.[33]

The evidence base underscores the potential of pharmacist prescribing to enhance accessibility, optimise medication use, and improve patient outcomes across settings.[24,31] Harmonising training standards and competency assessments, particularly through national examinations and structured competence frameworks, could support safe and effective prescribing.[15,35] Integrating economic evaluations and

implementation research will be critical to guide resource allocation and scale-up decisions, especially in community pharmacy and primary care.[27,30]

Future reviews should prioritise standardised reporting of quality appraisal in scoping reviews to strengthen credibility;[12,23] comparative analyses of prescribing models to identify optimal configurations across hospital and community settings;[11,26] longitudinal evaluations of clinical and economic outcomes to capture sustained impacts;[27,31] and exploration of patient and stakeholder perspectives to inform implementation strategies and acceptability.[32,34] The synthesis of included reviews reveals a dynamic, evolving landscape of pharmacist prescribing, characterised by methodological diversity and expanding clinical roles. While systematic reviews provide robust evidence on health outcomes, scoping reviews illuminate emerging practices and contextual considerations. Addressing methodological gaps, and incorporating economic and stakeholder dimensions, will be pivotal in advancing pharmacist prescribing as a cornerstone of integrated healthcare delivery.[28,31]

Evidence for accessibility due to pharmacist prescribing

Thirteen of the reviews reported either directly or indirectly on one of the pillars driving change in policy leading to the establishment and expansion of scope of practice for pharmacist led prescribing has been the need for increased patent accessibility in primary care (Appendix 2).

Across diverse programs and jurisdictions, pharmacist prescribing is reported to consistently enhance patient access to timely care. Multiple studies demonstrate shorter wait times, expanded hours, and higher rates of same-day treatment compared with physician-led pathways. In community management of minor ailments and acute infections, pharmacist prescribing reduces delays: Beahm et al. reported a median 1.7 days to see a prescribing pharmacist versus 2.8 days for a physician ($p = 0.0153$);[25,27] Hind et al. observed that 90% of attendees were seen within 10 minutes and that utilisation peaks on Friday-Saturday and after 6pm, when GP access is more limited.[27] Booth et al. further noted that a third of pharmacist-led care occurred on weekends, underscoring after-hour accessibility.[25]

In streptococcal pharyngitis programs spanning British Columbia and Nova Scotia, patients seen by prescribing pharmacists were substantially more likely to receive antibiotics on the same day than those seen by pharmacists without prescribing authority (75.8% vs 35.3% in British Columbia; 42.2% in Nova Scotia).[28] A broader multicenter study covering 7,050 patients reported 68.7% same-day antibiotic prescribing overall, with higher rates in Alberta (73.8%) compared with Nova Scotia (40.5%), aligning with Alberta's advanced prescribing authority.[12]

Pharmacist prescribing improves access beyond routine clinic hours and in settings with limited medical availability. Klepser et al. found that 43.9% of patients were seen outside regular medical office hours,[28] while Mansell et al. showed that ease of access accounted for 17.2% of patient decisions to choose pharmacy care; additional reasons included avoiding wait times (14.6%), inability to obtain timely physician appointments (9.9%), clinic closure (3.1%), or lack of a regular physician (1.0%).[28] Importantly, when pharmacist prescribing was unavailable, substantial proportions of patients indicated they would self-treat, do nothing, or attend emergency departments.[28]

Accessibility gains extend to chronic disease and preventive services. In cardiovascular risk management, Haby et al. reported an increase in statin eligibility/receipt among patients with atherosclerotic cardiovascular disease from 75.2% to 79.3% after pharmacist prescribing interventions.[28] In mental health services, Silvia et al. demonstrated markedly shorter access times to psychiatric pharmacists versus specialist physicians (31.3 vs 104.5 days), with 23% of patients seen within 7 days compared to 0% in the specialist pathway;[28] a separate analysis reported 22.6 versus 79.3 days to therapy start in psychiatric pharmacist prescribing compared with behavioural clinic providers.[21]

Contraception and sexual health services exhibit mixed but generally positive accessibility signals. Women requesting emergency contraception in the UK who received pharmacist-facilitated rapid access and a three-month supply of progestogen-only pills demonstrated a 20.1% higher use of effective contraception in the intervention group than controls (mean 58.4% vs 40.5%).[27] Stewart et al. reported patients' perceptions of greater access for pharmacist prescribing-led management of UTI, impetigo, and COPD, with 29/73

citing timeliness.[27] While Gibbs found no significant impact on hormonal contraception access,[28] other studies, such as Azad et al. in rural contraception, identified pharmacist accessibility as a facilitator.[15] The heterogeneity likely reflects local scope of practice, service design, and patient eligibility criteria; nevertheless, pharmacist-led models often reduce barriers created by appointment requirements and clinic hours.

Naloxone services illustrate pharmacist prescribing capacity to expand access in harm reduction. DeRonne observed increased eligibility for naloxone (33.8% to 46.7%) following pharmacist prescribing initiatives.[28] Xu reported an average increase of 331 naloxone dispensings (≈53%) after adjusting for confounders.[28] Pharmacist co-prescribing models trained law enforcement and facilitated mass dispensing (e.g., 350 officers trained; broad distribution in Indian Country),[33] and collaborative practice increased co-prescribing among patients receiving buprenorphine/naloxone (8.18% vs 5.14% under psychiatrist-only care).[33] Wilson et al. documented that, among chronic opioid users meeting criteria, 49.9% were eligible for naloxone via pharmacist co-prescribing.[33] Collectively, these interventions suggest pharmacist prescribing lowers procedural barriers and accelerates deployment of life-saving medications across clinical and community interfaces. Cancer services similarly benefit from pharmacist prescribing through improved timeliness and reduced cost burden. Lau et al. reported better medication access attributed to lower costs with pharmacist prescribing, and Wright et al. found positive effects on the timeliness of prescriptions in oncology settings.[23]

Geographic inequities remain a salient challenge. Bachyrycz et al. identified pharmacist accessibility as a facilitator in naloxone implementation yet noted rural access as a persistent barrier.[15] Green and Gumber observed that expanding non-medical prescribers, including nurse prescribers and pharmacist prescribers, improved access particularly in isolated areas.[21] Strategic scaling thus requires context-sensitive models that address workforce distribution, transportation, and service integration with local primary care teams. Soon's analysis of emergency contraception showed a 102% increase in pharmacist prescribing (≥ twofold increase among ages 25–54) without reducing physicians' prescribing rates.[28] Tinelli reported no difference in time to access prescriptions between physicians and pharmacist prescribing in certain contexts.[28] Where pharmacist prescribing delivers pronounced advantages (e.g., minor acute conditions, harm reduction, mental health triage), it often does so by meeting unmet demand rather than displacing existing services.

Synthesis of these findings points to several implementation lessons. First, accessibility improvements hinge on scope-of-practice and authority: jurisdictions granting independent or advanced prescribing achieve higher same-day treatment rates.[11] Second, service design matters: extended hours, walk-in pathways, and point-of-care testing enable rapid triage and therapy initiation.[27,28] Third, collaborative models can amplify reach in complex domains (oncology and harm reduction), while maintaining safety and continuity.[23,33] Fourth, attention to rural access and digital inclusion remains essential to avoid widening disparities.[15,21] Future work should standardise outcome measures (e.g., time-to-treatment, proportion receiving same-day therapy, ED deflection rates), expand data from rural settings, and incorporate patient-reported accessibility metrics.

Efficacy Impact of Pharmacist Prescribing

Evidence from multiple studies demonstrates that pharmacist prescribing improves access to care, optimises medication use, and achieves clinical outcomes comparable to physician-led models. This summary synthesises findings across diverse therapeutic areas, including UTIs, minor ailments, cardiovascular risk management, oncology, opioid overdose prevention, mental health, and emergency care (Appendix 3).

Studies consistently report high cure rates for pharmacist-managed uncomplicated UTIs. Beahm et al. documented clinical cure rates of 88.9%, comparable to physician-led care.[11,25] Booth et al. observed no significant difference in symptom resolution time between GP and pharmacist care, with pharmacy patients presenting earlier.[25,27]

Evidence supports pharmacist prescribing in managing minor conditions through structured protocols. Mansel et al. reported improvement in 99.2% of cases,[25] while Swiss decision-tree programs achieved

84.7% cure rates, with nearly half of patients avoiding GP or ED visits.[27] These outcomes highlight pharmacist prescribing's potential to reduce primary care burden and enhance patient convenience.

Pharmacist-led interventions significantly improve cardiovascular risk factors. RXEACH trials demonstrated reductions in LDL cholesterol, systolic blood pressure, and HbA1c, alongside higher smoking cessation rates.[25,36] Tsuyuki et al. reported a 21% greater relative reduction in estimated cardiovascular event risk.[15] Programs such as RxACTION and RxACT achieved substantial improvements in blood pressure control and LDL target attainment [20].[36] Economic models predict long-term risk reduction, with 30-year CVD risk decreasing from 0.61 to 0.41.[30] Diabetes-focused pharmacist prescribing interventions also improved glycemic control.[32]

Pharmacist prescribers enhance oncology care through therapeutic drug monitoring and adherence support. Hematopoietic therapy programs achieved 73.9% target ciclosporin levels.[23] Anti-nausea protocols reduced MASCC symptom scores to zero for acute and delayed phases.[23] Oral anticancer adherence improved markedly (88.6% vs. 65.8%), with better patient understanding and molecular response rates.[23] Palliative care clinics led by pharmacists demonstrated significant pain score reductions.[23]

The findings provide support for pharmacist-led naloxone programs expanding harm reduction strategies. Collaborative models increased naloxone prescribing and improved medication reconciliation, while public training initiatives enhanced awareness.[31] These services underscore pharmacist prescriber's role in addressing opioid-related morbidity and mortality.

In addition, specialist pharmacist prescribers reduce depression and anxiety symptoms, with >50% reductions in PHQ-9 and GAD scores.[21] Continuity-of-care models showed 80% prescription renewal rates and fewer psychiatric emergency visits.[22] Pharmacist prescribing thus supports mental health stability and access during care transitions.

Evidence for pharmacist prescribing in hospital settings is mixed. While mortality and length of stay remain unchanged,[24,31] pharmacist prescribing improves condition-specific outcomes such as INR control, blood pressure, and glycemic metrics.[31] COVID-19 management by pharmacist prescribers yielded significant improvements in oxygen saturation and vital signs.[31] Dyslipidemia studies report consistent LDL target attainment.[31]

Across conditions, pharmacist prescribing delivers outcomes comparable to or better than physician-led care, particularly guideline-based interventions. Strengths include infection cure rates, cardiovascular risk reduction, oncology adherence, and harm reduction. Integration within interprofessional teams and standardised protocols enhances success. Practice: Health systems should prioritise pharmacist prescribing for high-volume conditions such as UTIs, minor ailments, hypertension, and diabetes. Oncology and palliative care benefit from pharmacist-led adherence and symptom management. Naloxone programs should be scaled for harm reduction.

Safety Impact of Pharmacist Prescribing

Evaluating the safety of pharmacist prescribing is critical in understanding its role within modern healthcare systems. Evidence from multiple studies suggests that pharmacist-led prescribing improves adherence to clinical guidelines, reduces medication errors, and maintains comparable safety outcomes to physician-led care (Appendix 4).

Pharmacist prescribing demonstrates significant benefits in antimicrobial stewardship, particularly for UTIs. Studies report that guideline-concordant therapy occurred in 95.1% of pharmacist-initiated cases compared to only 35.1% in physician-led care, where physicians were more likely to prescribe longer durations and broad-spectrum agents such as fluoroquinolones.[11] Importantly, adverse event rates did not differ significantly between groups, reinforcing the safety of pharmacist interventions.[25,31] Beyond infections, pharmacists have shown effectiveness in cardiovascular risk management and anticoagulant prescribing for atrial fibrillation. Sandhu et al. (2024) highlighted improved adherence and reduced stroke risk when pharmacists managed anticoagulant therapy.[15] Similarly, pharmacist-led medication reviews and diagnostic testing, such as rapid antigen tests for strep throat, were performed at markedly higher rates than in physician arms, supporting timely and accurate treatment decisions.[25] In mental health, pharmacist involvement reduced inappropriate medication use, particularly unnecessary antipsychotic prescribing, with statistically significant improvements ($P = 0.015$).[21] Hospital-based studies further underscore the safety impact of pharmacist prescribing, especially in emergency departments where co-prescribing and co-charting by pharmacists achieved absolute risk reductions in medication errors ranging from 87% to 97%.[24] Omission errors were nearly eliminated, and severe error impacts were reduced by over 93%.[24] Collaborative models in Australia demonstrated similar success, reducing prescribing errors from 66% under independent medical prescribing to just 3.6% when pharmacists were integrated into decision-making teams.[26] However, interventions limited to staff education without direct pharmacist involvement were relatively less effective, emphasising the importance of active participation in prescribing and charting.[24]

The evidence supports pharmacist prescribing as a strategy to enhance patient safety, improve adherence to guidelines, and reduce medication errors. Integration of pharmacists into collaborative care models and direct involvement in prescribing decisions should be prioritised. Areas requiring further improvement include communication with primary care providers, and targeted support for conditions where prescribing appropriateness remains suboptimal.[27] Despite promising findings, variability in study designs and outcome measures limits cross-study comparisons. Some studies reported incomplete follow-up and insufficient statistical reporting for adverse events, highlighting the need for standardised methodologies in future research.

Economic Impact of Pharmacist Prescribing

Economic findings are reported across multiple reviews and primary studies on pharmacist prescribing in community and hospital settings. The compiled table highlights diverse contexts of minor ailments, cardiovascular disease, oncology, secondary care, mental health, and urinary tract infections areas where pharmacist prescribing has been evaluated for cost consequences, cost-effectiveness and system-level impacts (Appendix 5).

Similar modelling in hypertension demonstrates substantial US-wide savings and QALY gains under large-scale uptake of pharmacist prescribing.[25]

Oncology services provide granular examples of pharmacist prescribing-driven efficiencies. Dose rounding policies and collaborative pharmacist prescribing have been associated with meaningful annual cost avoidance and improved workflow, while targeted prescribing and generic substitution reduce patient out-of-pocket costs.[23] Empirical reports describe cost avoidance from dose rounding protocols endorsed by professional bodies and improvements in physician efficiency that translate into revenue gains.[23]

In acute care, collaborative pharmacist prescribing models in Australian hospitals (e.g., Partnered Pharmacist Medication Charting/Prescribing) are linked to reductions in medication errors, shorter length of

stay and lower admission costs; narrative syntheses indicate 10% shorter stays and per-admission cost savings in implementations with robust credentialling frameworks.[26]

For UTI, a Canadian decision-analytic study found pharmacist-initiated management cost the public system roughly CAD $72 per case, versus CAD $142 and $368 for GP and ED management respectively; budget-impact modelling projected multi-million-dollar savings with even partial uptake.[27]

In secondary care, several studies report lower total costs per patient and reductions in hospital and ED utilisation after pharmacist prescribing interventions.[31] However, a UK pilot RCT in chronic pain suggested pharmacist-led prescribing may be more costly with similar QALYs relative to usual care, underscoring heterogeneity by indication and model.[30]

Beyond payer-level savings, patient affordability emerges as an important, but under-reported, dimension. Evidence indicates most patients perceive pharmacist prescriber consultation fees as reasonable, and a notable share seek pharmacist care to avoid the costs of physician visits; yet studies seldom measure ability to pay or equity impacts directly, and coverage gaps can deter uptake where consultations or pharmacist-prescribed medicines are not reimbursed.[28]

Access impacts are particularly salient in rural and underserved areas. Expanded pharmacist prescribing can reduce time-to-treatment, increase dispensing for time-critical therapies (e.g., contraception, anticoagulation), and reallocate physician time toward complex cases. Geospatial analyses of pharmacy density and emergency services further support the role of pharmacists in improving timeliness and safety in high-risk settings.

Economic evaluations of pharmacist prescribing vary in perspective (public payer vs. societal), time horizon, and included cost categories (direct medical costs, consultation fees, training, patient travel/wait times, productivity). Studies employing cost-minimisation assume comparable effectiveness across settings, while Markov models extrapolate long-term event reductions from short-term risk changes, often discounting benefits and assuming waning effects.

Notably, heterogeneity in pharmacist prescribing models, independent vs. collaborative, initiation vs. continuation/modification, complicates comparisons. Many implementations rely on credentialed pharmacists with local governance; transferability across sites remains limited, and economic outcomes depend on remuneration and insurance coverage. Reviews call for more robust RCTs and comprehensive cost–consequence analyses capturing health outcomes, equity, and administrative costs to establish value for money across professions and conditions.[30]

The weight of evidence suggests pharmacist prescribing delivers economic value in well-specified indications, minor ailments, hypertension/CVD risk reduction, oncology supportive care, and within collaborative hospital models. To maximise system benefits: (1) align remuneration and coverage to remove patient-facing cost barriers; (2) standardise credentialling and clinical governance to enable scalability and transferability; (3) integrate pharmacist prescribing within value-based payment models and electronic health records to streamline workflows; and (4) invest in pragmatic trials and hybrid implementation–economic studies to evaluate outcomes across diverse populations.

For Australian hospitals, national credentials (e.g., PPMC/PPMP) and partnered charting/prescribing frameworks show promise in reducing errors and shortening stays; expanding these models, with clear legislative support and insurer recognition, can yield cost savings at scale and improve access, particularly in regional settings.[26]

The compiled evidence indicates that pharmacist prescribing can be cost-saving or cost-effective across multiple clinical domains, with benefits accruing to both payers and patients. While results are strongest for minor ailments and CVD, oncology and hospital collaborative models also show favorable economic signals. Future work should priorities rigorous, indication-specific evaluations that incorporate patient affordability, equity, and long-term system impacts to inform sustainable pharmacist prescribing policy.

Across minor ailments, Canadian economic evaluations consistently show cost savings when pharmacists assess and prescribe for conditions such as sore throat, upper respiratory tract infections, contact dermatitis and conjunctivitis.[11] In a cost-minimisation analysis spanning five provinces, community-pharmacy point-of-care testing and pharmacist treatment of severe sore throat reduced costs by

approximately CAD $12–$24 per patient, yielding annual savings estimated between CAD $1.3 and $2.6 million.[25] Complementary provincial analyses from Saskatchewan found net societal savings of roughly CAD $0.55 million in 2014 and projected cumulative savings of about CAD $3.5 million by year five, with a positive return on investment, reflecting both direct health-system and productivity gains.[25]

For cardiovascular disease (CVD), modelled long-horizon analyses suggest pharmacist prescribing can be economically dominant. A 30-year Markov model linked to the RxEACH trial estimated more than CAD $4.4 billion in health-system savings, 576,689 QALYs gained, and over 8.9 million cardiovascular events avoided with scaled pharmacist care.[25]

Part B Accreditation of prescriber education programs in Australia

Aim

This review aims to examine grey literature sources, including publicly available websites, that summarise and compare frameworks and accreditation standards applicable to Australian non-medical prescribing professions. The primary objective is to identify and describe the standards that explicitly govern prescribing practice across non-medical health professions authorised to prescribe medicines in Australia.

Methods

A review of publicly available grey literature was undertaken to identify accreditation standards applicable to non-medical health professions that currently prescribe medicines in Australia. Based on the methodology used by Godin et al.,[37] the grey literature search incorporated two search strategies: (a) using customised Google search engines to identify relevant literature pertaining to accreditation standards for non-medical prescribing professions; and (b) targeted hand-searching of government and professional organisation websites. This included professional websites, regulatory resources, and accreditation of body publications. Accreditation standards that explicitly addressed the prescribing of medicines were identified, extracted, and reviewed. Where accreditation standards referred to supporting documents such as competency statements or professional practice standards, the relevant components of those documents were incorporated into the summary.

Search strategy

Firstly, documents reporting accreditation standards for non-medical prescribing professions in Australia were identified by searching Google using a range of key words from the search strategy in Table 2. Searches in Google were conducted in a non-private browsing mode from an Australian IP address, with no manual adjustments made to regional settings. As outlined by Godin et al, it is impractical to screen all results retrieved from Google searches; therefore, the relevancy ranking capabilities of the Google search engine were relied upon. Consequently, the decision was made to screen the first 30 pages of Google search results (297 entries). The targeted-hand searches focused on key regulatory and accreditation sources, including profession-specific accreditation bodies and Ahpra. Ahpra's database of Approved Programs of Study was searched, and all programs enabling endorsed or extended non-medical prescribing functions were manually transcribed into a structured Excel database.

Table 2 Search strategy

("approved program of study" OR "prescribing endorsement" OR "non-medical prescriber" OR "extended scope" OR "extended practice") AND (physiotherapy OR pharmacy OR podiatry OR nursing OR midwifery OR optometry) AND ("accreditation" OR "standards" OR "competency" OR "framework") AND (Australia)

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) process was applied to the grey literature search methods. The title and source organization of the identified documents were entered into the Excel sheet, and duplicates were removed. Title and abstract screenings were undertaken by one reviewer against inclusion criteria, with an intentionally overinclusive approach. Records deemed potentially relevant progressed to full-text screening, which was also conducted by one reviewer based on the inclusion criteria. When it was unclear whether a report met the eligibility criteria during screening, it was taken for discussion with an additional reviewer for consensus. Reference lists of the accreditation standards included were searched for any other potential documents relating to prescribing endorsement standards. After screening, the grey literature was consolidated into a single Excel spreadsheet, organised by profession, title, year of publication, and URL.

Inclusion criteria

Reports were included if they reported the accreditation standards for endorsed prescribing of non-medical professionals in Australia.

Data extraction and data synthesis

Data extraction was undertaken by one reviewer and included details on profession, program title, qualification required for endorsed prescribing, Australian Qualifications Framework (AQF) level, program provider, and the accrediting body. The full text of each report was reviewed to identify accreditation standards for endorsed prescribing. Accreditation standards were mapped according to the professional accreditation authorities overseeing each profession. For example, the Australian Nursing and Midwifery Accreditation Council (ANMAC) accredits all nursing and midwifery programs in Australia, whereas the Australian Pharmacy Council (APC) oversees accreditation for all pharmacy programs. The extracted information is reported in a series of tables.

Results and Discussion

Six non-medical health professions are currently authorised to prescribe in Australia.

1. Midwifery
2. Nursing
3. Optometry
4. Pharmacy
5. Physiotherapy
6. Podiatry

Table 3 provides a summary of the non-medical professions authorised to prescribe in Australia, including of approved programs of study, their corresponding Australian Qualifications Framework (AQF) levels and the accrediting body for each profession's qualifications.

Table 3 Non-medical professions authorised to prescribe in Australia

Profession	Approved Program(s) of Study (e.g., degree type)	Australian Qualification Framework (AQF) Level	Accreditation Body
Midwifery	Bachelor of Midwifery	7	Australian Nursing and Midwifery Accreditation Council[38]
	Bachelor of Midwifery Honours	8	
	Graduate Certificate in Midwifery Screening, Diagnostics and Prescribing	8	
	Graduate Certificate in Midwifery Diagnostics and Prescribing	8	
	Graduate Certificate in Prescribing for Midwives	8	
	Master of Midwifery Practice (Advanced Clinical) with Medication Endorsement	9	
	Master of Midwifery	9	
Nursing (including registered nurses and nurse practitioners)	Bachelor of Nursing	7	Australian Nursing and Midwifery Accreditation Council[39–41]
	Bachelor of Nursing (Honours)	8	
	Master of Nursing (Nurse Practitioner)	9	

Profession	Approved Program(s) of Study (e.g., degree type)	Australian Qualification Framework (AQF) Level	Accreditation Body
	Master of Advanced Nursing Practice (Nurse Practitioner)	9	
	Master of Nurse Practitioner	9	
	Specialist Certificate in Registered Nurse Prescribing	Non-AQF*	
Optometry	Bachelor of Vision Science & Master of Optometry	7/9	Optometry Council of Australia and New Zealand[42,43]
	Graduate Certificate in Ocular Therapeutics	8	
	Doctor of Optometry	9	
Pharmacy	Bachelor of Pharmacy (Honours)	8	Australian Pharmacy Council[44]
	Master of Pharmacy	9	
	Doctor of Pharmacy	9	
Physiotherapy	Bachelor of Physiotherapy	7	Australian Physiotherapy Council[45]
	Bachelor of Physiotherapy (Honours)	8	
	Master of Physiotherapy Practice	9	
	Doctor of Physiotherapy Practice	9	
Podiatry	Bachelor of Podiatry	7	Podiatry Accreditation Committee[46–48]
	Bachelor of Podiatry (Honours)	8	
	Bachelor of Podiatric Medicine (Honours)	8	
	Bachelor of Podiatric Practice (Honours)	8	
	Doctor of Podiatric Medicine	9	

Appendix 6 specifies whether endorsed prescribing is incorporated within entry-level programs or requires additional post-qualification training. Optometry and podiatry are the only professions in which prescribing competencies are embedded in the initial qualification, enabling newly registered practitioners to obtain scheduled medicines endorsement upon registration, provided they meet the Board's requirements (e.g., completion of an approved qualification in ocular or podiatric therapeutics clinically supervised practice, and compliance with relevant registration standards).[42,43,49–51] Physiotherapy endorsed prescribing is not included in entry-level programs and is currently only permitted in Queensland through an extended practice authority, requiring completion of an AQF Level 8 qualification. [52] The program must include aspects of prescribing and be aligned to the NPCF, and they must practice supervised under an authorised prescriber. For the remaining professions, midwifery, nursing, and pharmacy, prescribing is not part of entry-level degrees and individuals must complete additional Board-approved or accredited training to become endorsed prescribers.[44,53]

Table 4 outlines whether information relating to prescribing endorsement is embedded within each profession's entry-level accreditation standards or published in separate regulatory documents. For most professions, midwifery, nursing, pharmacy, physiotherapy and podiatry, prescribing requirements are contained in standalone documents such as registration standards, accreditation standards for prescribing programs, or extended practice authorities. Optometry is the only profession in which prescribing competencies are embedded directly within the entry level accreditation standards, as outlined in the OCANZ Accreditation Standards and Evidence Guide.[42] The specific document containing prescribing endorsement requirements for each profession is also provided in Table 4.

Table 4 Non-medical health professional prescribing accreditation standards

Profession	Information on prescribing endorsement separate or embedded in entry-level accreditation standards?	Document containing information on prescribing endorsement
Midwifery	Separate	Nursing and Midwifery Board of Australia. Registration Standard: Endorsement for Scheduled Medicines for Midwives[54]
Nursing	Separate	Nursing and Midwifery Board of Australia. Registration Standard: Endorsement for scheduled medicines-designated registered nurse prescriber[53]
	Separate	Nursing and Midwifery Board of Australia. Registration Standard: Endorsement as a Nurse Practitioner[55]
Optometry	Embedded	Optometry Council of Australia and New Zealand: Accreditation Standards and Evidence Guide for Entry-Level Optometry Programs[42]
Pharmacy	Separate	Australian Pharmacy Council: Accreditation Standards for Pharmacist Prescriber Education Programs[44]
Physiotherapy	Separate	Extended Practice Authority 'Physiotherapists[52]*
Podiatry	Separate	Accreditation Standards: Programs for registered podiatrists and podiatric surgeons addressing the requirements for endorsement of registration in relation to scheduled medicines (ESM programs)[46]

**Only approved in Queensland*

Appendix 7 outlines the Domains relating to prescribing for non-medical health professions within prescribing accreditation standards. Findings across the accreditation standards for non-medical health professions highlight that all non-medical prescribing professions, except midwifery and physiotherapy, explicitly reference the National Prescribing Competency Framework within their accreditation standards. For nursing, optometry, pharmacy, and podiatry, the framework is embedded as a requirement to guide program content, assessment, and demonstration of prescribing competency. The table also summarises the domains contained within each profession's endorsed prescribing accreditation standards, along with the associated domain statements. Because nurse practitioners and midwives share the same accreditation domains for prescribing, these have been reported once under midwifery. Physiotherapy does not currently have a dedicated prescribing accreditation standard, nor are prescribing requirements embedded within entry-level accreditation standards. This reflects the fact that physiotherapy prescribing is a recent development, introduced only in Queensland under an extended practice authority. As such, no formal accreditation domains relating specifically to prescribing exist for physiotherapy at this time.[52]

Table 5 summaries the scope of practice (SOP) for non-medical health professionals authorised to prescribe medicines in Australia. It outlines the specific prescribing authorities conferred to each profession, including the schedules of medicines they are permitted to administer, obtain, possess, prescribe, supply or use, and the legislative or jurisdictional conditions under which this authority is granted. The table highlights the variability in prescribing SOP across professions and states, with some, such as nurse practitioners, pharmacist prescribers and physiotherapists, having state- or context-specific prescribing conditions, while others, such as optometrists, midwives and podiatrists have nationally defined prescribing endorsements aligned to their professional roles and relevant medicines legislation.

In April 2026, the Pharmacy Board of Australia commenced public consultation on a draft Endorsement for scheduled medicines for pharmacists following recommendation from Health Ministers' meeting in June 2025. The consultation documents include:[1]

i. draft Registration standard: Endorsement for scheduled medicines
ii. draft Guidelines: Endorsement for scheduled medicines

This will inform the review of the 2023 Accreditation Standards for Pharmacist Prescriber Education Programs (the Standards),[44] which the Board has engaged APC to undertake to ensure that the quality and consistency of training and education supports the endorsed pathways.

Table 5 Non-medical health professions prescribing scope of practice

Profession	Healthcare professional	Prescribing SOP
Midwifery	Midwife prescriber	An endorsed midwife qualified to prescribe can prescribe schedule 2, 3, 4 and 8 medicines and to provide associated services required for midwifery practice in accordance with relevant state and territory legislation.[54]
Nursing	Registered Nurse Prescriber	Endorsed as qualified to administer, obtain, possess, prescribe, supply and/or use Schedule 2, 3, 4 and 8 medicines for the purposes of prescribing as a designated registered nurse prescriber with an authorised health practitioner within the scope of registered nurse practice.[53,56]
	Nurse Practitioner	Prescribing authority is conferred under the relevant drugs and poisons legislation of the Australian state or territory in which the NP practises. [55,57] The conditions under which each authority is granted, and the scope of that authority depend on the requirements of the specific legislation in each state or territory[55,57] These may range from a blanket authority limited by the NP's scope of practice to a prescribing authority based on a formulary or protocol, or related to a specific context of practice. [55,57] NPs must work within the relevant drugs and poisons legislation in their state or territory. [55,57]

Profession	Healthcare professional	Prescribing SOP
Optometry	Optometrist	An endorsed optometrist is qualified to administer, obtain, possess, prescribe, supply or use medicines, in accordance with relevant state and territory legislation, in the following classes: [58] topical schedule 2, 3 or 4 medicines for the purposes of the practice of optometry. The endorsement relates to relevant schedule 2, 3 or 4 medicine pursuant to section 52D of the Therapeutic Goods Act 1989 (Cth).[58]
Pharmacy	Pharmacist Prescriber	In Australia, trained pharmacists can prescribe certain medications for common, acute conditions like uncomplicated urinary tract infections (UTIs), skin conditions, and hormonal contraception, but prescribing authority varies by state and is subject to specific protocols.[5,44] Pharmacists must complete accredited postgraduate training to be eligible for expanded prescribing services, and these services are available in varying capacities across states, with some programs permanent and others in pilot phases. [5,44] Pharmacists are permitted to prescribe schedule 2, 3 and select schedule 4 medicines for certain approved conditions as outlined by each state and territory. [5,44]
Physiotherapy	Physiotherapist	In Queensland, physiotherapists may prescribe from an approved list of medicines (drug-formulary). Under the Extended Practice Authority, this includes Schedule 2, 3, 4 and 8 medicines for the purposes of prescribing or administering a medicine within the scope of practice as a physiotherapist.[52] A physiotherapist working in a public sector urgent care setting who has completed training in accordance with Appendix 1 and who has been credentialed to prescribe and administer by the Hospital and Health Service in which they are working, may prescribe and administer a medicine listed in Appendix 2, column 1 only: a) by a route for the medicine stated in Appendix 2, column 2; and b) subject to the conditions for the medicine stated in Appendix 2, column 3 (if any). [52] Before prescribing or administering a medicine listed in Appendix 2, the physiotherapist must be familiar with the contra-indication(s) and known side effects of the medicine and advise the patient accordingly. [52]
Podiatry	Podiatrist	Endorsement of registration identifies practitioners with additional qualifications and specific expertise. A podiatrist or podiatric surgeon whose registration is endorsed for scheduled medicines under Section 94 of the National Law is qualified to administer, obtain, possess, prescribe, sell, supply or use Schedule 2, 3, 4 or 8 medicines for the treatment of podiatric conditions, as listed in the National podiatry scheduled medicines list and in accordance with the relevant legislation and regulations in each state or territory where they practise.

Part C Accreditation standards for international pharmacist prescribing programs

Aim

This review comprises an environmental scan of international accreditation standards that enable pharmacists to register as pharmacist prescribers, as defined by the regulatory, legislative, and professional practice requirements of each jurisdiction.

Methods

A review of publicly available grey literature was undertaken to identify international accreditation standards that enable pharmacists to obtain prescribing authority. Sources included professional and regulatory websites, accreditation of body publications, government documents, and prescribing competency frameworks from jurisdictions where pharmacist prescribing is authorised. To maintain consistency in regulatory comparability, the search was restricted to anglophone countries within the Anglosphere that have established pharmacist prescribing pathways, specifically Canada, New Zealand (NZ), the United Kingdom (UK) and the United States of America (US). Documents were included if they described accreditation standards, educational requirements, or regulatory expectations that govern pharmacist prescribing with that jurisdiction.

Where accreditation standards referred to supporting documents such as prescribing competency statements, clinical governance standards or professional practice standards, relevant prescribing-related components of those documents were incorporated into the summary.

Search strategy

Following the methodology outlined by Godin et al.[37] the grey literature search used two complementary search strategies: (a) customized Google searches to identify relevant literature pertaining to prescribing accreditation standards for pharmacists; and (b) targeted hand-searching of government and professional organisation websites.[37] Google searches were conducted using a combination of key terms related to pharmacist prescribing accreditation (Table 6) and were conducted in a non-private browsing mode from an Australian IP address, with no manual adjustments made to regional settings. As outlined by Godin et al, it is impractical to screen all results retrieved from Google searches; therefore, the relevancy ranking capabilities of the Google search engine were relied upon. Consequently, the decision was made to screen the first 29 pages of the Google search results (286 entries). The targeted-hand searches focused on key international organisations, including national pharmacy regulators (e.g., General Pharmaceutical Council, UK; Pharmacy Council of New Zealand; and provincial regulatory authorities in Canada), accreditation bodies (e.g., UK Quality Assurance Agency, Canadian Council for Accreditation of pharmacy programs), government health departments (e.g., NHS England, Canadian provincial ministries) and professional associations (e.g., Royal Pharmaceutical Society, Pharmaceutical Society of Ireland). Where pharmacist prescribing exists within collaborative, supplementary, or independent models, associated accreditation or training requirements were also captured.

Table 6 Search strategy

("approved program of study" OR "prescribing endorsement" OR "pharmacist prescriber" OR "extended scope" OR "extended practice") AND (pharmacy OR pharmacist) AND ("accreditation" OR "standards" OR "competency" OR "framework") AND (Canada OR United Kingdom OR United States of America OR New Zealand)

Article selection

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) process was applied to the grey literature search methods. Titles and sources of retrieved documents were recorded in an Excel spreadsheet, and duplicates were removed. Title and abstract screening were undertaken by one reviewer against inclusion criteria, with an intentionally overinclusive approach. Records deemed potentially relevant progressed to full-text screening, which was also conducted by one reviewer based on the inclusion criteria. When it was unclear whether a report met the eligibility criteria during screening, it was taken for discussion with an additional reviewer for consensus. Reference lists of the accreditation standards included were searched for any other potential documents relating to prescribing endorsement standards. After screening, the grey literature sources were consolidated into a single Excel spreadsheet organised by country or jurisdiction, regulatory authority, accreditation body, prescribing model (independent, collaborative, supplementary), educational or competency requirements, legislative requirements, URL and year of publication.

Inclusion criteria

Reports were included if they: (a) described accreditation standards, educational requirements, or competency frameworks relevant to pharmacist prescribing; and (b) originated from Anglosphere countries where pharmacists are authorised to prescribe.

Data extraction and data synthesis

Data extraction was undertaken by one reviewer and included details on jurisdiction/country, prescribing model (independent, collaborative, supplementary), accreditation standards governing prescribing programs, competency or training frameworks referenced, entry requirements for prescribing authority, and regulatory or legislative conditions. The full text of each report was reviewed to identify accreditation standards for endorsed prescribing. Extracted information was summarised narratively and tabulated.

Results and Discussion

Table 7 summarises the prescribing requirements and authorised scope of practice for pharmacists across Canada, New Zealand, the United Kingdom and the United States of America. Considerable variation exists across jurisdictions in both the educational pathways required to obtain prescribing authority and the breadth of prescribing activities permitted.

Table 7 International educational requirements and conditions/medications for pharmacist prescribing

Country	Requirement to prescribe	What and where can pharmacists prescribe
Canada	Currently in Canada, there are no specific university based postgraduate prescribing courses as their regulatory bodies regard a certain level of prescribing as a standard qualification for graduates of pharmacy programmes. [59,60] However, in some provinces, there are requirements for continuing education modules to provide prescribing for minor ailments that may include ethical, legal, professional or clinical aspects. [59,60]	Scope varies considerably by province.[59] For example, all pharmacists registered on the Alberta College of Pharmacy clinical register may prescribe narcotics, controlled substances, and targeted drugs under defined legislative exemptions. [59] In Ontario, pharmacists may prescribe in emergencies, for smoking cessation, and for a range of minor ailments, with ongoing reforms expanding this scope to include additional ailments, vaccinations, and point-of-care testing. [59]
New Zealand	Completion of accredited postgraduate prescriber education program comprising the equivalent of 600 hours of study, half of which must be practical learning.[61]	Pharmacists prescribe from an approved list of medicines as defined in the *Medicines (Designated Pharmacist Prescribers) Regulations*.[62] Although the regulations specify the classes of medicines that may be prescribed, the practical scope of prescribing is shaped by the pharmacist prescriber's area of clinical practice.[61,62] Pharmacist prescribers commonly work within defined therapeutic areas or generalist roles, and their prescribing reflects the medicines relevant to those contexts.[61,62] Examples include prescribing with specialty services such as renal, paediatrics, aged care, oncology, HIV, mental health, respiratory medicine, diabetes, cardiology, stroke or subspecialties (e.g., heart failure).[61,62] Generalist pharmacist prescribers, such as those working in primary care, ambulatory care, emergency departments, or aged-care facilities, may prescribe across a broad range of conditions including chronic disease management, polypharmacy, gout and diabetes. [61,62] Prescribing commonly occurs within collaborative team settings in which providers share clinical information and manage patient care jointly. [61,62]
United Kingdom	From 2026 independent prescribing education and training delivered at master's level (equivalent to Bachelors in Australia), as defined in UK national qualification frameworks entitles individuals to practice as a prescriber from the date of registration.[63,64] Conversely, pharmacists who graduated before 2026 are required to complete a postgraduate prescribing course to become qualified as an accredited independent prescribing.[63,65] The program typically requires six months of part-time study, combining face-to-face teaching (often one day per week) with self-directed learning. [63,65]	A pharmacist independent prescriber may prescribe autonomously for any condition within their clinical competence.[66] This currently excludes three controlled drugs to treat addiction.[66]
United States of America	Varies by state; may include training modules, supervised practice, or certification through mechanisms such as the Board of Pharmacy Specialties.[67]	Scope varies widely.[67,68] Pharmacists prescribe under state-specific protocols or collaborative practice agreements. [67,68] State-wide protocols often cover public-health–focused prescribing, such as smoking cessation, contraception, or vaccinations.[67]

Canada

In Canada, pharmacist prescribing is not granted through entry-level (Baccalaureate or PharmD) accreditation standards, prescribing authority is instead regulated at the provincial level, with regulators determining the scope of pharmacist prescribing following graduation from an accredited first professional degree. The Canadian Council for Accreditation of Pharmacy Programs (CCAPP) accredits all entry-to-practice Baccalaureate and Doctor of Pharmacy (PharmD) programs, ensuring graduates possess the competencies required for contemporary pharmacist practice across the country.[69,70]

Across both CCAPP documents, *Accreditation Standards for Canadian First Professional Degree in Pharmacy Programs (2018, revised 2020)* and *Accreditation Standards for Canadian Educational Programs Leading to the Doctor of Pharmacy (2023)*, prescribing-related competencies appear in multiple domains.[69,70] The standards emphasise the pharmacist's role as a medication-therapy expert, responsible for assessment, clinical decision-making, planning and monitoring therapy, documentation, collaboration, and patient-centred care.[69,70] These elements support the competencies necessary for prescribing. Both sets of standards require that graduates demonstrate competence in the pharmacist patient care process, which includes collecting information, assessing therapy, planning care, implementing decisions, following up/evaluating outcomes, communicating with patients and teams, and documenting care.[69,70]

Curriculum requirements mandate depth and breadth across advanced clinical sciences, pathophysiology, pharmacotherapeutics, evidence-based practice, point-of-care testing, diagnostic reasoning, physical assessment, and prescriptive decision-making.[69,70] Both standards explicitly list prescribing-related practice skills such as patient assessment, outcomes monitoring, shared decision-making, medication therapy management, and prescriptive decision-making under the practice-skills curriculum.[69,70] Experiential learning is also central. Both sets of standards require extensive direct patient-care practice experiences, including primary care, acute care, and exposure to patients with chronic and acute conditions.[69,70] These placements must allow students to participate meaningfully in clinical decision-making, manage real medication regimens, and exercise therapeutic reasoning.[69,70]

Interprofessional practice, communication, and collaboration standards reinforce the requirement that pharmacists be able to function within multidisciplinary teams. [69,70] Educational outcomes are explicitly aligned with national professional competency frameworks, including the NAPRA Professional Competencies for Canadian Pharmacists at Entry to Practice. Although Canada does not accredit specific postgraduate pharmacist prescribing programs, provincial regulators confer prescribing authority based on these entry-level competencies and additional jurisdiction-specific requirements.

New Zealand

In New Zealand, prescribing is not embedded within entry-level pharmacy programs; instead, pharmacists must obtain prescribing authority through a separate postgraduate pharmacist prescriber qualification. Entry-level BPharm programs are accredited against the *Aotearoa New Zealand Accreditation Standards for Pharmacy Programmes*, which apply across all scopes of practice, but do not themselves confer prescribing capability.[71] These entry-level standards ensure graduates can practise safely as intern pharmacists and, subsequently, as pharmacists, by meeting requirements in areas such as Te Tiriti o Waitangi and hauora Māori, public and patient safety, cultural safety, academic governance, and clinical and experiential learning. Although these standards emphasise legal, ethical, and clinical decision-making relevant to medicines optimisation, they do not include independent prescribing training.

Pharmacist prescribing in New Zealand is instead obtained through a dedicated postgraduate pharmacist prescriber program, accredited and regulated under the *Pharmacist Prescriber Competence Standards*.[72] These prescribing-specific standards define the capabilities required for pharmacist prescribers, including advanced clinical assessment, diagnostic reasoning, formulation of treatment plans, prescribing within collaborative care agreements, safe and effective monitoring, culturally safe practice, and accountability for clinical decisions. [72] Prescriber training must demonstrate how learners achieve these competencies, and assessment must verify competence in complex clinical reasoning, interpretation of diagnostic information, shared decision making, and integration of Māori health perspectives into prescribing practice. [72] These postgraduate standards also require robust governance structures, supervised clinical placements, direct

patient care activities, and demonstration of prescribing autonomy within the prescriber's designated therapeutic area. [72] The Pharmacist Prescriber Competence Standards note that pharmacists may practise as prescribers in a broad range of specialty and generalist roles, including primary care, emergency departments, aged care, surgical pre-admission, anticoagulation management, antimicrobial stewardship, and complex polypharmacy. [72]

Consistent with this framework, the University of Auckland's Postgraduate Certificate in Clinical Pharmacy was purpose-built to align with the Pharmacy Council's prescriber competencies. [72] Its curriculum draws on the UK's model of prescribing education, particularly the clinical assessment and diagnostic components embedded in the UK's initial-education and independent-prescriber standards, but is adapted to the NZ regulatory context, incorporating local requirements for example Te Tiriti responsiveness, hauora Māori, collaborative practice, and safe, culturally appropriate prescribing.

United Kingdom

In the United Kingdom, prescribing is addressed comprehensively across both entry-level and postgraduate accreditation standards. The General Pharmaceutical Council (GPhC) embeds prescribing capability within initial pharmacy education through the *Standards for the Initial Education and Training of Pharmacists*, which require prescribing knowledge and skills to be progressively developed throughout the MPharm program and consolidated during the foundation training year.[64] These standards integrate diagnostic reasoning, clinical assessment, therapeutic decision-making, legal and ethical aspects of prescribing, and the governance and accountability responsibilities associated with prescribing practice. Prescribing learning outcomes are embedded across all four core domains and culminate in supervised, practice-based prescribing training. [64] Trainee pharmacists must complete a minimum of 90 hours of supervised prescribing-related practice under the oversight of a designated prescribing practitioner, enabling graduates from 2026 onward to qualify as independent prescribers at the point of registration. [64] The standards emphasise competence in history taking, interpretation of clinical data, risk stratification, shared decision making, monitoring and reviewing treatment, deprescribing, and safe documentation, ensuring that prescribing becomes an integral part of the pharmacist's initial scope of practice. [64]

For the existing pharmacist workforce, prescribing remains a post-registration qualification and is governed by the GPhC's. [65] These standards define the accreditation requirements for standalone independent prescribing programs, specifying entry criteria (including registration as a pharmacist and relevant UK practice experience), course structure, governance arrangements, staffing, and quality assurance expectations. [65] The standards outline detailed learning outcomes that prescribers must achieve, covering person-centred consultations, clinical reasoning, application of clinical therapeutics, diagnostic skills, management of complex patients, prescribing within legal and regulatory frameworks, and professional accountability. [65] Training comprises at least 26 days of structured learning alongside a minimum of 90 hours of supervised clinical practice with a designated prescribing practitioner, who must meet specific experience requirements. [65] Assessment standards require learners to demonstrate safe, effective, and evidence-based prescribing without compensation or condonation.[65]

United States

In the US, prescribing authority for pharmacists is regulated at the state level and is commonly enacted through collaborative practice agreements, statewide protocols, or public-health prescribing authorities rather than a national endorsement system. Accordingly, the Accreditation Council for Pharmacy Education (ACPE) *Standards 2025* function as the foundational prescribing-relevant accreditation standards for all entry-level Doctor of Pharmacy (PharmD) programs.[73] The Standards require graduates to demonstrate competencies in therapeutic decision-making, person-centred care, clinical assessment, and evidence-based pharmacotherapy, with explicit expectations that students can interpret clinical data, diagnose and manage common conditions, and contribute to prescribing decisions within interprofessional teams. [73] Prescribing-related requirements appear throughout the curriculum standards, including mandated content on "medication prescribing, preparation, distribution, dispensing, and administration," and pharmacotherapy instruction that encompasses diagnosing, prescribing, and developing therapeutic plans across acute and chronic disease states.[73] Experiential training further reinforces these capabilities by requiring participation in therapeutic

decision-making during both introductory and advanced practice experiences, consistent with US collaborative prescribing models. [73] Although ACPE does not accredit postgraduate prescriber qualifications, the Standards ensure all US pharmacy graduates attain baseline competencies that support prescribing functions permitted under state legislation. [73]

Table 8 summarises the jurisdictions that permit pharmacist prescribing and details the associated accreditation standards. For Canada, NZ, the UK, and the US, these standards are examined and categorised according to whether they apply to initial university pharmacy education, intern training or to postgraduate prescribing programs.

Table 8 Educational requirements for pharmacist prescribing Authority

Country	Initial registerable pharmacy degree	Intern period	Post graduate	Right to prescribe at:
United Kingdom: Graduation pre 2026	No	No	Yes	National in own area of compentency
United Kingdom: Graduation post 2026	Yes	Yes	Yes	National in own area of compentency
Canada	No	No	Yes	Provincial courses in various conditions
New Zealand	No	No	Yes	National in own area of compentency
United States of America	No	No	Yes	State level for different conditions/medicines

International Models of Prescribing

Three overarching models describe how pharmacists obtain prescribing authority internationally (Table 8). Model A refers to jurisdictions where prescribing rights are embedded within initial pharmacy education and training; once pharmacists complete their entry-level degree and mandated internship or foundation year, they are eligible to prescribe upon registration. Model B applies where entry-level programs develop clinical and therapeutic competencies relevant to prescribing but do not confer prescribing authority, requiring registered pharmacists to complete a nationally accredited postgraduate prescribing qualification to obtain prescribing rights. Model C is similar to Model B in that initial training does not grant prescribing authority; however, prescribing rights are contingent on completing jurisdiction-specific (state or provincial) training or certification, determined by local legislation rather than a national prescribing qualification.

In the United Kingdom, both Model A (for pharmacists graduating from 2026 onwards, who qualify as independent prescribers at registration) and Model B (for the existing workforce requiring a postgraduate independent prescribing program) operate concurrently. In Canada and New Zealand, prescribing follows Model B, whereby entry-level programs provide the foundational competencies, but pharmacists must undertake an additional accredited prescribing qualification to gain prescribing authority (Table 9).

Table 9 Entry-level, Intern-level, and Postgraduate pharmacist prescribing accreditation standards

Country	Title of document	Organisation	What support learning does the prescribing accreditation apply to (i.e., entry-level program, intern-level program, post-graduate program)	Standards for pharmacist prescribing
Canada	Accreditation standards for Canadian first professional degree in Batchelor pharmacy programs[69]	The Canadian Council for Accreditation of Pharmacy Programs	Entry-level program	Standards for provincial level (unavailable)
	Accreditation standards for Canadian Educational Programs Leading to the Doctor of Pharmacy (PHARM.D.) Degree [70]	The Canadian Council for Accreditation of Pharmacy Programs	Entry-level program	Standards for provincial level (unavailable)
New Zealand*	Aotearoa New Zealand Competence Standards for pharmacist prescribers[72]	Pharmacy Council of New Zealand	Post-Graduate program	Standards (competency standards for pharmacist prescriber
United Kingdom	Standards for the initial education and training of pharmacists[64]	General Pharmaceutical Council	Entry-level & Intern-level program	Standards are included within the degree and Intern level programs
	Standards for the education and training of pharmacist independent prescribers[65]	General Pharmaceutical Council	Postgraduate program	Standards for postgraduate program
United States of America	Accreditation Standards and key elements for the professional program in pharmacy leading to the Doctor of Pharmacy Degree[73]	Accreditation Council for Pharmacy Education	Entry-level program	Standards for provincial level (unavailable)

** The University of Auckland's Postgraduate Certificate in Clinical Pharmacy in Prescribing was created to align with the competency standards set by the Pharmacy Council of New Zealand. The program's curriculum was based on the UK's competency requirements and adapted to meet those of the Pharmacy Council of New Zealand, with a key focus on practical, supervised prescribing experience.*

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Glossary

For the purposes of this document, the following definitions apply.

Term	Meaning
Consumer	A person who has used, currently uses, or will use health care services. This includes the person's family and carers.
Minor ailment service	Pharmacist diagnosis and management of common, self-limiting, or uncomplicated conditions.
Independent prescribing	Prescribing undertaken by a professional who assumes responsibility for all parts of the prescribing process according to their scope of practice.
Patient	The term 'consumer' has been used preferentially throughout the document. The term 'patient' is used when the source information (e.g., research study, standard) has employed this term.
Prescribing	An iterative process involving the steps of information gathering, clinical decision making, communication and evaluation which results in the initiation, continuation or cessation of a medicine.
Prescribing Competencies Framework (The Framework)	A national prescribing competencies framework which describes prescribing expectations for prescribers in Australia, regardless of profession.
Scope of practice	A time sensitive, dynamic aspect of practice which indicates those professional activities that a pharmacist is educated, competent and authorised to perform and for which they are accountable.
Supported prescribing	Prescribing undertaken with support provided by a defined formulary, medicines use protocol and/or a collaborative agreement describing shared responsibility.

List of Abbreviations

Abbreviation	Meaning
ADC	Australian Dental Council
AMC	Australian Medical Council
ANMAC	Australian Nursing and Midwifery Accreditation Council
APA	Additional Prescribing Authorisation
APC	Australian Pharmacy Council
CPA	Collaborative practice agreement
CPD	Continuing Professional Development
DBA	Dental Board of Australia
DMP	Designated medical practitioner
DPP	Designated prescribing practitioner
ED	Emergency department
ESM	Endorsement for Scheduled Medicines
EPA	Extended Practice Authority
GP	General Practitioner, General Practice
GPhC	General Pharmaceutical Council (UK)
GPP	General Practice Pharmacist
MAS	Minor ailment service
MBS	Medical Benefits Schedule
NPCF	National Prescribing Competencies Framework
NMBA	Nursing and Midwifery Board of Australia
NNT	Number needed to treat
NP	Nurse practitioner
NPS	National Prescribing Service (also referred to as NPS MedicineWise)
OBA	Optometry Board of Australia
OCANZ	Optometry Council of Australia and New Zealand
PBS	Pharmaceutical Benefits Scheme
PCNZ	Pharmacy Council of New Zealand
PharmBA	Pharmacy Board of Australia
PodBA	Podiatry Board of Australia
PPMC	Partnered pharmacist medication charting
PSA	Pharmaceutical Society of Australia
QUM	Quality use of medicines
UTI	Urinary tract infection
UITPP-Q	Urinary Tract Infection Pharmacy Pilot-Queensland
VTE	Venous thromboembolism

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Appendix 1 Summary of the included review characteristics

Title	Author, Year and Review type	Number of studies	Model of Pharmacist Prescribing	Objective	Framework and guidelines	Quality assessment tool
Mapping the US literature on pharmacists prescribing to initiate medications: A scoping review of terminology, responsibilities, and alignment with international models[29]	Ahmed et al October 2025 Scoping review	92	Mixed	To characterise US prescribing terminology and pharmacists' responsibilities when initiating medication under various US prescribing models and map the US literature on pharmacists' initiating medication to the international context.	Arksey and O'Malley's framework an PRISMA-ScR guidelines	Not reported
Effects of pharmacist prescribing on health-related outcomes in secondary care compared with medical prescribing or no treatment: A systematic review[31]	Akintunde et al November 2025 Systematic review	21	Mixed	To assess the effects of pharmacist prescribing on health-related outcomes in secondary care.	MEDLINE, Cochrane, CINAHL, Scopus, and Web of Science Core Collection databases were searched for studies published in English from database inception to 3 October 2024. Studies were included if the intervention was pharmacist prescribing and the outcomes were health-related and measurable. Narrative synthesis of the outcomes from included studies was conducted. Results: A total of 21 studies from five countries (Australia, Egypt, Hong Kong, UK, USA) were included.	Randomised trials were assessed for quality using the Cochrane revised tool to assess risk of bias in randomised trials (RoB 2). The non-randomised studies were assessed using the ROBINS-I tool for assessing risk of bias in non-randomised studies of interventions. Grades of Recommendation, Assessment, Development and Evaluation tool (GRADE) was used to determine confidence that the cumulative evidence represented closely approached the true value of impacts of pharmacist prescribing
Interventions to expand community pharmacists' scope of practice[36]	Ali et al June 2024	14	Mixed	To describe the interventions that expand the pharmacist's scope of	Joanna Briggs Institute methodology (JBI)	The JBI critical appraisal tool

Title	Author, Year and Review type	Number of studies	Model of Pharmacist Prescribing	Objective	Framework and guidelines	Quality assessment tool
	Scoping review			practice within a community pharmacy setting and assess their effectiveness.		
Exploring non-medical prescribing for patients with mental illness: a scoping review[21]	Alsaeed et al. May 2025 Scoping review	63	Mixed	To map published research evidence concerning non-medical prescribing for patients with mental illness.	The method used in this scoping review was based on the framework initially established by Arksey and O'Malley, as further enhanced by Levac, Colquhoun, and O'Brien	Not reported
Global advancement in pharmacy services for mental health: A review for evidence-based practices[22]	Alshammari et al April 2023 Review	68	Mixed	This review provides a rapid overview of the scope of services and a segmentation of services with reference to transformation, highlights the associated challenges in services, provides an overview of the quality of the provided services with reference to societal and professional perspectives, and concludes with a futuristic approach to services on the basis of results obtained from pilot projects as well as recommendations to strengthen the pharmacy services in Mental Health.	Assessed for quality and bias	The Mixed Methods Appraisal Tool (MMAT)
Collaborative pharmacist prescribing models in Australian hospitals: a scoping study[26]	Amer et al September 2025 Scoping Study	15 models across 35 Hospitals	Collaborative	To identify pharmacist prescribing policies and procedures in Australian hospitals and provide a narrative summary of the models and associated training.	Not reported	Not reported
Impact of pharmacist interventions provided in the emergency department	Atey et al	31	Mixed	To synthesise evidence from studies examining the impact of interventions	Summary estimates were pooled using random-effects meta-	Cochrane Risk of Bias-2 and Newcastle-Ottawa

Title	Author, Year and Review type	Number of studies	Model of Pharmacist Prescribing	Objective	Framework and guidelines	Quality assessment tool
on quality use of medicines: a systematic review and meta-analysis [24]	Feb 2023 Systemic review			provided by pharmacists on the quality use of medicines in adults presenting to the emergency department.	analysis, along with sensitivity and sub-group analyses	
Costs, consequences and value for money in non-medical prescribing: a scoping review[30]	Babashahi May 2023 Scoping review	9	Independent	To identify, synthesise and report the evidence on the costs, consequences and value for money of non-medical prescribing provided by non-medical healthcare professionals.	Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) reporting guideline recommended by Tricco et al to report our scoping review study.29 Also used the five stage methodological framework developed by Arksey and O'Malley and further developed by Levac et al and the Joanna Briggs Institute to ensure rigour in reporting the review and its methodology	Not reported
Pharmacists' acceptability of provision of sexually transmitted infection services: a scoping review[34]	Bergin et al June 2025 Scoping review	22	Not reported	To map, characterise, and explicate the acceptability of pharmacist-delivered STI services.	The results were mapped to the theoretical framework of acceptability (TFA)	Not reported

Title	Author, Year and Review type	Number of studies	Model of Pharmacist Prescribing	Objective	Framework and guidelines	Quality assessment tool
Community pharmacist prescribing: Roles and competencies - A systematic review and implications[15]	Clemens et al November 2025 Systematic review	23	Mixed	compares international roles, identifies inferred competencies, and explores implications for role expansion	Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines	studies were appraised with Critical Appraisal Skills Programme (CASP) checklists, and interrater reliability assessed via Cohen's Kappa
Pharmacist prescribing in cancer services: a scoping review[23]	Johnson et al May 2025 Scoping review	41	Mixed	To explore pharmacist prescribing in cancer services, prescribing models used, impact on patient outcomes and stakeholders' views.	The Joanna Briggs Institute's scoping review guidelines	Not reported
A scoping review of evidence of community pharmacist independent prescribing for common clinical conditions: beyond protocol prescribing[11]	Karim et al August 2025 Scoping review	10	Independent	To collate and characterise literature on the integration of 'standard of care' model delivered by Pharmacist Independent Prescribers in Community Pharmacy for acute common clinical conditions (CCCs).	Arksey and O'Malley framework. Barriers and facilitators for integration used the Consolidated Framework for Implementation Research as a theoretical lens	Not reported

Title	Author, Year and Review type	Number of studies	Model of Pharmacist Prescribing	Objective	Framework and guidelines	Quality assessment tool
Assessment and evaluation of prescribing competences: A systematic review and recommendations[35]	McLachlan et al March 2024 Systemic review	54	Not reported	To summarise existing national-level approaches, provide a systematic review of current literature, indicate the frequency of various methodologies, and make recommendations to promote and extend existing practice.	Regulatory body websites were accessed for details of national examinations	Medical Education Research Quality Instrument (MERSQI)
Pharmacists as independent prescribers in community pharmacy[12]	Mesbahi et al, October 2024 Scoping review	88	Independent	To summarise evidence around independent Pharmacist Prescribing (IPP) globally and in relevant jurisdictions. It focuses on IPP in community pharmacies, conditions to be managed, medications that could be prescribed, and reimbursement policies.	PRISMA-ScR guidelines	Not reported
A systematic review of the role of community pharmacists in the prevention and control of cardiovascular diseases: the perceptions of patients[32]	Motlohi et al September 2023 Systematic review	45	Independent	To identify the roles of community pharmacists in preventing and controlling cardiovascular diseases and patients' perceptions towards such functions.	Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines The quality of studies was appraised using the Joanne Briggs Institute checklist	Joanne Briggs Institute checklist
The community pharmacist as an independent prescriber: A scoping review[25]	Piraux et al Nov-Dec 2024 Scoping review	13	Independent	To analyse the contribution of independent prescribing by community pharmacists, in primary care, using the micro, meso, macro level framework	Not reported	Not reported

Title	Author, Year and Review type	Number of studies	Model of Pharmacist Prescribing	Objective	Framework and guidelines	Quality assessment tool
Pharmacists' naloxone services beyond community pharmacy settings: A systematic review[33]	Rawal et al Feb 2023 Systemic review	76	Mixed	identify pharmacists' naloxone services and their outcomes, and b) examine knowledge, attitudes, and barriers (KAB) related to naloxone service provision in non-community pharmacy settings	Joanna Briggs Institute (JBI) checklist Methodological Index for Non-Randomised Studies (MINORS) tool	National Institutes of Health (NIH) tool, the Mixed-methods Appraisal Tool (MMAT)
The clinical and economic evidence of the management of urinary tract infections by community pharmacists in women aged 16 to 65 years: a systematic review[27]	Swart et al Jan 2024 Systematic review	10	Government protocol	To systematically gather, assess, and synthesise the available peer-reviewed published literature on the management of uncomplicated UTIs by community pharmacists in women aged 16–65 years, provide an understanding of the clinical and economic evidence, while also identifying the essential components of interventions employed.	Joanna Briggs Institute (JBI) checklist	Not reported ,
The accessibility of pharmacist prescribing and impacts on medicines access: A systematic review[28]	Walpola et al May 2024	47	Mixed	To assess the direct impacts of pharmacist prescribing on medicines access, and the accessibility of pharmacist prescribing services, in community and primary care settings.	Not reported	Quality Assessment for Diverse Studies (QuADs)

*Appendix 2 Evidence-based summary of accessibility in pharmacist prescribing**

Title	Accessibility
Pharmacists as independent prescribers in community pharmacy[12]	Access to treatment for conditions like uncomplicated UTI for women, hormonal contraception, smoking cessation by pharmacist prescribing has been established in some countries such as Australia and Canada. There is emerging evidence about pharmacists being authorised to initiate treatment for chronic conditions such as hypertension and diabetes. Access for managing these conditions means better access to healthcare.
The community pharmacist as an independent prescriber: A scoping review[25]	Beaham et al. reported a significant time difference between accessing the pharmacist and the GP "(1.7 days vs. 2.8 days, respectively; p=0.0153)". Mansell et al. reported pharmacist prescribing for managing minor ailments to avoid medical consultation in "35.2%, and emergency department visit in 3.4%". Booth et al. reported that people who came to the pharmacy for pharmacist-led care were treated quicker than those who came to fill prescriptions, and that a third of the people who received pharmacist care, received it on a weekend when medical offices were closed which highlights the role of pharmacist prescribing to improve access to care [30] for people including those who require access beyond regular operating hours.
A scoping review of evidence of community pharmacist independent prescribing for common clinical conditions: beyond protocol prescribing[11]	Papastergiou et al. 2018; in a study included 7050 patients across 204 participating sites, 25.5% tested positive for Group A Streptococcus infection. Same day prescribing of antibiotics was achieved in 68.7%, which highlights the independent pharmacist prescriber's role in improving accessibility. Same day prescribing was 73.8% in Alberta, and 40.5% in Nova Scotia, noting that pharmacists have advanced prescribing authority in Alberta.
Community pharmacist prescribing: Roles and competencies - A systematic review and implications[15]	Bachyrycz et al. 2017; a study that investigated implementation of naloxone prescribing concluded that pharmacist direct accessibility was a noted facilitator in implementing naloxone pharmacist prescribing service, while rural access was a barrier. Azad et al. 2024 investigated access to contraception in rural areas, and concluded that high accessibility was a facilitator to contraception access.
The accessibility of pharmacist prescribing and impacts on medicines access: A systematic review[28]	Chavez et al. 2019 found an increase in the percentage of patients diagnosed with depression and eligible to receive medication from 49% to 58%. DeRonne et al. 2021 found an increase in percentage of people eligible to receive naloxone from 33.8% to 46.7%. Haby et al. 2020 found an increase in people with atherosclerotic cardiovascular disease to receive statins increased from 75.2% to 79.3%. Soon et al. 2005 found an increase in total emergency contraception prescribing by 102% compared to the prior 5-year mean in all age groups, with a ≥2-fold increase in prescribing among patients aged 25–54 years. The increase in pharmacist prescribing did not relate to a decrease in physicians' prescribing. Xu et al. 2021 found an averaged increase of 331 in naloxone dispensing which comes to 53% increase after confounding policy variables adjusting. Gibbs et al. 2021 found no significant impact of pharmacist prescribing on hormonal contraception access. Beahm et al. 2018 found that median number of days to see a pharmacist prescribing was 1.7 compared to 2.8 to see a physician in people who received treatment for urinary tract infections.

Title	Accessibility
	Papastergiou et al. 2018 identified that “patients seen by a prescribing pharmacist were more likely to receive an antibiotic on the same day as receiving a positive Group A streptococcus test result than those seeing a pharmacist without prescribing authority (75.8 % vs 35.3 % in British Columbia and 42.2 % in Nova Scotia)” Tinelli et al. 2013 found no difference in time people need to access prescriptions between physicians and pharmacist prescribing. Silvia et al. 2020 showed that time to see the mental health pharmacist prescribing was 3 times less than time needed to see a specialist physician (31.3 days vs 104.5 days respectively), and percentage of patients seen within 7 days of referral was 23% vs 0% between mental health pharmacist prescribing and specialist physician respectively. Klepser et al. 2016 reported that 43.9% of patients were seen by the pharmacist outside regular opening hours of medical clinic office. Mansell et al. 2015 stated that ease of access represented 17.2% of reasons why people chose a pharmacist-led care, “not wanting to wait for a physician’s appointment (14.6 %), being unable to get a physician’s appointment in a timely manner (9.9 %), the medical clinic being closed (3.1 %), or not having a regular physician (1.0 %)”. This study also reported that patients “would have self-selected over-the-counter medicine (43.2 %), gone to a physician (35.2 %), used something at home (8.0 %), done nothing (5.7 %), or attended an emergency department (3.4 %)” if pharmacist prescribing was not available. Papastergiou et al. 2018 reported the following reasons for reusing the pharmacist prescribing service: “fast and efficient service (54 %), it was easy (18 %), it was convenient (16 %), and no appointment was necessary (6 %)” Additionally; the study reported that “54 % of patients reported their physician was unavailable at the time they saw the pharmacist prescriber”. The study stated these probabilities if the pharmacist prescribing was not available; 37% of participants would have attended a walk-in-clinic, 26% would have visited their physician, 14% would have waited for their physician, 9% would have attended emergency department, and 9% would have self-treated or done nothing.
Interventions to expand community pharmacists’ scope of practice[36]	Cameron et al. conducted a study in the UK offering women who requested emergency contraception a three-month supply of the progestogen-only pill along with a rapid-access card to a participating sexual health clinic, with the goal of reducing unwanted pregnancies. After the intervention was implemented, the proportion of women using effective contraception was 20.1% higher in the intervention group (mean 58.4%, 48.6–68.2) compared with the control group (mean 40.5%, 29.7–51.3).
Pharmacist prescribing in cancer services: a scoping review[23]	Lau et al. 2020 found that patients’ access to medication was improved due to lower cost burden with pharmacist prescribing. Wright et al., 2020 showed a positive impact of pharmacist prescribing on timely supply of prescriptions.
Pharmacists' naloxone services beyond community pharmacy settings: A systematic review[33]	Duvivier et al. 2017 found that pharmacist co prescribing of naloxone has increased to the medication, as pharmacists trained 350 law enforcement officers and carried out a mass naloxone dispensing in Indian Country. Mailloux et al. 2021 investigated physician-pharmacist collaborative practice model and found that naloxone prescriptions percentage among people who were treated with buprenorphine/naloxone was 8.18% compared to 5.14% in a psychiatrist only model. Wilson et al. 2017 utilised pharmacist co-prescribing of naloxone, 350 people were eligible to receive naloxone, from 709 who met the chronic opioid use criteria, averaging a percentage of 49.9%.

Title	Accessibility
Exploring non-medical prescribing for patients with mental illness: a scoping review[21]	Patients reported to have improved access to pharmacist prescribing compared to doctors in two studies. Silvia R et al. 2020 showed that the waiting time for people to start therapy by psychiatric pharmacist was 22.6 days in comparison to 79.3 days with behavioural clinic providers. Green B et al. 2008 and Gumber et al. 2012 showed that increased nurse prescribers and pharmacist prescribing availability enhanced access to service and medications particularly for those in isolated areas. Non-medical prescribing appropriate and accessible services may alleviate challenges related to the mismatch between ADHD increasing rate of diagnosing, and the limitation of the ADHD medications supply in ways including offering alternative therapies.
Global advancement in pharmacy services for mental health: A review for evidence-based practices[22]	Gibu et al. 2017 in a retrospective cohort study on 81 patients investigating a number of interventions reported that 80% of prescriptions were renewed and subsequently Emergency visits by patients were decreased by pharmacist interventions including interim prescribing.
Pharmacists' acceptability of provision of sexually transmitted infection services: a scoping review[34]	Hunter et al. 2023; in a study that investigated pharmacist prescribing of PrEP, it was concluded that despite pharmacist initiation of therapy and supportive pharmacists' attitudes the implementation of the service was "short of the vision for significantly expanded access".
The clinical and economic evidence of the management of urinary tract infections by community pharmacists in women aged 16 to 65 years: a systematic review[27]	Stewart et al. 2018; investigated a service by pharmacist prescribers to manage UTI, impetigo, COPD in community pharmacy, reported more access to treatment. Patients who commented on the timeliness of service were 29 out of 73 people who responded to a feedback survey. Beahm et al. 2018 evaluated the efficacy, safety and patients' satisfaction of pharmacist prescribing UTI-management services; it was found that patients were seen by a pharmacist sooner than they would see a GP "p =0.0153", and that 92% of the participants who responded to a satisfaction survey (n=398) reported satisfaction with the pharmacists' accessibility. Hind et al. 2018 showed that people presented pharmacies on Friday and Saturday more than other days of the week, and 90% of them were seen within 10 minutes. The study also reported that higher utilisation of the service was experienced "during the afternoon and after 6pm [29], times when GP accessibility might be relatively limited" Accessibility to the service could stem from the nature of pharmacies' opening hours and their availability.
Costs, consequences and value for money in non-medical prescribing: a scoping review[30]	Accessibility was not reported in pharmacist prescribing studies in this review, however ease of access to services provided by non-medical prescribing, namely "Physiotherapist IP and Podiatrist IP'' was reported by Carey et al.

** Data were extracted from the systematic reviews rather than the original reference paper*

Appendix 3 Efficacy impact of pharmacist prescribing

Title	Condition	Pharmacist prescribing impact on efficacy
The community pharmacist as an independent prescriber: A scoping review[25]	Urinary tract infections	Beahm et al. 2018; showed a clinical cure rate of 88.9% and found no significant difference in clinical cure between the pharmacist and physician arms in a prospective clinical study. The study reported that pharmacists' management of uncomplicated UTI infections is safe and effective. Booth et al. 2013; reported no significant difference in symptoms' resolution time between GP or pharmacist care. It is worth noting that the symptoms duration before treatment was shorter in the group of patients presented for pharmacist management.
	Minor ailments	Mansel et al. reported improvement in 99.2% of patients.
	Cardiovascular risk management	RXEACH study by Tsuyuki et al reported that the intervention group had a higher smoking cessation rate, lower LDL cholesterol, lower systolic blood pressure, and lower glycosylated haemoglobin.
A scoping review of evidence of community pharmacist independent prescribing for common clinical conditions: beyond protocol prescribing[11]	Urinary Tract Infection	Beahm et al. 2018 showed clinical cure in 88.9% of patients with uncomplicated UTI. Most people who did not experience symptoms' resolution had symptoms recurrence (5.5% overall).
	Group A Streptococcus testing	Papastergiou et al. 2018 in study of 7050 patients across 204 participating sites reported that 25.5% of participants tested positive for Group A Streptococcus infection. Same day prescribing of antibiotics was achieved in 68.7%.
Community pharmacist prescribing: Roles and competencies - A systematic review and implications[15]	Cardiovascular risk management	Tsuyuki et al. 2016 reported a 21% greater relative reduction in estimated cardiovascular event risk.
Interventions to expand community pharmacists' scope of practice[36]	Contraception	Cameron et al. 2020 conducted a study in which women requesting emergency contraception were offered a three-month supply of progestogen-only pills (75 µg desogestrel, 84 tablets) following their use of emergency contraception, along with a rapid-access card to a participating sexual health clinic. The intervention resulted in a significant increase in the subsequent use of effective contraception.

Title	Condition	Pharmacist prescribing impact on efficacy
	Blood pressure	Tsuyuki et al. 2015 in a randomised trial that evaluated the effect of pharmacist prescribing on improving blood pressure (RxACTION) found significant reductions in systolic and diastolic BPs and significant improvements in the proportion of patients achieving recommended BP targets compared with usual pharmacist and physician care were reported.
	Dyslipidaemia management	Tsuyuki et al. 2016 in a randomised trial that evaluated Community-based approach to dyslipidaemia management (RxACT) "resulted in >3-fold more patients achieving target LDL-c levels".
	Cardiovascular risk management	Al Hamarneh et al. 2017 in an RCT evaluating the Effectiveness of Pharmacist Interventions on Cardiovascular Risk in Adult Patients with Type 2 Diabetes (RxEach) found "significant improvement in diabetes, hypertension and dyslipidaemia treatments in the intervention-group were observed compared to control group".
Pharmacist prescribing in cancer services: a scoping review[23]	Cancer	Andrick et al. 2022 evaluated a hematopoietic cellular therapy and reported effective immunosuppression management in 35 eligible patients with 814 out of 1192 blood measurements (73.9%) were achieving targeted ciclosporin trough concentration in institutional guidelines of 160 to 400 ng/dL.
		Jackson et al. 2021 determined the pharmacy impact of implementing a chemotherapy induced nausea or vomiting collaborative disease therapy management protocol in the outpatient oncology clinics at a cancer centre and reported improvement in MASCC (Multinational Association for Supportive Care in Cancer); symptom scores for CINV. Acute nausea median was reduced from 8 to 0. Delayed vomiting median was reduced from 4 to 0. Delayed nausea median was reduced from 10 to 0.
		Lam & Cheung 2016 evaluated the impact of an oncology pharmacist-managed oral anticancer therapy program on oral medication adherence in CML patients versus usual care and statistically significant improved tyrosine kinase inhibitors adherence rate in intervention group (88.6 %) compared to usual care group (65.8 %) (p 0 < .0046) was reported.
		Ma et al. 2016 evaluated 'pharmacist interventions and patient outcomes of a pharmacist-led outpatient palliative care practice. "Trends were observed in pain stabilisation over three clinic visits. 'A statistically significant change in pain score (mild, moderate, severe) was observed for the third visit (better (33 %), stable (49 %) and worse (19 %)) ($p \leq 0.05$) but was not sustained at the next-follow up visit'".
		Muluneh et al. 2018 addressed the growing use of oral anticancer therapy, an integrated, closed-loop, pharmacist-led oral chemotherapy management program was created within an academic medical centre, and

Title	Condition	Pharmacist prescribing impact on efficacy
		reported “Improved knowledge and adherence rates compared to historical data. Understanding of treatment increased from 43 % to 95 %’. Patient-reported adherence was 86% and 94.7 % and MPR adherence was 85 % and 93.9 % for the GI/breast and malignant haematology patient groups respectively. A higher major molecular response rate (83 %) for patients with chronic myeloid leukaemia compared with published clinical trials (average major molecular response rates, 40 % and 60 % with 1- and 2- year follow-up, respectively)”.
Pharmacists' naloxone services beyond community pharmacy settings: A systematic review[33]	Harm minimisation	Wulz et al. 2017 reported on pharmacist prescribed naloxone and trained on its use to the public through a collaborative protocol. They also participated in spreading awareness of Alabama HB 208 by providing information on naloxone and opioid overdose to family”. A total of 83 clients (heroin and opioid users, concerned family members or friends, and TASC employees) were trained in naloxone.
		Takeda et al. 2016 reported that an interprofessional team, including a pharmacist who implemented naloxone co-prescribing, significantly improved care. Pharmacist-led interventions, including prescribing saved psychiatrists’ time and led to more frequent medication reconciliations, improved identification and management of medications for opioid use disorder, better detection of adherence issues, and increased referrals to additional services.
		Mailloux et al. 2021 examined a physician-pharmacist collaborative practice model (PPCPM) to increase access to Medications for Opioid Use Disorder (MOUD). The number of new naloxone prescriptions were slightly higher in PPCPM (Physician-pharmacist collaborative practice model) appointments (n = 8, 18%) than in psychiatrist-only appointments (n = 5, 14%). Sample size of 50 patients who were treated with buprenorphine/ naloxone.
Exploring non-medical prescribing for patients with mental illness: a scoping review[21]	Depression/anxiety	Mental health specialist pharmacists were found to reduce depression/anxiety symptoms’ scores based on the Patient Health Questionnaire (PHQ-9) and Generalised Anxiety Disorder by 50%. They were also found to decrease these scores based on PHQ-9 by more than 50% reduction in another study.
Global advancement in pharmacy services for mental health: A review for evidence-based practices[22]	Mental Health Conditions	Gibu et al. 2017 conducted a retrospective cohort study of 81 outpatients who lost their mental health prescriber due to transfer or turnover. In total 80% of prescriptions were renewed by pharmacists' interim prescribers, in addition to that a decrease in patients’ presentation to psychiatric emergency department was reported.
Effects of pharmacist prescribing on health-related outcomes in secondary care compared with medical prescribing or no treatment: A systematic review[31]	Pain management	Roman et al. 2024 evaluated if “an emergency pharmacist addition to an emergency medicine (EM) team would improve analgesia administration within 30 minutes of patient arrival”. No significant statistical difference in length of hospital stays between the intervention and the control groups was reported.

Title	Condition	Pharmacist prescribing impact on efficacy
		Hammond et al., 2024 in a study which evaluated in hospital morality reported that “no statistically significant difference between the pharmacist prescribing and the non-pharmacist prescribing group”.
	Anticoagulant prescribing	Chan et al., 2006 reported that the control of INR was significantly improved ($p < 0.001$) for patients when anticoagulant therapy was prescribed by a pharmacist compared to when managed by a medical prescriber.” “Patients in the pharmacist-managed group spent more patient time (64%) in therapeutic INR range than those in the physician-managed group (59%) ($p < 0.001$). When the INR results from both groups were pooled, the 137 patients spent 61% of time in the therapeutic INR range and 77% of time in the expanded range”.
	Blood Pressure	Vivian et al. 2002 found significantly higher reduction ($p < 0.003$) in blood pressure when the pharmacist prescribed compared to when a doctor prescribed.
	Blood Glucose level	Anaya et al. 2008 found a significant reduction ($p < 0.001$) in both blood glucose levels and glycosylated haemoglobin post-intervention”.
	COVID-19	Kassem et al. 2024 identified that “the management of COVID-19 by an independent pharmacist prescriber exhibited a statistically significant increase ($p = 0.011$) in oxygen saturation levels, a significant reduction ($p = 0.001$) in temperature and respiratory rate, a non-significant increase in platelet count, and a non-significant decrease in white blood cell count.”
	Dyslipidaemia	Weeks et al. 2012: “had too small a sample size to draw statistical comparison” and “concluded that low-density lipoprotein (LDL) levels were consistently at target for the pharmacist intervention group as opposed to the control group”.
		Bowron et al. 2011 identified that the mean reduction in cholesterol levels was significantly higher ($p = 0.038$) in the pharmacist independent prescriber group compared to the doctor group, and no significant difference in glycosylated haemoglobin between pharmacist prescribing and medical prescribing.
Impact of pharmacist interventions provided in the emergency department on quality use of medicines: a systematic review and meta-analysis[24]	Quality use of medicines	Limited evidence about the impact of pharmacists’ interventions including prescribing and co-prescribing on in-hospital morality or length of hospital or Emergency Department stay, however there was some evidence that those interventions are linked to a reduced probability of representing to ED, and readmission to hospital.
A systematic review of the role of community pharmacists in the prevention and control of cardiovascular diseases: the perceptions of patients[32]	Cardiovascular risk management	Al Hamarney et al. 2013 found reduced CV risk findings which were comparable to prior physician-led care interventions, and indicated that “improved blood pressure, blood glucose, and cholesterol measurements and tobacco use over a period of 3 months” have contributed to the lower CV risk attained. The study reported that “1.8% (CI 95% 1.4–2, P<0.0001) change in glycaemic control and 4.1 mmol/L (CI 95% 3.3–5, P=0.007)

Title	Condition	Pharmacist prescribing impact on efficacy
		decrease in fasting blood glucose were achieved in 51% of the enrolled patients following initiation of pharmacist-prescribed insulin''.
The clinical and economic evidence of the management of urinary tract infections by community pharmacists in women aged 16 to 65 years: a systematic review[27]	Urinary Tract Infection	Beahm et al. 2018 in a study that evaluated "the effectiveness, safety of, and patient satisfaction with, pharmacist assessment and management of patients with uncomplicated UTI" reported 88.9% clinical cure rate in a sample size of 750 patients and 39 pharmacies.
		Booth et al. 2013 United Kingdom in a study that compared "the care pathway of patients with UTI symptoms attending GP services with those receiving management from community pharmacies" reported that there was no significant difference in time taken to achieve symptoms' resolution between Pharmacist and GP management of UTI.
	Minor conditions	Stampfli et al. 2022 in a study that evaluated the "utilisation description, symptom resolving rate of, and the need for more, decision trees for managing minor conditions in community pharmacies"; The overall cure rate was 84.7%. In addition, 43.8% of 1866 clients indicated that they would have consulted a GP or an ED in case of the inaccessibility of that intervention.
Costs, consequences and value for money in non-medical prescribing: a scoping review[30]	Cardiovascular Diseases	Marra et al. 2017 reported that "the 30-year risk of CVD in the pharmacist prescriber group was reduced from 0.61 in base case to 0.41 (indicating a reduction of two CVD events in every 10 individuals receiving the intervention)".

** Data were extracted from the systematic reviews rather than the original reference pape*

*Appendix 4 Evidence of safety of pharmacist prescribing**

Title	Condition	Safety (Adherence to guidelines, reported adverse events)
The community pharmacist as an independent prescriber: A scoping review[25]	Urinary tract infections	Beahm et al. 2018 found no significant difference in adverse events between the pharmacist and physician arms in a prospective clinical study.
	Strep throat	Lathia et al. investigated community pharmacy-based point-of-care testing for strep throat and found that independent pharmacist prescribing reduces inappropriate use of antimicrobials as there was improved detection with pharmacist prescribing. A rapid antigen test was performed in around 25% of presentations to physicians compared to 92% and 75% of presentations to independent pharmacist care in Alberta and Ontario respectively.
A scoping review of evidence of community pharmacist independent prescribing for common clinical conditions: beyond protocol prescribing[11]	UTI, cellulitis, adolescent acne, paediatric ear infection and bacterial sinusitis	Ung et al. 2017 reported that 75% of returned questionnaires indicated selecting the most appropriate treatment for UTI, cellulitis, and adolescent acne, while recurrent UTI, paediatric ear infection and bacterial sinusitis were associated with poorer antibiotic prescribing. Eight cases of inappropriately prescribed penicillin to a child with allergy to penicillin documented as “rash”, were reported.
	Urinary tract infections	Beahm et al. 2021 “Therapy was guideline concordant for 95.1% of patients in the pharmacist-initial arm and 35.1% of patients in the physician-initial arm.” Physicians, representing usual care, prescribed for longer treatment durations and more fluoroquinolone”. Beahm et al. 2018 “About 7.2% had transient gastrointestinal related adverse events, 88.9% continuing medication”.
Community pharmacist prescribing: Roles and competencies - A systematic review and implications[15]	Uncomplicated UTI, cellulitis, adolescent acne	In Thailand and Australia, pharmacists demonstrated high appropriateness in antibiotic prescribing for common infections, i.e., uncomplicated UTI, cellulitis, adolescent acne.
	Anticoagulants in Atrial Fibrillation	Sandhu et al. 2024 evaluated pharmacist prescribing of anticoagulants in demonstrated reduced stroke risk. The study showed evidence of increased guidelines, concordant anticoagulant prescribing, and better patient adherence.
Interventions to expand community pharmacists’ scope of practice[36]	Cardiovascular Diseases	The RxEACH study involved assessing laboratory testing, cardiovascular risk and provided treatment recommendations when clinically appropriate including modifying and/or initiating therapies to achieve “glycaemic, blood pressure and lipid-control targets and tobacco cessation”. “The estimated CV risk was reduced from 26.9+/−21% to 26.5+/−21.3% in the control group and from 25.8+/−19.4% to 20.1+/−17.2% in the intervention group within the 3-month follow-up period (ARR 5.38; 95% CI 4.24–6.52; p < 0.001).”

Title	Condition	Safety (Adherence to guidelines, reported adverse events)
Pharmacist prescribing in cancer services: a scoping review[23]	Cancer	Moore et al. 2021 reported “no increase in the rate of immune-related reactions with ‘rituximab infusions that were deemed eligible for conversion”.
Pharmacists' naloxone services beyond community pharmacy settings: A systematic review[33]	Harm minimisation	“Several studies described pharmacists using their prescriptive authority to prescribe and distribute naloxone. In some of these studies, pharmacists followed the mandates of co-prescribing naloxone for at-risk patients or those receiving high-dose opioids of more than 90 MME per day. There was a significant increase ($p < 0.05$) in naloxone prescribing and co-prescribing when pharmacists implemented naloxone services”.
Effects of pharmacist prescribing on health-related outcomes in secondary care compared with medical prescribing or no treatment: A systematic review[31]	Several conditions	“Four of the five studies that assessed the number of adverse events reported decreased number of adverse events in the pharmacist managed group although statistical significance was not reported. The fifth study reported statistically non-significant difference in the number of adverse events between the pharmacist managed group and the physician-managed group. The number of medication errors was evaluated by one study which showed a statistically significant reduction ($p < 0.01$) in medication errors in the post-intervention period compared to the pre-intervention period without the pharmacist prescriber. Pharmacist prescribing was either comparable to or better than medical prescribing in decreasing the number of adverse events and medication errors”.
Impact of pharmacist interventions provided in the emergency department on quality use of medicines: a systematic review and meta-analysis[24]	Emergency departments	The studies by Taylor et al., Koehl et al. and Vasileff et al. where pharmacists have co-prescribed or co-charted medications in ED have reported the highest reduction in number of medications’ errors, with absolute risk reduction per patient ranging from 87% to 97%. Mills et al. and Vasileff et al. showed that the rates of drug omission errors to be reduced by 97.5% and 100% The risk of “errors causing ‘moderate/significant’ or ‘serious/catastrophic’ impacts was also reduced by 93.3% and 100% in Taylor et al. and Vasileff et al. Pharmacists' interventions that did not represent direct involvement in ordering, charting, modifying doses of medications, rounds or consultations, such as staff education, were “relatively less effective in reducing the number of errors per patient”.
Collaborative pharmacist prescribing models in Australian hospitals: a scoping study[30]	Emergency departments, maternity and gynaecology units, surgical and pre-admission units, and haematology and oncology units.	An Australian study has shown rate of prescribing error to reduce from 66% with independent medical prescribing to 3.6% with collaborative pharmacist prescribing. Adopting collaborative approach to clinical and prescribing decisions’ making between doctors and pharmacists has proven to reduce prescribing errors in emergency departments, maternity and gynaecology units, surgical and pre-admission units, and haematology and oncology units.
The clinical and economic evidence of the management of urinary tract infections by community pharmacists	Urinary tract infections	Beahm et al. 2018 reported a 7.2% rate of adverse events. Beahm et al. 2021 reported that “Pharmacist prescriptions adhered to the guidelines more often than GP prescriptions did ($p <0.001$). Pharmacists modified 45.9% of guideline discordant GP orders.

Title	Condition	Safety (Adherence to guidelines, reported adverse events)
in women aged 16 to 65 years: a systematic review[27]		Booth et al. 2013 reported that 76% of those provided trimethoprim by a pharmacist met the PGD criteria for inclusion. Patients presented sooner to pharmacists than GPs (p =0.026). The difference in time to resolution between pharmacist and GP management was not significant. Lee et al. 2021 reported that loss to follow up was 35.8%. Of those followed up, only 32% pharmacists send a specific notification to the patient's GP indicating they were treated for UTI. 79.3% of women indicated they would have gone to another primary healthcare service if the pharmacy service was not available. Stewart et al. 2018 found all the 30 reviewed referral cases were deemed appropriate. Thornley et al. 2020 identified that 71.1% of women accessing treatment would have attended their GP had this service been unavailable. 97.8% received first-line treatment.

** Data were extracted from the systematic reviews rather than the original reference paper*

*Appendix 5 Economic evidence for pharmacist prescribing**

Title	Economic impact of pharmacist prescribing
The community pharmacist as an independent prescriber: A scoping review[25]	Lathia et al. conducted an economic evaluation of severe sore throat treatment by community pharmacists which resulted in average savings from $12.47 to $24.36 depending on the province. These savings are estimated to be $1.3 to $2.6 million per year for the five provinces. These estimates were supported by Rafferty who focused Saskatchewan, Canada. Canada achieved cost savings of $800,000 savings in 2014 by pharmacists managing minor ailments, these savings are estimated to reach $3.5 million after one year. Hamarneh et al. estimated pharmacist care to save $576,689 QALYs and avoided over 8.9 cardiovascular events, with estimated savings of $4.4 billion over 30 years after pharmacist prescribing in cardiovascular diseases. It was estimated that pharmacist prescribing in blood pressure control would prevent 2100 cases of CVD and 8 cases of kidney disease per 10000 patients over thirty years; the intervention could save more than $10,000 per patient.
A scoping review of evidence of community pharmacist independent prescribing for common clinical conditions: beyond protocol prescribing[11]	Kim et al. 2021 stated that pharmacist prescribing for Upper Respiratory Tract infections, Contact Dermatitis and conjunctivitis resulted in less emergency department, walk-in clinics, family physicians' presentations which ultimately produces cost savings for the health system.
Community pharmacist prescribing: Roles and competencies - A systematic review and implications[15]	Pharmacist-led anticoagulation management and atrial fibrillation monitoring demonstrated high clinical efficacy (treatment and cost efficiency) and safety (stroke risk reduction).
The accessibility of pharmacist prescribing and impacts on medicines access: A systematic review [28]	One study examined affordability from the patient's perspective, with 84 % of participants reporting the pharmacist prescriber consultation fee was reasonable or lower than they were expecting. In the same study, 28 % reported seeing a pharmacist prescriber because they would save money by avoiding a physician's visit. Similarly, while many studies described the cost of pharmacist prescriber consultations, only one reported whether services were perceived to be affordable, and no studies reported on people's ability to pay for pharmacist prescribing services. Pharmacist prescribers themselves have previously reported the perception that cost is a major barrier to uptake in jurisdictions where pharmacist consultations and/or pharmacist-prescribed medicines are not covered by health systems or insurers.
Interventions to expand community pharmacists' scope of practice[36]	This review noted that the cost burden on the healthcare system could be reduced by optimising the utilisation of pharmacists' knowledge and experience in their role.
Pharmacist prescribing in cancer services: a scoping review[23]	Wright et al. 2020 reported dose rounding for capecitabine and temozolomide to have generated annual cost savings for patients of $9858.24 and $3281.85 respectively with pharmacist prescribing. Lau et al. 2020 reported reduced costs via generic substitution and assistance in co-pay covering.

Title	Economic impact of pharmacist prescribing
	Valgus et al. 2011 showed improved physician efficiency which improved revenue gains and conclude that having pharmacists on the team improves physicians' efficiency, allowing them to see more patients and to generate more revenue. Easaw et al. 2019 showed 94% of cost saving per each patient utilising pharmacy care (Emergency department visit costing $750 vs $45 for community-based pharmacy service visit).
Global advancement in pharmacy services for mental health: A review for evidence-based practices[22]	Economic impact of pharmacist prescribing was not explicitly discussed for the two studies that involved pharmacist prescribing. Although Gibu et al, showed reduced visits to the emergency department due to pharmacists interim prescribing intervention.
Effects of pharmacist prescribing on health-related outcomes in secondary care compared with medical prescribing or no treatment: A systematic review[31]	Three studies discussed the economic outcome of pharmacist prescribing: Kassem et al. “Antibiotic expenditure was retrieved from the hospital database. Without the intervention, the medication cost was supposed to be 12695.9 dollars. The medication cost after the intervention was 6195 dollars and the cost for pharmacist service in the intervention was 2483 dollars. About 4017.8 dollars were saved after subtracting the cost of pharmacists’ services. The findings showed a statistically significant decrease in the median cost of treatment after pharmacist interventions (82.0$ pre-intervention vs. 29.3$ post-intervention)”. Anaya et al. “Average costs for inpatient hospitalisation and ED admissions were significantly higher in the pre-intervention period than in the post-intervention period for patients with DM as the primary or secondary diagnosis ($2434 versus $636, respectively; p = 0.015). For patients with a primary diagnosis of diabetes, pre-intervention costs were higher than post-intervention costs, but this difference was not significant ($3082 versus $696, respectively; p = 0.100). Chan et al. reported that the “mean total cPPPM of the pharmacist-managed group (US$76 ± 95) was significantly lower than that of the physician-managed group (US$98 ± 158) (p < 0.01)”.
Collaborative pharmacist prescribing models in Australian hospitals: a scoping study[26]	Collaborative prescribing reduced the median length of stay from 6.5 to 5.8 days (10% reduction) and reduced average admission cost from $9803 to 8802 with savings of $726 per admission.
The clinical and economic evidence of the management of urinary tract infections by community pharmacists in women aged 16 to 65 years: a systematic review[27]	Sanyal et al. 2019 measured the cost effectiveness of UTI- management by community pharmacists and it was found that the service would cost $141,53 and $368. If it was managed by GP and emergency department respectively while the pharmacist led care cost the public health system $ 72.47. Additionally, it estimated $ 2.9 million in year one and $16.3 million by year 5 if 25% of the targeted population used the pharmacy service. Quality adjusted life months (QALM) were 0.75137, 0.75142, 0.75146 between pharmacists, GP and ED care.
Costs, consequences and value for money in non-medical prescribing: a scoping review[30]	Al Hamarneh et al. 2019 reported that pharmacist prescribing was cost-effective and cost saving for patients with CVD. Hale et al. 2018 reported that pharmacist prescribing was cost-effective and cost saving for patients with venous thromboembolism. Marra et al. 2017 found that the pharmacist prescribing intervention was associated with increased cost of C$7145 due to the intervention and the medication cost; this was mitigated by a cost saving of C$15094 in CVD and other comorbidities cost and it was concluded that pharmacist prescribing intervention is cost effective.

Title	Economic impact of pharmacist prescribing
	Neilson et al. 2015, in a sample size of 125 patients found that pharmacist prescribing for chronic pain is more costly as it was estimated as £77.5 for prescribing and £54.4 for review arms with similar Quality Adjusted Life Years (QALY), and author recommended larger size to improve reliability and reduce uncertainty.

** Data were extracted from the systematic reviews rather than the original reference paper*

Appendix 6 Level of qualifications required for endorsement for prescribing

Profession	Qualification required for endorsed prescribing	Requirements for endorsed prescribing
Midwifery	Not included as part of an entry-level midwifery degree. Required to apply for endorsement of prescribing scheduled medicines.	When applying for endorsement for prescribing of scheduled medicines as a midwife, a midwife must be able to demonstrate all of the following:[54] a. Current general registration as a midwife in Australia with no conditions or undertakings relating to unsatisfactory professional performance or unprofessional conduct[54] b. Registration as a midwife that is equivalent of three years' full-time clinical practice (5,000 hours) in the past six years that is either: [54] c. Across the continuum of care, or in a specified context of practice d. From the date when the complete application seeking endorsement for scheduled medicines is received by the NMBA e. Successful completion of: [54] an NMBA-approved program of study leading to endorsement for scheduled medicines, or a program that is substantially equivalent to an NMBA-approved program of study leading to endorsement for scheduled medicines as determined by the NMBA (AQF Level 8).
Nursing	Not included as part of an entry-level nursing degree. Required to apply for endorsement of prescribing of scheduled medicines.	Registered nurses (RNs) must be able to demonstrate that they are meeting the following requirements for registration standard a the time of their application for endorsement of prescribing of scheduled medications: a. Current general registration as an RN in Australia with no conditions or undertakings relevant to this endorsement.[56] b. The equivalent of three years' full-time post initial registration clinical experience (5,000 hours) as an RN within the past six years, from the date when the complete application seeking endorsement for scheduled medicines as a designated RN prescriber is received by the NMBA.[56] c. Successful completion of: NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber, or units of study that are equivalent to the NMBA-approved units of study leading to endorsement for scheduled medicines as a designated RN prescriber.[56]
	Requirement for registered nurse practitioner. Required to apply for endorsement of prescribing of scheduled medicines.	A registered nurse seeking endorsement as a nurse practitioner (NP) must be able to demonstrate the following: a. Current general registration as an RN in Australia with no conditions or undertakings on their registration relating to unsatisfactory professional performance or unprofessional conduct. b. The equivalent of three years' (5,000 hours) full-time experience at an advanced practice level, within the past six years, from the date when the application seeking endorsement as an NP is received by the NMBA. c. Successful completion of: Pathway 1: an NMBA-approved program of study leading to endorsement as an NP or Pathway 2: a program that is substantially equivalent to an NMBA-approved program of study leading to endorsement as an NP, as determined by the NMBA* Compliance with the NMBA Nurse practitioner standards for practice. *An approved program of study means a postgraduate nursing master's degree (AQF Level 9) approved by the NMBA under section 49 of the National Law and included in the NMBA-approved list of programs of study for endorsement as a nurse practitioner. This included NMBA-approved master's level units in advanced

		health assessment, pharmacology for prescribing, therapeutics and diagnostics and research.
Optometry	Endorsement to prescribe scheduled medicines is now embedded in a majority of entry-level optometry programs.	Entry-level programs in optometry encompass ocular therapeutics. In Australia, from December 2014, therapeutic prescribing became a requirement for an individual's initial registration as a practising optometrist. Australian optometrists have a notation on their registration indicating whether they are qualified for scheduled medicines endorsement. The OCANZ Standards explicitly require program providers to provide documentary evidence.
Pharmacy	Not included as part of an entry-level pharmacy degree. Required to complete additional training in the area of prescribing.	Pharmacists are required to complete an accredited pharmacist prescriber education program. The accreditation standards for pharmacist prescriber education programs will ensure that graduates from an accredited program:[3,44] a. Meet the competencies in the National Prescribing Competency Framework (3rd Edition) which describes the practice expectations of Australian prescribers regardless of profession. [3,44] d. Are competent and qualified to prescribe medicines according to their scope of practice as authorised under state and territory medicines and poisons legislation. e. Are ethical, safe practitioners for the benefit and well-being of the public they serve. [44] Are flexible, adaptable and responsive to the evolving needs of individuals and communities and fully comprehend their role as prescribers within that changing environment.[44] The Performance Outcomes Framework that accompanies the accreditation standards for pharmacist prescriber education programs is aligned to the National Prescribing Competency Framework (3rd Edition). [3,44]
Physiotherapy	Not included as part of an entry-level physiotherapy degree. AQF level 8 program required.	Approved training is a tertiary level study program equivalent to Australian Qualifications Framework (AQF) level 8.[52] The study program must cover: a. the knowledge, skills and behaviours set out in the National Prescribing Competencies Framework 3. [52] b. Assessment must cover the essential competencies of clinical therapeutics, safe prescribing and quality use of medicines.[52] c. A period of supervised practice must be a component of the study program, and the physiotherapist prescriber must be supervised by an authorised prescriber for this element. [52]
Podiatry	Endorsement to prescribe scheduled medicines is now embedded in a majority of entry-level	The registration standard outlines two pathways to endorsement: Pathway A: Approved qualification pathway or Pathway B: Supervised practice pathway.[49–51] Pathway A: Approved qualification pathway A podiatrist or podiatric surgeon is qualified for endorsement if they hold a qualification that is Board approved for endorsement for scheduled medicines. The approved qualification is obtained by completing a Board-approved program of study for endorsement for scheduled medicines.[49–51]* Pathway B: Supervised practice pathway A registered podiatrist or podiatric surgeon is eligible for endorsement for Scheduled medicines through a combination of: a. Holding an approved qualification in podiatric therapeutics (or another qualification the Board considers substantially equivalent, or based on similar competencies to, an approved qualification in podiatric therapeutics) and d. Completing additional requirements as outlined in the Board's ESM registration standard. [49–51]

		*An approved qualification for endorsement for scheduled medicines means a qualification obtained by completing a podiatry program of study that has been accredited by the podiatry accreditation committee and subsequently approved by the Board as providing a qualification for the purpose for endorsement for scheduled medicines for the podiatry profession under Pathway A. [49–51] The program of study is aligned to the National Prescribing Competencies Framework and includes education and training in podiatric therapeutics as well as clinically supervised practice to ensure that graduates have the required competencies for endorsement for scheduled medicines. [49–51]

Appendix 7 Domains relating to prescribing for non-medical health professions within prescribing accreditation standards

Profession	National Prescribing Competency Framework referenced?	Domain within the standards of the endorsed prescribing accreditation standard	Standard (statement)
Midwifery[54]	Yes	Domain 3: Program development and structure	The program of study is developed in collaboration with key stakeholders reflecting contemporary trends in midwifery, prescribing practice and education. It should comply in length and structure with the Australian Qualifications Framework for the qualification offered and enabling graduates to meet the National Prescribing Competency Framework. Domain 3.3 of the standards state: A map of subjects against the National Prescribing Competencies Framework that clearly identifies the links between learning outcomes, assessments and required graduate competencies.
		Domain 4: Program content	The program content delivered by the program provider comprehensively addresses the National Prescribing Competency Framework within the midwifery context and incorporates Australian and international best practice perspectives on midwifery practice. Domain 4. A comprehensive curriculum document, based on the conceptual framework that includes: links between subject objectives, learning outcomes, learning assessments and the National Prescribing Competency Framework in the midwifery context. 4.2 The program's central focus is on contemporary prescribing in midwifery practice. In addition to the content required to meet the attainment of the National Prescribing Competency Framework, this includes: a. comprehensive understanding of the relevant State and Territory Drugs and Poisons legislation and Pharmaceutical Benefits Scheme requirements b. professional relationships and referral, including establishing collaborative arrangements with General Practitioners and Obstetricians and/or health services c. comprehensive understanding of and ability to work with the Medical Benefits Schedule and Pharmaceutical Benefits Scheme.
		Domain 5: Student assessment	The curriculum incorporates a variety of approaches to assessment that suit the nature of the learning experience and robustly measure achievement of required learning outcomes, including a summative assessment of student performance against the current National Prescribing Competency Framework. The program provider must demonstrate evidence of: 5.6 Appropriate assessments used in professional practice experience to evaluate students' abilities to meet the National Prescribing Competency Framework within midwifery practice. 5.11 Summative assessments of student achievement of competence against the current National Prescribing Competency Framework within midwifery practice, conducted by a health professional who is appropriately qualified, prepared and able to demonstrate current

Profession	National Prescribing Competency Framework referenced?	Domain within the standards of the endorsed prescribing accreditation standard	Standard (statement)
			experience in assessing prescribing practice in an Australian midwifery context before program completion. 5.12 Clearly articulated models of supervision, support, facilitation and assessment being in place to enable students to achieve required learning outcomes and current National Prescribing Competency Framework within midwifery practice.
Nursing (Inclusive of registered nurse and nurse practitioner).[53,55–57]	Yes	Domain 3: Program of study	3.3 Program content and subject alignment ensure: a. achievement of competencies described in the National Prescribing Competency Framework b. preparation of students to prescribe scheduled medicines c. knowledge and understanding of legal and medicolegal principles and relevant legislative frameworks that enable designated registered nurses to prescribe in each state and territory d. understanding of ethical and professional obligations of prescribing within the scope of designated registered nurse prescribing practice e. an opportunity for students to demonstrate an integrated approach to prescribing f. an understanding of the designated registered nurse prescribing model g. knowledge of relevant medicine funding models in Australia h. prescribing practice learning plans
		Domain 5: Student assessment	5.2 Subject learning outcomes, with associated subject assessments, are clearly mapped to the National Prescribing Competencies Framework 5.4 Assessments include the prescribing process, underpinned by the quality use of medicines and the National Prescribing Competencies Framework
Optometry[58]	Yes	Domain 4: Program of study	The curriculum should provide students with the competencies to prescribe medicines judiciously, appropriately, safely and effectively, as set out in the National Prescribing Competencies Framework.
Pharmacy[5,44]	Yes	Domain 1: Safe and socially accountable practice	The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable responsible, person-centred approach to practice.
		Domain 2: Governance and quality	Program governance, quality assurance and quality improvement structures and systems are effective in developing and delivering sustainable, high-quality pharmacist prescriber education programs.
		Domain 3: Program	Program design, implementation and resourcing enable graduates of the program to demonstrate achievement of all prescribing performance outcomes.

Profession	National Prescribing Competency Framework referenced?	Domain within the standards of the endorsed prescribing accreditation standard	Standard (statement)
		Domain 4: Learner experience	Learners are provided with equitable and timely access to information and support relevant to the program.
		Domain 5: Outcomes and assessment	Graduates of the program demonstrate achievement of all the required performance outcomes and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.
Podiatry	Yes	Domain 2: Academic governance, quality assurance and resourcing	The focus of this standard is on the overall context in which education about podiatry scheduled medicines is implemented; specifically, the administrative and academic organisational structure to support that. This standard also focuses on identifying the degree of control that the academics who lead and implement the program, the podiatry profession and other external stakeholders have over the relevance and quality of the program, to produce graduates who are safe and competent to administer, obtain, possess, prescribe, sell, supply or use Schedule 2, 3, 4 or 8 medicines for the treatment of podiatric conditions.
		Domain 3: Program design	Program design, including curriculum, learning and teaching and work integrated learning enables students to achieve all the professional capabilities for prescribing scheduled medicines for podiatric conditions. This standard focuses on how the program is designed and implemented to produce graduates who have demonstrated the relevant professional capabilities that are required for endorsement of registration for scheduled medicines. These include the National Prescribing Service Competencies Framework, and the relevant professional capabilities as described in the Professional capabilities for podiatrists and the Professional capabilities for podiatric surgeons.
		Domain 4: Assessment	The Committee expects the education provider to show how they assure that every student who passes the unit and/or subject has achieved all the professional capabilities required for a podiatrist or podiatric surgeon to qualify for endorsement of their registration in relation to scheduled medicines. The education provider must use fit for purpose and comprehensive assessment methods and formats to assess learning outcomes, and to ensure a balance of formative and summative assessments throughout podiatry scheduled medicines education.

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Accreditation Standards for Pharmacist Prescriber Education Programs

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Acknowledgement of Country

We acknowledge the Ngunnawal people, the Traditional Owners of the land on which the Australian Pharmacy Council is based. We pay our respects to the Ngunnawal people and recognise their deep connection to this incredible place we now share. We also pay our respects to the resilience, strength, and wisdom of Aboriginal and Torres Strait Islander Elders, past and present, across the nation.

We recognise First Nations people's vast knowledge in native plants and their uses. Indigenous Australians were our first pharmacists. Country has provided medicines and healing throughout history. We acknowledge this important connection to Country and the impacts colonisation continues to have on this integral practice.

Canberra, the location of the Australian Pharmacy Council means meeting place in Ngunnawal, and is a place where people have been meeting, living, and learning for thousands of years. We hope to continue this tradition as we work toward our vision of collaborative, committed and safe pharmacy practice.

Contents

Executive Summary

The Accreditation Standards for Pharmacist Prescriber Programs (the Standards)

The Standards are used to accredit programs and ensure that graduates from an accredited program:

- meet the competencies in the National Prescribing Competencies Framework (3rd Edition September 2025)[1] which describes the practice expectations of Australian prescribers regardless of profession
- are competent and qualified to prescribe medicines according to their scope of practice as authorised under state and territory medicines and poisons legislation
- are ethical, safe practitioners for the benefit and well-being of the public
- are flexible, adaptable and responsive to the evolving needs of individuals and communities and fully comprehend their role as prescribers within that changing environment.

How is it used?

The Standards will be used to support education providers when completing applications for accreditation and for those involved in making accreditation decisions.

The Standards cover concepts about pharmacist prescribing, including conflict of interest management, clinical skills assessment, and education standards. They are underpinned by the National Prescribing Competencies Framework (NPCF), which articulates the knowledge, skills and professional behaviours that prescribers must demonstrate.

The Standards have been developed with the intention that graduates of accredited programs will be able to, in the future, apply for endorsement on their general registration, should the Pharmacy Board of Australia establish an endorsement for scheduled medicines for pharmacists.

The APC's accreditation standards and processes support, and are aligned with, the Pharmacy Board of Australia's *Draft Guidelines: Endorsement for schedule medicines*, enabling a coordinated, nationally consistent approach to pharmacist prescribing in Australia.

How are the Standards structured?

The Standards are structured into six Domains:

- Safe and socially accountable practice
- Governance and quality
- Program
- Learner experience
- Outcomes and assessment
- Cultural safety

Each domain comprises a standard (statement) which outlines the scope of the domain and criteria against which education providers will provide evidence of compliance.

1. Introduction

The purpose of accreditation is to assure the quality of pharmacy education programs, and to promote ongoing quality assurance. The accreditation of education and training programs is intended both to serve and to safeguard the public by ensuring that graduates of programs are able to demonstrate defined competencies relevant to the activity or role.

1.1. Pharmacy regulation

In Australia, the pharmacy profession is regulated by the Pharmacy Board of Australia (PharmBA) under the *National Registration and Accreditation Scheme* (the National Scheme, 2010), created under the *Health Practitioner Regulation National Law Act* (the National Law, 2009)[2] and enacted in all states and territories.

The Standards have been developed with the intention that graduates of accredited programs will be able to, in the future, apply for endorsement on their registration, should the Pharmacy Board of Australia establish an endorsement for scheduled medicines for pharmacists.

1.2. Accreditation Standards for Pharmacist Prescriber Education Programs

The Standards ensure that graduates from an accredited program:

- meet the competencies in the National Prescribing Competencies Framework (3rd Edition September 2025)[1] which describes the practice expectations of Australian prescribers regardless of profession;
- are competent and qualified to prescribe medicines according to their scope of practice as authorised under state and territory medicines and poisons legislation;
- are ethical, safe practitioners for the benefit and well-being of the public they serve; and
- are flexible, adaptable and responsive to the evolving needs of individuals and communities and fully comprehend their role as prescribers within that changing environment.

The programs are required to meet a minimum Australian Qualifications Framework (AQF)[3] level of 8 (or above), representing postgraduate-level study, including Graduate Certificates, and Graduate Diplomas. AQF Level 8 focuses on advanced knowledge, critical reflection, and technical skills for professional work or further learning.

1.3. Education program content

Education providers will be required to develop program content that aligns with the National Prescribing Competencies Framework (3rd edition). To be granted accreditation, programs need to demonstrate that learners have been assessed against all of these competencies. This ensures that programs equip learners with essential clinical competencies, which include but are not limited to:

- undertaking patient history
- clinical examination
- diagnostic investigations and interpretation
- documentation in electronic health records
- referral processes within multidisciplinary teams.

1.4. Learner supervision

The Standards highlight the importance of supervised practical experience, or Work-Integrated Learning (WIL) and experiential learning to the development of safe, effective prescribing skills. It is acknowledged that the role of the supervising prescriber is crucial to successful outcomes and that clear responsibilities and robust relationships between the supervisor, learner and education provider will be required to support the education process.

APC also recognises that, at times, supervision may be delegated to other members of the healthcare team. As such, the term '**designated prescriber**' is used to describe the **prescriber responsible** for co-ordinating and overseeing learner supervision and the provision of effective mentorship to support their learning, while recognising the valuable contribution of other members of the healthcare team.

2. Pharmacist prescribing and scope of practice

The pharmacist role in medicines management and safety continually evolves to meet the needs of the public and includes prescribing.

The National Prescribing Competencies Framework (3rd Edition September 2025) defines prescribing for all prescribers in Australia as:[1]

> *"A dynamic process involving the steps of information gathering, clinical and shared decision making, communication and evaluation which results in the initiation, continuation or cessation of a medicine"*.[1]

This definition highlights that a pharmacist's scope of prescribing practice comprises:

- Competence – based on education, training and professional experiences,
- Authority – defined by federal and state/territory legislation and regulation and local systems and policies, and
- Accountability – articulated in applicable professional practice standards and competencies.

As the definition describes, a pharmacist's scope of practice changes with time, an important consideration relevant to all areas of practice, including prescribing.

Prescribing must be undertaken according to the parameters of the prescribing context. Factors such as the practice setting, service delivery model, contribution of other health practitioners within the multidisciplinary team, and the specific preferences and needs of the consumer influence prescribing. The demonstration of prescribing performance by learners must include consideration of, and an appropriate response to, relevant factors.

Clinical Skills

Safe prescribing requires time, clinical judgement, continuity of care, and shared decision-making. Knowledge of body systems, including pathophysiology and pathology, are extended through existing pharmacist expertise in pharmacology and pharmacotherapeutics. Pharmacotherapeutics knowledge is a prerequisite for rational prescribing and prepares the learner to be an efficient prescriber.[4]

The National Prescribing Competencies Framework,[1] competency areas, describe that prescribers should request, interpret, and act on diagnostic tests. Additionally, clinical skills, including physical examination, clinical assessment, and clinical reasoning relevant to the learner's scope of prescribing practice have been included in the Standards, requiring programs to provide evidence of compliance.

Managing Conflicts of Interest

Conflicts of interest (COI) should be identified, disclosed, and managed to ensure objectivity, integrity and transparency. Clear requirements need to be included for the identification and management of COI to support impartial decision making.

Ahpra suggests *"an actual, potential or perceived Conflict of Interest (COI) exists [when a practitioner is] influenced by a personal interest in the course of performing [their] professional duties under the National Law. A COI could arise through a range of personal*

interests or connections including family, friends and associates, or as a result of financial, employment and/or community or political interests or activities".[5]

The Pharmaceutical Society of Australia's (PSA) Code of Ethics defines a COI as "*...a particular relationship or practice leads to risk that professional judgements or actions regarding a primary interest (e.g. the responsibilities of a pharmacist)...[is] unduly influenced by a secondary interest (e.g. financial gain)."*[6]

The PSA Code of Ethics,[7] (currently under review) clarifies pharmacists' obligations when conflicts of interest arise. Integrity Principle 1 includes a disclosure position: *"disclosing and managing actual, potential or perceived conflicts of interest ensures professional decisions are not (and nor are they perceived to be) improperly impacted by other pecuniary or non-pecuniary interests."*[6]

The College of Physicians and Surgeons of Ontario (CPSO) also have a disclosure position, *"where avoidance of conflicts of interest is not possible, it may be appropriately managed through disclosure to patients, making them aware of alternatives, and offering reassurance that the patient's choice of an alternative will not affect the quality of care"*.[8]

In pharmacy practice in Australia, pharmacist dispensing of medication prescribed by non-pharmacist prescribers allows separation of prescribing and dispensing. Where a pharmacist prescribes a medication, it is important to acknowledge the conflict of interest that results if the pharmacist prescriber is also in the position of being the only person able to dispense the medication. It is noted that this is not always the case but may occur in remote areas or after hours.

The National Prescribing Competencies Framework [Competency area 7.6 (f)] requires disclosure of conflicts of interest to minimise the impact on prescribing decisions and ensure transparency.[1] Ongoing monitoring and reporting structures enable regulatory action by Ahpra against individual practitioners where required.[9].

The UK Royal Pharmaceutical Society has released a position statement that *"where there is a risk assessment in place and in the best interests of the patient, the same healthcare professional can be responsible for the prescribing and dispensing/supply/administration of medicines."*[10]

APC has incorporated the management of conflict of interest into these Standards as a necessary step to reflect the role of pharmacists in Australia's healthcare system, ensuring that prescribing pharmacists have the competencies to identify, disclose and manage conflict of interest, ensuring the safety of the public and reinforcing safe and effective prescribing.

3. Domains and Standards (statements)

The 2026 Accreditation Standards are structured into six domains, with each domain comprising:

- a standard (statement) which outlines the scope of the domain
- criteria against which education providers will provide evidence of compliance

The following table summarises the Standards, subsequent sections provide details of the criteria, their intent and evidence guide.

DOMAIN	STANDARD (STATEMENT)
1. Safe and socially accountable practice	The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable responsible, person-centred approach to practice.
2. Governance and quality	Program governance, quality assurance, and quality improvement structures and systems are effective in developing and delivering sustainable, high-quality pharmacist prescriber education programs.
3. Program	Program design and implementation support learners to demonstrate achievement of all the competency areas of the National Prescribing Competencies Framework.
4. Learner experience	Learners are provided with equitable and timely access to information and support relevant to the program.
5. Outcomes and assessment	Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.
6. Cultural safety*	The program and its graduates support Aboriginal and Torres Strait Islander Peoples to work, learn, and receive care in environments that are culturally safe and free from racism.

** **Note:** While Domain 6 focuses on cultural safety for Aboriginal and Torres Strait Islander Peoples, providers are expected to address racism and discrimination more broadly through organisational culture, policies and practices.*

Domain 1 Safe and socially accountable practice

Domain 1 Safe and socially accountable practice The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable, person-centred approach to practice.		
Criterion	**Intent**	**Evidence guide**
Criterion 1.1 The program promotes the development of learners' knowledge, skills and behaviours aligned with a commitment to public safety and person-centred care.	To ensure that learners, as health professionals, are committed to safe and socially accountable practice and recognise their responsibility and obligation to serve society by seeking both to prevent harm and to promote optimal health outcomes.	Outline how the program includes and assesses these elements. Demonstrate how professional behaviours and values are promoted through program-level learning outcomes, assessment tasks and associated rubrics. Demonstrate how the program supports the development of competencies related to medication safety prescribing and harm minimisation within the scope of practice. Demonstrate how professional communication, ethical practice, professionalism and professional representation are developed and assessed within the scope of practice. Evidence for this criterion is likely to be based primarily on mapping curriculum and assessments to the National Prescribing Competencies Framework. Providers may make reference to appropriate clinical standards such as the National Safety and Quality Health Service (NSQHS) Standards[11] or equivalent. **Examples of evidence may include:** Program level outcomes or equivalent; curriculum and assessment maps; WIL objectives and assessments; assessment rubrics.
Criterion 1.2 Effective fitness-to-practise monitoring and management processes are implemented in relation to learners which promote and protect public safety at all times.	To ensure ongoing identification, monitoring and management of fitness-to-practise concerns across the program lifecycle, including in Work-Integrated	Outline policies and procedures for identifying learners at risk of not being fit-to-practise. Demonstrate how fitness-to-practise concerns are raised, recorded, escalated and managed, including in WIL settings, and how appropriate support and remediation are provided where required. Documented inherent requirements may form part of fitness-to-practise processes and education providers are expected to be aware

Domain 1 Safe and socially accountable practice The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable, person-centred approach to practice.		
Criterion	Intent	Evidence guide
	Learning (WIL) environments.	of, and to fulfil their responsibilities under Ahpra and the National Boards' Guidelines: Mandatory notifications about registered students and Guidelines: Mandatory notifications about registered health practitioners. **Examples of evidence may include:** Policies and procedures; informational materials; Curriculum and assessment maps; inherent requirements; protocols for raising concerns; incident reports and logs; screening activities such as criminal record checks, and vaccination records.
Criterion 1.3 All learners have demonstrated relevant competencies before interacting with the public or providing professional services as a component of the program.	To ensure that assessment sequencing allows the education provider to assess that learners have relevant competencies to deliver safe (supervised) care prior to undertaking WIL stages.	Describe how learners are adequately prepared and assessed to ensure public safety is protected. Demonstrate how curriculum design and assessment sequencing ensure that learners achieve required competencies before progressing to WIL activities involving public or patient contact. Evidence must include curriculum and assessment mapping to the National Prescribing Competencies Framework, demonstrating how relevant competency areas are achieved prior to learner interaction with the public. **Examples of evidence may include:** Curriculum and assessment maps
Criterion 1.4 The program upholds recognised standards of professional, regulatory, and ethical conduct for staff and learners.	To ensure public safety through monitoring and maintaining compliance to professional,	Outline how appropriate standards of professional, regulatory and ethical practice/conduct and are upheld, including pharmacy profession and organisation-specific guidelines, codes of conduct, and codes of ethics.

Domain 1 Safe and socially accountable practice The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable, person-centred approach to practice.		
Criterion	Intent	Evidence guide
	regulatory and ethical standards. Learners and supervisors who are registered pharmacists or other health practitioners are accountable for their practice and conduct through the registration standards, code and guidelines of PharmBA or their respective National Board.	Demonstrate how graduates will continue to meet Pharmacy Board requirements for endorsement (including defining, developing, maintaining, and documenting their individual scope of practice). Where relevant, describe how jurisdictional requirements to undertake experiential placements are met (such as criminal record checks, Working with Children Checks, or other statutory screening requirements). Outline the processes used to identify concerns related to staff professional and ethical practice and conduct and how such concerns are managed, investigated, and resolved. Demonstrate how informed consent is obtained when learners are involved in the provision of care. Demonstrate the processes for managing and escalating breaches of professional conduct, and the program-level systems in place to promote, monitor, and reinforce ethical practice. **Examples of evidence may include:** Policies and procedures; curriculum and assessment maps; learner orientation and/or induction processes; staff orientation and/or induction processes; Supervisor orientation and/or induction processes; WIL handbook; protocols for raising and addressing concerns; incident reports and logs.
Criterion 1.5 The quality and quantity of Work Integrated Learning (WIL) in the program is sufficient to produce a graduate capable to prescribe across	To ensure learners can demonstrate achievement of the prescribing competencies in practical 'real-life' environments.	Describe how WIL is integrated into the program and the rationale for its design, specifically addressing the timing and duration of each period of WIL within the overall program structure.

Domain 1 Safe and socially accountable practice The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable, person-centred approach to practice.		
Criterion	Intent	Evidence guide
diverse patient populations and in a range of environments.	The program must include direct supervision by a Designated Prescriber to allow for workplace-based assessment of the prescribing competencies.	Outline the goals and/or purposes of each WIL period and explain how learners achieve and demonstrate the expected competencies. Explain how learners are exposed to a diverse range of patients with diverse prescribing needs. Explain how WIL sites are selected and allocated, managed and outline the processes used to evaluate their quality and suitability and alignment with learning outcomes. Outline the scope of competency which is appropriately addressed through WIL. Explain how any gaps in competency are addressed through other means including simulation. Providers are responsible for collecting evidence that learners have achieved the required prescribing competencies by monitoring assessments carried out within WIL. **Examples of evidence may include:** Curriculum and assessment maps; WIL map; WIL outlines or descriptions; WIL assessment tasks; Simulation activity details; Summaries of site details; Policies and procedures, including verifying supervisor credentials, managing conflicts of interest; guidelines or manuals for learners, sites and Designated Prescribers; WIL quality evaluation and assurance policies and procedures; learner feedback; learner reflections; feedback to sites and designated prescribers.
Criterion 1.6 All Work Integrated Learning (WIL) sites are compliant with documented standards for quality, suitability and safety.	To ensure the provider has appropriate oversight of the WIL program to deliver a quality and safe	Outline how the program documents standards and criteria for sites, including cultural, physical and emotional safety, consistent with workplace health and safety principles and legislation.

Domain 1 Safe and socially accountable practice The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable, person-centred approach to practice.		
Criterion	Intent	Evidence guide
	experience for learners and allow them to achieve the required competency areas to an appropriate level.	Describe the mechanisms to ensure all sites maintain ongoing compliance. Outline the mechanisms to ensure WIL supervisors are competent, trained and suitably qualified healthcare professionals. Describe how WIL capacity and resourcing are sufficient to support the learner cohort. Describe mechanisms to ensure that learning and practice site are accessible, inclusive and fit for purpose, including consideration of diverse needs related to disability, gender, age, cultural background and geographic location are made available to the learners. **Examples of evidence may include:** Policies and procedures; handbooks and manuals; contracts and agreements; eligibility criteria for designated prescriber examples of communications with WIL sites managers; emergency protocols for learners; incident reports; site visit reports.
Criterion 1.7 Effective processes are in place to ensure that the education provider maintains compliance with all obligations under the Health Practitioner Regulation National Law Act, of the Pharmacy Board of Australia, and any applicable national and state/territory regulatory frameworks.	To ensure providers meet their obligations under relevant legislative and regulatory frameworks.	Describe the policies, procedures and governance mechanisms in place to support ongoing compliance with legislative and regulatory obligations throughout the program lifecycle. Demonstrate how the provider ensures compliance with: • learner impairment provisions under the Health Practitioner Regulation legislation Ahpra and the National Boards' *Guidelines: Mandatory notifications about registered students and Guidelines: Mandatory notifications about registered health practitioners.* Outline how jurisdictional requirements affecting eligibility to undertake WIL placements are identified and met.

Domain 1 Safe and socially accountable practice The program develops pharmacist prescribers who are competent to prescribe safely with a socially accountable, person-centred approach to practice.		
Criterion	Intent	Evidence guide
		Examples of evidence may include: Policies and procedures; relevant excerpts from committee meeting minutes and action plans; incident reports and logs.

Domain 2 Governance and quality

Domain 2 Governance and quality Program governance, quality assurance, and quality improvement structures and systems are effective in developing and delivering sustainable, high-quality pharmacy programs.		
Criterion	Intent of criterion	Evidence guide
Criterion 2.1 Australian provider organisations are registered with either the Tertiary Education Quality and Standards Agency (TEQSA) or Australian Skills Quality Authority (ASQA) (RTOs).[12]	To ensure that the provider has appropriate organisational governance in place to maintain sustainability of the organisation to continue to deliver the program and protect learners' rights.	Outline the providers organisation's current registration status with the relevant regulatory authority. Where registration is subject to conditions, limitations, or other constraints, describe the nature of these conditions, their implications for delivery of the program, and where applicable, the actions in place to address or mitigate any impact. **Examples of evidence may include:** Narrative summary of registration status, including regarding details of any conditional registration and associated management or action plans (if where applicable).
Criterion 2.2 Academic governance structures are in place within the provider organisation to support the program.	To ensure that the delivery of the program is adequately supported by the provider organisation to be able to deliver the program to required standards.	Describe the academic governance structure supporting the program including: • the authority, responsibility, and capacity of the delivery to plan, develop, implement, and improve the program • Describe how governance arrangements ensure academic oversight and integrity of the program, including curriculum approval, assessment quality assurance, and monitoring of academic standards. Outline the mechanisms used to identify and manage academic, operational, and financial risks associated with program delivery. Describe the processes in place to identify, declare, and manage actual, potential, or perceived conflicts of interest to the program governance and delivery.

Domain 2 Governance and quality Program governance, quality assurance, and quality improvement structures and systems are effective in developing and delivering sustainable, high-quality pharmacy programs.		
Criterion	Intent of criterion	Evidence guide
		Examples of evidence may include: Documentation describing academic governance structures; terms of reference for committees; decision-making authorities and reporting lines; records demonstrating accountability for program oversight; and relevant policy documents.
Criterion 2.3 The program has rigorous quality assurance, monitoring and evaluation mechanisms in place.	To ensure that the program has systematic internal quality assurance, monitoring, and evaluation processes that support continuous improvement	Outline the processes by which the education provider assures the quality of the program. Describe the sources of data that inform quality assurance, monitoring, and evaluation activities, and explain how the outcomes of these processes are used to inform the program design, delivery, and management to support continuous improvement. Stakeholder input informing program quality improvement is addressed separately under Criterion 3.3. **Examples of evidence may include:** Program and delivery review schedules and outcomes; policies and procedures (including conflict of interest policies and procedures); evaluation and review cycles; relevant excerpts from committee meeting minutes and action plans; outcomes of quality assurance processes.
Criterion 2.4 The leadership, teaching, and technical staff cohort are adequate for the program requirements and are appropriately qualified and experienced.	To ensure the leadership, teaching, and professional and technical staff cohort are adequate, appropriately qualified, experienced, supported, and	Demonstrate that the program has a designated program leader with relevant profession-specific experience and expertise who is responsible for providing effective professional and academic leadership, engagement, and advocacy for the program.

Domain 2 Governance and quality Program governance, quality assurance, and quality improvement structures and systems are effective in developing and delivering sustainable, high-quality pharmacy programs.		
Criterion	Intent of criterion	Evidence guide
	resourced to meet program requirements.	Outline how the staff cohort, including sessional or causal staff meet the needs of program delivery, including consideration of staff qualifications, professional, experience, expertise in prescribing and roles. **Examples of evidence may include:** Organisational charts; structured staff listings including expertise and experience; terms of reference, minutes and action plans of relevant committees; recruitment planning for vacancies (if relevant); learner feedback
Criterion 2.5 Program resources are fit-for-purpose, sufficient for the needs of the learner cohort, and regularly reviewed and updated.	To ensure that sufficient resources are available for delivery of the program, including physical facilities, equipment, technology, and information resources. To ensure that effective mechanisms for review and updating of resources are in place.	Demonstrate that sufficient resources are available for current delivery of a fit-for-purpose program. Outline the mechanisms used to regularly review program requirements to ensure they remain appropriate over time, including in response to actual or anticipated changes cohort size, mode of delivery or program scope. Demonstrate how program autonomy is supported by access to fit-for-purpose resources, including budgetary control where applicable. **Examples of evidence may include:** Summaries of available resources; learner and staff feedback (e.g., satisfaction); terms of reference, minutes, and action plans of relevant committees; needs analysis documentation; review, maintenance, and replacement policies and schedules; internal and/or external evaluation documentation.

Domain 2 Governance and quality Program governance, quality assurance, and quality improvement structures and systems are effective in developing and delivering sustainable, high-quality pharmacy programs.		
Criterion	Intent of criterion	Evidence guide
Criterion 2.6 Risks to the sustainable delivery of the program are regularly monitored and evaluated, and appropriate mitigation strategies are clearly documented.	To ensure effective risk identification and management processes are in place to support ongoing program delivery and sustainability.	Explain the processes used at the program level to identify, assess, monitor, mitigate, and manage risks affecting the ongoing and sustainable delivery of the program. **Examples of evidence may include:** Risk management plan, at program level; risk reporting and assessment; business continuity plan; relevant excerpts from committee meeting minutes and action plans; risk records (e.g., registers, logs).

Domain 3 Program

Domain 3 Program Program design and implementation support learners to demonstrate achievement of all the competency areas of the National Prescribing Competencies Framework.		
Criterion	Intent of criterion	Evidence guide
Criterion 3.1 A coherent and contemporary educational philosophy is aligned with the design and delivery of the program.	To ensure the program is grounded in a clearly articulated educational philosophy.	Demonstrate how the program's structure, learning activities and assessment approaches align with the philosophy and support the achievement of program competencies. **Examples of evidence may include:** Summary table of program structure (e.g., subjects and WIL undertaken); statement of philosophy and/or strategy; program maps highlighting alignment; assessment maps or matrices.
Criterion 3.2 The program design, content and assessments reflect contemporary evidence-based prescribing practice. The program duration and sequencing support achievement of the required competency areas described in the National Prescribing Competencies Framework over a sufficient time period.	To ensure the program is contemporary and remains fit-for-purpose. To ensure that the duration of the program is appropriate to allow learners to achieve and demonstrate the required prescribing competencies, and to avoid negative impacts on staff and learner workloads.	**Program currency and contemporary practice** Demonstrate how program design, content, and assessment reflect contemporary, evidence-based pharmacy practice. **Examples of evidence may include:** Curriculum documentation that reflects contemporary pharmacy practice; examples of evidence-based teaching and assessment approaches; details of teaching staff who maintain current pharmacy registration and/or active professional practice. **Program duration and sequencing** Demonstrate that program duration and curriculum sequencing support progressive development of required competencies over a sufficient time period. This includes: • curriculum structure and sequencing

Domain 3 Program

Program design and implementation support learners to demonstrate achievement of all the competency areas of the National Prescribing Competencies Framework.

Criterion	Intent of criterion	Evidence guide
		that enable competency development over time, and • workload and study design that allow learners to achieve required outcomes within realistic and appropriate timeframes **Examples of evidence may include:** Curriculum and assessment mapping showing learner study load, contact hours, and program sequencing; evidence of learner and staff feedback on workload and program structure; documentation demonstrating how program duration supports achievement of the required competency areas in the National Prescribing Competencies Framework. **Alignment with frameworks and regulatory requirements** Demonstrate that the program is aligned with relevant professional and regulatory requirements, including: • explicit alignment with, and mapping to, the National Prescribing Competencies Framework, and; • AQF Level 8 (or above) **Examples of evidence may include:** Competencies mapping; regulatory alignment statements.

Domain 3 Program

Program design and implementation support learners to demonstrate achievement of all the competency areas of the National Prescribing Competencies Framework.

Criterion	Intent of criterion	Evidence guide
Criterion 3.3 Key stakeholder input into program design, evaluation, and quality improvement processes are sought, considered, and incorporated into the program where appropriate.	To ensure that a wide range of stakeholders can provide ongoing feedback on the program.	Outline the formal and informal mechanisms used to gather feedback from staff, learners, graduates, supervisors, practitioners, employers, professional bodies and patients and consumers. Learners are considered to be a critical stakeholder group and should be included in formal governance structures and decision-making processes. Describe the mechanisms used to record, consider, action, and communicate the outcomes of feedback that is gathered, including how feedback informs program changes and enhancements. **Examples of evidence may include:** Terms of reference and current membership of committees or stakeholder groups; meeting minutes; governance/program structures that consider feedback; examples of change made in response to feedback; examples of feedback outcomes shared with stakeholders.
Criterion 3.4 All learners learn with, about, and from other health professions through structured interprofessional education that supports collaboration and improved health outcomes.	To ensure all graduates are prepared to collaborate effectively with other health professionals to improve health outcomes.	Outline how interprofessional education is included in the program. Describe how learners engage with other health professions in both real and simulated learning environments, and how these activities support the development of collaborative practice competencies as prescribers Provide examples of interprofessional learning activities that reflect diverse practice settings.

Domain 3 Program

Program design and implementation support learners to demonstrate achievement of all the competency areas of the National Prescribing Competencies Framework.

Criterion	Intent of criterion	Evidence guide
		Examples of evidence may include: Curriculum and assessment maps; program outlines; learning objectives, and task descriptions; learner feedback and reflections; stakeholder evaluations, including where possible, those from consumers.
Criterion 3.5 The program content explicitly includes training in physical examination, clinical assessment, and diagnostic reasoning relevant to the learner's scope of prescribing practice.	To ensure learners can demonstrate foundational clinical skills and reasoning necessary for safe and effective prescribing.	Demonstrate that the program content includes structured teaching and practice in physical examination techniques, interpretation of clinical signs, and diagnostic reasoning. Demonstrate that learners are able to use diagnostic tools and interpret results to inform prescribing decisions. Outline where simulation, case-based learning, and supervised clinical practice is used to reinforce clinical skills. Demonstrate how the program content detailed above aligns with the learner's intended scope of practice. **Examples of evidence may include:** Curriculum and assessment maps; assessment rubrics; program outlines.

Domain 4 Learner experience

Domain 4 Learner experience Learners are provided with equitable and timely access to information and support.		
Criterion	Intent of criterion	Evidence guide
Criterion 4.1 Program admission and progression requirements and processes are fair and transparent.	To ensure that learners will experience admission and progression processes that are fair and reasonable.	Outline how admission and progression requirements and related policies are applied consistently across the program. Outline any program inherent requirements (or equivalent) and describe how these requirements are communicated, assessed and applied. **Examples of evidence may include:** Published entry criteria; inherent requirements or equivalent; policies and procedures for special consideration and reasonable accommodations relating to admission; examples of cases where exceptions are made; minutes and action plans of relevant committees; communications relating to decisions to make or refuse exceptions.
Criterion 4.2 Program information is clear and accessible.	To ensure that prospective learners are to make an informed decision about the program.	Provide details of the program information made available to prospective learners, such as selection policies, entry criteria and processes, inherent requirements, experiential and WIL requirements, PharmBA requirements and current accreditation status. Outline how prospective learners can access this program information, including the timing, format, and channels through which this information is provided. **Examples of evidence may include:** Promotional and informational materials excerpts/screenshots from websites minutes and action plans of relevant committees; FAQs; enquiry logs.

Domain 4 Learner experience Learners are provided with equitable and timely access to information and support.		
Criterion	Intent of criterion	Evidence guide
Criterion 4.3 The education provider ensures that learners can access relevant resources and support systems in a timely manner to facilitate achievement of the required competencies.	To ensure learners are supported throughout the duration of the program, including academic support, general welfare, and wellbeing	Outline the range of resources and support systems available to learners which may include, but not limited to: • orientation and induction processes; • academic support, general welfare and wellbeing services; learning resources such as physical spaces, online learning management system, information and library resources, and self-directed learning resources; • peer support networks; and • effective supervision and mentoring. Describe how communications with learners is planned and delivered to balance both learners' and staff needs, including how urgent communications are facilitated when required. **Examples of evidence may include:** Informational materials; excerpts/screenshots from websites; electronic and other communications; learner feedback; required resources including software and other technology to support learning, including during WIL experiences.
Criterion 4.4 The education provider ensures that the principles of equity and diversity are applied.	To ensure learners are informed of their rights, treated fairly and lawfully, and supported through equitable access to learning opportunities, reasonable adjustments, and	Outline the processes for identifying learners whose backgrounds or circumstances may present challenges for equitable participation in the program, including (but not limited) to cultural and linguistic diversity, English language proficiency, socioeconomic circumstances, disability, and health issues.

Domain 4 Learner experience Learners are provided with equitable and timely access to information and support.		
Criterion	Intent of criterion	Evidence guide
	appropriate supports to enable progression through the program.	Describe the program, services, and mechanisms available to support these learners and explain how mechanisms enhance equity of access and participation. Outline how learners are informed about available support options, and how outcomes for learners are monitored. Explain how regarding reasonable accommodations are made and applied, including how relevant policies and procedures of the provider organisation are implemented at the level of program delivery. Demonstrate how equity and diversity principles are operationalised within the program, including mechanisms to monitor outcomes and evaluate the effectiveness of support strategies. **Examples of evidence may include:** Policies and procedures for reasonable accommodations; accessibility options; financial support, counselling, and other relevant learner services; informational materials; minutes and action plans of relevant committees; decision logs.
Criterion 4.5 Learners can access effective appeals and grievance processes.	To ensure the provider has in place processes to manage appeals and grievances from learners.	Outline how the education provider manages learners appeals and grievances, including the policies, procedures, and frameworks applied to ensure natural justice, procedural fairness, and timely resolution. Describe how learners are informed about appeals and grievance processes, how matters are escalated and reviewed, and how outcomes are communicated to relevant parties.

Domain 4 Learner experience Learners are provided with equitable and timely access to information and support.		
Criterion	Intent of criterion	Evidence guide
		Demonstrate how appeals and grievances are recorded, monitored and reviewed to inform quality assurance and continuous improvement. **Examples of evidence may include:** Policies and procedures; records of appeals and outcomes; records of complaints and outcomes; student/intern feedback.

Domain 5 Outcomes and assessment

Domain 5 Outcomes and assessment Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.		
Criterion	**Intent of criterion**	**Evidence guide**
Criterion 5.1 The program has a contemporary evidence-based assessment strategy.	To ensure the overall program assessment methodology and approach is planned and regularly reviewed, and that emerging technologies, such as artificial intelligence are considered.	Describe the overall assessment strategy that underpins the program, including the principles guiding assessment design and the relevant assessment-related policies and procedures. Demonstrate the mechanisms in place to identify, monitor and respond to emerging risks in assessment practices, including risks associated with technological developments such as artificial intelligence. **Examples of evidence may include:** Assessment strategies or frameworks; assessment-related policies and procedures; guidance on acceptable use of digital technologies and artificial intelligence in assessment; academic integrity policies and resources; records of assessment review and quality assurance activities; assessment maps; and examples of assessment tasks and marking rubrics.
Criterion 5.2 Program assessments, including during Work Integrated Learning (WIL) are contemporary, evidence based and diverse.	To ensure that the program includes a range of assessment types that are appropriate for each learning outcome.	Outline the types of assessment tools used across the program, including assessments undertaken in WIL settings. Explain how assessment types are aligned with learning outcomes and learning activities and describe the rationale for the assessment approaches adopted, including reference to relevant prescribing or

Domain 5 Outcomes and assessment Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.		
Criterion	**Intent of criterion**	**Evidence guide**
		professional standards where appropriate. Describe how the validity and reliability of assessment practices are evaluated and monitored, including mechanisms for moderation, benchmarking and review, where relevant. **Examples of evidence may include:** Examples of assessment types; evidence of alignment with APC and PharmBA assessment requirements, including WBAs.
Criterion 5.3 All required professional competencies and program learning outcomes are assessed, aligned with the National Prescribing Competencies Framework.	To ensure graduates are competent to practise prescribing safely, legally, professionally, and ethically as a member of an interprofessional health care team.	Outline how program assessment approaches ensure that learners demonstrate achievement of the required competencies and program learning outcomes, with alignment to professional, regulatory and registration frameworks and codes. Demonstrate inclusion of assessment of strategies to manage conflict of interest when prescribing and supply is unable to be separated. **Examples of evidence may include:** Curriculum and assessment maps demonstrating alignment between program learning outcomes, assessment tasks, and the National Prescribing Competencies Framework.
Criterion 5.4 The program has effective policies and procedural controls in operation for external	To ensure the external moderation of assessments as part of continuous quality improvement	Outline the policies and processes in place for independent and external review of assessments tasks and outcomes for quality assurance and improvement purposes.

Domain 5 Outcomes and assessment Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.		
Criterion	**Intent of criterion**	**Evidence guide**
moderation of assessments.	to assure validity, integrity, reliability, fairness and transparency in the assessment of learners, with outcomes used to inform program development and enhancement.	Explain how assessment moderation processes are implemented in practice, and how the feedback and findings from moderation activities are analysed, actioned and used to improve assessment design and program delivery. Demonstrate that assessment moderation and review activities involve appropriately qualified and experienced internal and/or external staff. **Examples of evidence may include:** Policies and procedures; review/moderation schedules; review/moderation agreements; examples of external moderation reports; excerpts of committee meeting minutes and action plans; learners feedback.
Criterion 5.5 All assessments are fair, valid and reliable.	To ensure that there are clear criteria for assessments that are shared with learners, supervisors, and assessors undertaking the assessments for consistency.	Outline the policies and processes in place to ensure that assessment criteria are clearly defined, communicated, and applied consistently across assessment tasks, including WIL. Describe how assessments are conducted by appropriately qualified, trained assessors and/or designated prescriber, including the recruitment, induction, briefing, training, and ongoing support of assessors. Explain how fairness in assessment is promoted, including the identification, declaration, and management of actual, potential, or perceived conflicts of interest.

Domain 5 Outcomes and assessment Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.		
Criterion	**Intent of criterion**	**Evidence guide**
		Examples of evidence may include: Examples of assessment task descriptions and rubrics; external moderation reports; incident and appeal reports; policies and procedures for assessment of group work; induction, training, and briefing documentation; peer review or moderation processes for individual assessment tasks.
Criterion 5.6 Learners are provided with effective, appropriate, and timely assessment feedback.	To ensure learners are able to improve their performance.	Outline the mechanisms through which learners receive feedback from assessors. Describe how feedback practices are designed to promote future learning and development, with a focus on the quality, specificity and developmental nature of feedback, in addition to administrative considerations such as turnaround times and modes of delivery. Demonstrate how feedback supports learners learning and improvement across the program. **Examples of evidence may include:** Examples of completed assessments and feedback provided; feedback from assessors and/or designated prescriber; learner feedback and satisfaction, including through formal evaluations and informal mechanisms.
Criterion 5.7 Program content and assessments ensure graduates are able to undertake comprehensive patient assessment and differential diagnosis in practice.	To ensure graduates are competent and safe to complete patient assessment and differential diagnosis that informs prescribing decisions.	*The competency areas below are adapted from the National Prescribing Competencies Framework:* Demonstrate how program, WIL, and/or assessment activities include a comprehensive assessment of the patient and their needs, including but not limited to, anatomy, physiology, pathology,

Domain 5 Outcomes and assessment Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.		
Criterion	**Intent of criterion**	**Evidence guide**
		pathophysiology, microbiology, and immunology. Outline how diagnosis and treatment are assessed during the prescribing process, within the program. Demonstrate how program, WIL, and/or assessment activities include assessment of the patient according to the clinical context and the learner scope of practice. Demonstrate how the program ensures learners accurately diagnose or understand a diagnosis of illness according to their scope of practice. Demonstrate how the program ensures learners are able to use equipment to make observations in the context of the patient's medical history, and during examination. Demonstrate how the program ensures familiarity with a range of disease states and their evidence-based management essential to guide treatment, both non-pharmacological and pharmacological. Demonstrate how clinical assessment, including clinical reasoning and differential diagnosis to reduce missed, delayed, or incorrect diagnoses, is incorporated in the program. Outline how prescribing a particular medicine has implications to the wider community is incorporated in the program. Demonstrate how the program ensures learners prioritise the patient's needs and health above all considerations in prescribing decisions. **Examples of evidence may include:**

Domain 5 Outcomes and assessment Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.		
Criterion	**Intent of criterion**	**Evidence guide**
		Assessment map (including formative, summative, WBA), rubrics, cross referenced to the National Prescribing Competencies Framework; examples of assessments, including those that review the ability to perform whole process (OSCE); examples of feedback provided to learners.
Criterion 5.8 Learners complete comprehensive assessments that ensure they are competent to undertake the full prescribing process.	To ensure learners are assessed on their ability to complete the entire prescribing process and demonstrate consolidated prescribing competencies. It is expected that the program includes a capstone (final) assessment.	*The competency areas below are adapted from the National Prescribing Competencies Framework:* Outline the mechanisms used to ensure opportunities for learners to practise and demonstrate achievement of all competencies across the prescribing process. Demonstrate how the program ensures learners: • Take patient history • Diagnose prior to prescribing • Recognise and communicate when it is clinically appropriate not to prescribe medicines • Follow a clinical decision-making process (including clinical examination, diagnostic investigations and interpretation, and documentation aligning with health system requirements) • Prescribe medicines safely and communicate the agreed treatment decision with the patient • Know when and how to refer for further assessment when outside their scope of practice • Monitor, review, stop or modify existing medicines and other treatments, where appropriate

Domain 5 Outcomes and assessment Graduates of the program demonstrate achievement of all the required National Prescribing Competencies Framework competency areas and to a standard commensurate with competent, safe, and socially accountable professional prescribing practice.		
Criterion	**Intent of criterion**	**Evidence guide**
		• Accept responsibility and accountability for prescribing decisions • Prescribe medicines compliant with relevant legislation, regulatory frameworks, guidelines, codes of practice, scope of practice, and organisational policies and procedures. Describe how the learners will be assessed on completing an entire patient consultation, demonstrating consolidated competencies across the full prescribing process consistent with the competency areas. **Examples of evidence may include:** Assessment map (including formative, summative, WBA), rubrics; examples of assessments, including those that review the ability to perform whole process (OSCE).

Domain 6 Cultural safety

Domain 6 Cultural safety The program and its graduates support Aboriginal and Torres Strait Islander Peoples to work, learn, and receive care in environments that are culturally safe and free from racism.		
Criterion	Intent of criterion	Evidence guide
Criterion 6.1 Program design, content, delivery, and assessment specifically emphasise and promote Aboriginal and Torres Strait Islander cultures, cultural safety, and improving health outcomes, and support the development of skills that enable the provision of culturally safe care.	To ensure that the program supports the development of cultural responsiveness, knowledge, and reflective practice among staff and learners, enabling the provision of culturally safe care as determined by Aboriginal and Torres Strait Islander Peoples.	Outline how, where, and at what stages cultural safety is embedded within curriculum, including Aboriginal and Torres Strait Islander cultures, histories, and knowledges, and how these inform learning, teaching, and assessment activities. Demonstrate how curriculum design, content and delivery related to Aboriginal and Torres Strait Islander Peoples adopts a strengths-based approach, avoids deficit framing and align with principles of self-determination, respect, and partnership. **Examples of evidence may include:** Curriculum and assessment mapping to the Aboriginal and Torres Strait Islander Health Curriculum Framework,[13] examples of curriculum activities, and/or assessments.
Criterion 6.2 Aboriginal and Torres Strait Islander Peoples have input into curriculum design and management.	To ensure that the program provider actively engages with Aboriginal and Torres Strait Islander Peoples to ensure the program reflects Indigenous perspectives and supports the development of culturally safe graduates.	Outline how Aboriginal and Torres Strait Islander Peoples input informs curriculum design, governance', and continuous improvement processes within the program. Describe how this input is considered, actioned, and reflected in curriculum development, teaching, and learning activities, assessment practices, and program review. Explain the mechanisms used to engage Aboriginal and Torres Strait Islander Peoples, including the frequency, scope, and formality of engagement, and how feedback and advice are documented and incorporated into program decision-making.

Domain 6 Cultural safety The program and its graduates support Aboriginal and Torres Strait Islander Peoples to work, learn, and receive care in environments that are culturally safe and free from racism.		
Criterion	Intent of criterion	Evidence guide
		Examples of evidence may include: Descriptions of engagement with Aboriginal and Torres Strait Islander individuals or groups; minutes and action plans of relevant committees/advisory groups; description of frequency of input.
Criterion 6.3 Staff delivering the program have the knowledge, expertise, and cultural capability to guide and support student learning about Aboriginal and Torres Strait Islander cultures, cultural safety, and improved health outcomes.	To ensure that program content relating to Indigenous cultures and cultural safety is delivered by or with the involvement of Aboriginal and Torres Strait Islander Peoples, or people with relevant knowledge and expertise.	Explain how staff involved in delivering the program build, maintain, and demonstrate their understanding of Aboriginal and Torres Strait Islander cultures, cultural safety, and their application within pharmacy education and practice. Demonstrate the mechanisms that support the ongoing development and maintenance of staff cultural capability, including professional learning, reflective practice and engagement with Aboriginal and Torres Strait Islander Peoples and communities. Outline how Aboriginal and Torres Strait Islander Peoples are involved in the delivery, codesign or oversight of curriculum content related to Indigenous cultures, cultural safety and health outcomes. **Examples of evidence may include:** how Description of how Indigenous Peoples are involved with program delivery; documentation of relevant training completed by staff; description of staff expertise and knowledge to deliver content on Indigenous cultures and cultural safety.
Criterion 6.4 The education provider promotes and supports the recruitment,	To ensure that Aboriginal and Torres Strait Islander learners are	Describe the recruitment, admission, and retention strategies in place to support

Domain 6 Cultural safety The program and its graduates support Aboriginal and Torres Strait Islander Peoples to work, learn, and receive care in environments that are culturally safe and free from racism.		
Criterion	Intent of criterion	Evidence guide
admission, participation, retention, and completion of the program by Aboriginal and Torres Strait Islander Peoples.	supported through the program to increase the number of Indigenous pharmacists prescribers in Australia.	Aboriginal and Torres Strait Islander students within the program. Outline the culturally safe, tailored supports available to Aboriginal and Torres Strait Islander learners once enrolled, including academic, pastoral, mentoring, and wellbeing supports. Demonstrate preparedness to provide culturally safe learning environments and responsive support mechanisms that promote participation, progression, and completion for Aboriginal and Torres Strait Islander learners. **Examples of evidence may include:** Targeted recruitment and outreach activities; Indigenous-specific entry or support pathways (where applicable); involvement of Aboriginal and Torres Strait Islander staff, advisors, or mentors; dedicated cultural, academic, or wellbeing support services; and documentation outlining support strategies and outcomes for Aboriginal and Torres Strait Islander learners.
Criterion 6.5 Staff and learners work and learn in a culturally safe environment that is free from racism.	To ensure that providers demonstrate how they promote appreciation of cultural differences and development of cultural safety among both staff and learners.	Describe the mechanisms in place to create, promote, and maintain a culturally safe learning and working environment for staff and learners. Explain how racism, discrimination, and culturally unsafe behaviours are identified, prevented, and addressed through organisational culture, policy, education, and practice. Demonstrate how staff and learners are supported to develop cultural safety awareness, reflective practice, and

Domain 6 Cultural safety The program and its graduates support Aboriginal and Torres Strait Islander Peoples to work, learn, and receive care in environments that are culturally safe and free from racism.		
Criterion	Intent of criterion	Evidence guide
		accountability, and how feedback is used to strengthen culturally safe environments. **Examples of evidence may include:** Staff training and professional development related to cultural safety and anti-racism (including frequency and participation rates); cultural safety, anti-racism, and discrimination policies and procedures; reporting and response mechanisms; and feedback from staff and students/interns regarding cultural safety and inclusion.
Criterion 6.6 Learners have authentic practice-based learning experiences that enable them to apply culturally safe care for Aboriginal and Torres Strait Islander Peoples.	To ensure that learners can apply their program learning about cultural safety in the practice of prescribing.	Describe how WIL opportunities include and/or support engagement with Aboriginal and Torres Strait Islander patients, communities, or organisations in a manner appropriate to the practice of prescribing. Explain how learning activities are designed to support culturally safe practice while avoiding unnecessary cultural load or tokenistic participation by Aboriginal and Torres Strait Islander Peoples. Demonstrate how culturally safe learning experiences are designed in alignment with Aboriginal and Torres Strait Islander community prescribing needs and expectations, and how feedback from communities or partners informs program quality improvement. **Examples of evidence may include:** WIL mapping; examples of activities (real or simulated); on-Country learning experiences; supervised community engagement; partnerships with Aboriginal and Torres Strait Islander

Domain 6 Cultural safety The program and its graduates support Aboriginal and Torres Strait Islander Peoples to work, learn, and receive care in environments that are culturally safe and free from racism.		
Criterion	Intent of criterion	Evidence guide
		organisations; other context-appropriate learning activities.

Abbreviations

Abbreviation	Meaning
Ahpra	Australian Health Practitioner Regulation Agency
APC	Australian Pharmacy Council
AQF	Australian Qualifications Framework
NRAS	National Registration and Accreditation Scheme
OSCE	Objective Structured Clinical Examination
PharmBA	Pharmacy Board of Australia
QUM	Quality Use of Medicines
RTO	Registered Training Organisation
TESQA	Tertiary Education Quality and Standards Agency
WBA	Workplace Based Assessment
WIL	Work-integrated learning

Glossary

Term	Definition
Accreditation	Evaluation of a program against defined standards that ensures that the education and training is rigorous and prepares individuals to practise safely.
Accredited	A training program that has been assessed by the authorised organisation as meeting the relevant Accreditation Standards. It is not a self-assessment.
Assessment	An activity that gathers evidence to determine that a learner knows, understands, and meets the required competencies. Comprehensive assessment approaches include a combination of formal and informal assessment (formative, interim, and summative).
Competencies	Used by National Scheme entities to describe the knowledge, skills, and professional attributes needed to safely and competently practice the relevant health profession in Australia.[14]
Criteria	For each **domain,** the criteria are the specific statements against which the program is to be evaluated, and which are designed to be addressed by an education provider when undergoing accreditation. For accreditation of a program (without conditions), it is necessary for compliance to be demonstrated against all **criteria.**
Cultural diversity	Cultural diversity means having a mix of people from different cultural backgrounds; it can include differences in cultural/ethnic identity (how we identify ourselves and how others identify us), language, country of birth, religion, heritage/ancestry, national origin, and/or race.[15]
Cultural safety	Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families, and communities. Culturally safe practise is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours, and power differentials in delivering safe, accessible, and responsive healthcare free of racism.[16,17]
Domain	A high-level thematic grouping that brings together related accreditation expectations under a single area of focus, expressed through a Standard Statement and supported by multiple criteria**.**

Education provider	A university, tertiary education institution, or another institution or organisation, that provides vocational training, or a specialist medical college or other health profession college.[18]
Fitness-to-practise	Fitness-to-practise encompasses both readiness-to-practise from a competency perspective (including knowledge, skills, behaviours and attitudes), and the capacity to undertake professional practice safely from the perspective of wellbeing and impairment. As outlined in the National Law, fitness-to-practise can be framed using the categories of conduct, performance, and health where the first two relate to readiness-to-practise and the third to wellbeing and impairment.[18–20]
Patients	Also known as health consumer, clients, family, community, carers and secondary consumers. A person with lived or living experience who receives care from health practitioners either directly or in a secondary capacity as a family member, carer or community.[14]
Interprofessional collaborative practice	Refers to health care practice where multiple health workers from different professional backgrounds work together, with patients, families, carers and communities to deliver the highest quality of care that is free of racism and other forms of discrimination.[14]
Interprofessional education	The Health Professions Accreditation Collaborative (HPAC) Forum has endorsed World Health Organization's (WHO) definition of interprofessional education: "*Interprofessional education occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes.*"[21]
Moderation of assessment	Quality assurance andcontrol processes and activities such as peer review that aim to assure: • consistency or comparability, appropriateness, and fairness of assessment judgments • the validity and reliability of assessment tasks, criteria and standards. Moderation of assessment processes establish comparability of standards of student performance across, for example, different markers, locations, subjects, providers and/or courses of study.[3]

Person-centred care	Care that is respectful of, and responsive to, the preferences, needs and values of the individual consumer/patient/client and recognises the role of family and community. It involves seeking out and understanding what is important to the consumer/ patient/client and their family, community and/or carer, fostering trust, establishing mutual respect and working together to share decisions and plan care, whilst recognising that consumer/patient/client safety remains paramount.[14]
Designated prescriber	A registered health professional with current prescribing qualifications and experience relevant to the learner's scope of practice who formally agrees to supervise and provide mentorship to a learner consistent with the defined expectations provided by the education provider.
Scope of Practice	Professional activities that a health professional is educated (skill and knowledge), competent and authorised to perform, and for which they are accountable. Individual scope is time-sensitive and dynamic. Scope of practice for individual health professionals is influenced by the settings in which they practise, the health needs of people, the level of their individual competence and confidence and the policy requirements (authority/governance) of the service provider.[1]
Simulation-based learning	Interactive educational methods or clinical experiences that evoke or replicate real-life characteristics of an event or situation as the basis for developing skills, confidence and problem-solving abilities in a safe, controlled and monitored environment.[22]
Social accountability	Pharmacists are willing and able to: • deliver culturally safe and responsive person-centred care • address the health care needs of individuals and the wider society • assume responsibility for the sustainable use of healthcare resources • contribute to the ongoing improvement of individual and societal health outcomes. For education providers, it is an obligation to:

	• provide education that promotes the development of socially accountable pharmacists undertake research and service activities targeted towards addressing the current and future priority health concerns of society.[23,24]
Standard (statement)	For each **domain**, a standard (statement) describes the overall scope of the **domain**.
Supervisor	A registered health professional who works as a member of a healthcare team and provides work-based supervision to the learner under direction or delegation by the designated prescriber.
Work-integrated Learning (WIL)	The component of a program of study, undertaken with supervision, in a clinical or professional practice environment that assists students to put theoretical knowledge into practice.[22] For the purpose of these standards, the APC considers supervised practice undertaken by an intern as a type of WIL.

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Attachment B

Summary of Proposed Changes to the Pharmacist Prescriber Standards

Within each criterion, the notes from the Standards and the evidence guide document have been revised and merged to create an updated evidence guide, that has been included in the Proposed Draft revised Standards.

Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Domain 1 – Safe and socially accountable practice		
Criterion 1.1 The program is underpinned by the principles of cultural safety, respect and responsiveness; equity, diversity and inclusiveness; person-centred care; reduction of disparities in health care; addressing community aspirations for health; and a commitment to public service and safety.	**Criterion 1.1** The program promotes the development by learners of knowledge, skills and behaviours aligned with a commitment to public safety and person-centred care.	Simplified wording.
Criterion 1.2 Effective fitness-to-practise monitoring and management processes are implemented in relation to learners which promote and protect the safety of the public at all times.	**Criterion 1.2** Effective fitness-to-practise monitoring and management processes are implemented in relation to learners which promote and protect public safety at all times.	No change.
Criterion 1.3 All learners have demonstrated relevant pre-requisite knowledge, skills, behaviours and attitudes before undertaking supervised work-integrated-learning (WIL) as a component of the program.	**Criterion 1.3** All learners have demonstrated relevant competencies before interacting with the public or providing professional services as a component of the program.	Simplified wording.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Criterion 1.4 All teaching staff, supervisors and learners are held accountable to endorsed standards of professional and ethical practice and conduct at all times, including during WIL.	**Criterion 1.4** The program upholds recognised standards of professional, regulatory and ethical conduct for staff and learners.	Simplified wording.
Criterion 1.5 Program graduates have demonstrated an understanding of their legal, ethical and professional responsibilities in relation to prescribing.	**Removed**	Incorporated into Criterion 1.4
Criterion 1.6 The program includes sufficient high quality, supervised WIL in relevant settings to facilitate learners to consolidate prescribing competencies and demonstrate performance outcomes.	**Criterion 1.5** The quality and quantity of Work Integrated Learning (WIL) in the program is sufficient to produce a graduate capable to practise across diverse patient populations and in a range of environments.	Simplified wording and new numbering.
Criterion 1.7 Processes support effective relationships between the program provider, the learner, the WIL site, and the primary supervisor. All parties agree to, and comply with, documented processes to support a safe and quality WIL experience.	**Criterion 1.6** All Work Integrated Learning (WIL) sites are compliant with documented standards for quality, suitability and safety.	Simplified wording and new numbering.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Criterion 1.8 Effective processes are in place to ensure that the program provider complies with all obligations under the Health Practitioner Regulation National Law Act, Pharmacy Board of Australia and relevant national and state/territory legislation and frameworks.	**Criterion 1.7** Effective processes are in place to ensure that the **education provider maintains compliance** with all obligations under the Health Practitioner Regulation National Law Act, of the Pharmacy Board of Australia, and any applicable national and state/territory regulatory frameworks.	Minor rewording and new numbering.
Domain 2 – Governance and Quality		
Criterion 2.1 The program is delivered by a clearly identifiable operational unit (the 'program provider') within the provider organisation. The program provider operates with appropriate autonomy, authority and responsibility for designing, implementing, evaluating and resourcing the program.	Removed. Covered in the proposed criteria 2.2, 2.3 and 2.5	This criterion relates to the unit delivering the program having autonomy for the design, implementation and resourcing of the program. The requirement for 'autonomy, authority and responsibility' for the program can be assessed through proposed Criterion 2.2 (academic governance structures), proposed Criterion 2.3 (quality assurance) and proposed Criterion 2.5 (program resources). Removing the requirement for a 'clearly identifiable operational unit' aligns with other health profession accreditation standards.
Criterion 2.2 The program provider is registered with either the Tertiary Education Quality and Standards Agency	**Criterion 2.1**	Minor rewording and new numbering.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
(TEQSA) (HEIs) or Australian Skills Quality Authority (ASQA) (RTOs).	Australian provider organisations are registered with either the Tertiary Education Quality and Standards Agency (TEQSA) or Australian Skills Quality Authority (ASQA).	
Criterion 2.3 Governance structures and processes within the provider organisation direct and support the design, implementation, evaluation and quality improvement at the program level and ensure that graduates are able to demonstrate the performance outcomes.	**Criterion 2.2** Academic governance structures are in place within the provider organisation to support the program.	Simplified wording and new numbering. Alignment with other health profession accreditation standards.
Criterion 2.4 The maintenance, assurance and improvement of program quality is facilitated by effective relationships and accountability between the program provider and the provider organisation.	**Criterion 2.3** The program has rigorous quality assurance, monitoring and evaluation mechanisms in place.	Simplified wording and new numbering. Alignment with other health profession accreditation standards.
Criterion 2.5 The program provider has a designated leader with relevant experience and expertise who is responsible for ensuring the effective provision of professional and academic leadership, engagement and advocacy for the program provider and the profession within and beyond the provider organisation.	**Criterion 2.4** The leadership, teaching and technical staff cohort are adequate for the program requirements and are appropriately qualified and experienced.	Simplified wording and new numbering. Alignment with other health profession accreditation standards.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Criterion 2.6 There are clearly defined, robust, transparent and effective mechanisms by which the designated leader secures and is accountable for the financial and other resources necessary to ensure the sustainable operation of the program.	**Criterion 2.5** Program resources are fit-for-purpose, sufficient for the needs of the learner cohort and regularly reviewed and updated.	Simplified wording and new numbering.
Criterion 2.7 The program provider operates under a clearly defined strategic plan which is aligned with that of the provider organisation, congruent with the vision, purpose and goals of the program provider, and systematically reviewed and updated to ensure fitness-for-purpose and currency with contemporary prescribing practice.	Removed.	Alignment with other health profession accreditation standards.
Criterion 2.8 Risks to the sustainable delivery of the program are regularly monitored and evaluated, and appropriate mitigation strategies are clearly documented.	**Criterion 2.6** Risks to the sustainable delivery of the program are regularly monitored and evaluated, and appropriate mitigation strategies are clearly documented.	New numbering.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Domain 3 – Program		
Criterion 3.1 The program is underpinned by a coherent, contemporary, and clearly articulated educational philosophy and/or learning and teaching strategy, which is clearly reflected and articulated in the program goals/objectives, curriculum, learning and teaching approaches, and assessment methodology.	**Criterion 3.1** A coherent and contemporary educational philosophy is aligned with the design and delivery of the program.	Simplified wording.
Criterion 3.2 Program design, content, delivery, and assessment align with contemporary evidence-based prescribing practice and are designed to facilitate achievement and demonstration by learners of the performance outcomes. Emerging developments and legislation relevant to prescribing are reflected in the program (including WIL) in a timely manner consistent with the defined program purpose.	**Criterion 3.2** The program design, content and assessments reflect contemporary evidence-based prescribing practice. The program duration and sequencing support achievement of the required competency areas described in the National Prescribing Competencies Framework over a sufficient period of time.	Simplified wording.
Criterion 3.3 Program planning, design, implementation, evaluation, review and quality improvement processes are carried out in a systematic and inclusive manner, involving input where relevant from staff, learners, graduates, supervisors, health professionals with prescribing expertise, employers, patients and consumers, Aboriginal and Torres Strait	**Criterion 3.3** Key stakeholder input into program design, evaluation and quality improvement processes are sought, considered and incorporated into the program where appropriate.	Simplified wording.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Islander peoples, and other key external stakeholders to ensure that the program remains consistent with its defined purpose. Outcomes from these processes are clearly communicated in a timely manner to stakeholders.		
Criterion 3.4 Program design, content, delivery and assessment specifically emphasise and promote Aboriginal and Torres Strait Islander cultures, cultural safety and improved health outcomes. Aboriginal and Torres Strait Islander peoples should have direct input into curriculum design and content, and where possible should be involved directly in delivery and assessment.	Moved to new Domain 6.	Proposed new Domain 6 – Cultural safety. Alignment with Ahpra's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy. Alignment with APC's Reconciliation Action Plan. Alignment with other health profession accreditation standards.
Criterion 3.5 Program design, content, delivery and assessment promote an understanding and appreciation of cultural diversity by both staff and learners, and the development of learner skills that enable the provision of culturally safe, inclusive and responsive person-centred care.	Moved to new Domain 6.	As above.
Criterion 3.6 Resources including physical facilities, infrastructure, technological capacity and information resources available to learners undertaking the program are	Moved to Domain 2 (merged with proposed criterion 2.5)	Alignment with other health profession accreditation standards.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
current, fit-for-purpose, sufficient for the needs of the learner cohort and systematically reviewed and updated on a regular basis.		Resource management fits with governance and quality. Reducing duplication.
Criterion 3.7 The program provider maintains a leadership and staff complement which is demonstrably sufficient for the needs of the program, appropriately qualified and experienced, sustainably resourced and supported, and provided with regular opportunities for relevant professional review and development.	Moved to Domain 2 (merged with proposed criterion 2.6)	Alignment with other health profession accreditation standards. Staff management fits with governance and quality. Reduces duplication.
Criterion 3.8 The program provides sufficient opportunities for all learners to engage in interprofessional learning and practice (in real and/or simulated environments) to enable graduates to achieve the required performance outcomes including the provision of person-centred care, as a collaborative member of an interprofessional team.	**Criterion 3.4** All learners learn with, about and from other health professions through structured interprofessional education that supports collaboration and improved health outcomes.	Simplified wording and new numbering. Changed wording from interprofessional education to interprofessional collaborative practice.
Criterion 3.9 The program provider operates in an environment informed by contemporary scholarship, research and enquiry.	Moved to Criterion 3.2	

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
	Criterion 3.5 The program content explicitly includes training in physical examination, clinical assessment, and diagnostic reasoning relevant to the learner's scope of prescribing practice.	Simplified wording and alignment to prescribing outcomes. New numbering. Wording updated to reflect specific prescribing skills.
Domain 4 – Learner experience		
Criterion 4.1 Selection policies and criteria for entry to the program are transparent, equitable, and applied fairly and consistently to ensure that applicants are not subject to unfair/unlawful discrimination.	**Criterion 4.1** Program admission and progression requirements and processes are fair and transparent.	Simplified wording.
Criterion 4.2 Program information, including program purpose, selection policies, criteria and processes, program structure, inherent requirements, recognition of prior learning (RPL) processes, experiential and WIL requirements, PharmBA requirements, current accreditation status and any other relevant information is accurate, accessible and comprehensive to ensure that potential applicants are given sufficient guidance to make an informed decision.	**Criterion 4.2** Program information is clear and accessible.	Simplified wording.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Criterion 4.3 The program provider ensures that learners are able to access relevant resources and support systems that assist learners to achieve the performance outcomes regardless of practice setting.	**Criterion 4.3** The education provider ensures that learners are able to access relevant resources and support systems in a timely manner to facilitate achievement of the required competencies.	Simplified wording.
Criterion 4.4 The program provider ensures that the principles of equity and diversity are embedded in the program to ensure the absence of unfair/unlawful discrimination.	**Criterion 4.4** The education provider ensures that the principles of equity and diversity are applied.	Simplified wording.
Criterion 4.5 The program provider ensures that learners are aware of and able to access effective appeals and grievance processes, and that these processes are managed consistently, fairly and with appropriate impartiality and confidentiality to ensure that learners are treated justly.	**Criterion 4.5** Learners are able to access effective appeals and grievance processes.	Simplified wording.
Criterion 4.6 The program provider identifies and manages all actual, perceived and potential conflicts of interest proactively, consistently and fairly.	Removed, included in proposed Criterion 2.2	Alignment with other health profession accreditation standards. Managing conflict of interest is part of good governance. Evidence descriptor for Criterion 2.2 states that the governance structure should include mechanisms to identify and manage conflict of interest.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
		Reducing duplication.
Criterion 4.7 Learners are actively engaged with governance and program management structures and decision-making processes, through both formal and informal mechanisms.	Removed, included in proposed Criterion 3.3	Criterion 3.3 relates to input from relevant stakeholders, including students. The evidence descriptor states that students are considered to be a very important stakeholder group and should be included in formal governance structures and decision-making processes. Reducing duplication.
Domain 5 - Outcomes and assessment		
Criterion 5.1 The program has an assessment strategy that describes the purpose and range of assessments, aligns assessments to program learning outcomes, and ensures all performance outcomes are assessed in relevant prescribing contexts including WIL settings.	**Criterion 5.1** The program has a contemporary evidence-based assessment strategy.	Added the requirement for an 'assessment strategy' to ensure that assessment design and planning considers the overall program, as well as emerging assessment areas and challenges, such as AI. Alignment with other health profession accreditation standards. Simplified wording.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Criterion 5.2 A range of relevant, evidence-informed assessment methods including formative, summative, and workplace based are implemented progressively throughout the program to ensure that the overall assessment system is valid, reliable and provides progressive evidence of learner competence leading to demonstration of all performance outcomes.	**Criterion 5.2** Program assessments, including during Work Integrated Learning (WIL) are contemporary, evidence based and diverse.	Alignment with other health profession accreditation standards. Simplified wording.
Criterion 5.3 The program provider has effective policies and procedural controls in operation for external evaluation or moderation to assure integrity, reliability, fairness and transparency in the assessment of learners, and uses the feedback to develop the program.	**Criterion 5.3** All required professional competencies and program learning outcomes are assessed, aligned with the National Prescribing Competencies Framework.	Simplified wording.
Criterion 5.4 All assessments are undertaken fairly and according to clear criteria. The standard of performance expected of learners is explicit and clearly communicated to learners, staff and health professionals involved in the assessment.	**Criterion 5.4** The program has effective policies and procedural controls in operation for external moderation of assessments.	Simplified wording.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
Criterion 5.5 Staff and health professionals who assess learners in the academic and WIL environments are suitably qualified, experienced and prepared for the role, provided with appropriate guidance and support and are held accountable for their decisions to ensure that assessment is carried out fairly, impartially and consistently.	**Criterion 5.5** All assessments are fair, valid and reliable.	Simplified wording.
Criterion 5.6 Learners are provided with appropriate, timely and sufficient feedback to enable them to improve future performance.	**Criterion 5.6** Learners are provided with effective, appropriate and timely assessment feedback.	Simplified wording.
Criterion 5.7 Comprehensive assessment/s of prescribing performance is/are completed to provide evidence of the learner's ability to perform the entire prescribing process consistent with defined performance outcomes.	**Criterion 5.7** Program content and assessments ensure graduates are able to undertake comprehensive patient assessment and differential diagnosis in practice. **Criterion 5.8** Learners complete comprehensive assessments that ensure they are competent to undertake the full prescribing process.	Split Criterion into two, to reflect the differing prescribing competencies required. New numbering.

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
NEW | Domain 6 - Cultural Safety		
	Criterion 6.1 Program design, content, delivery and assessment specifically emphasise and promote Aboriginal and Torres Strait Islander cultures, cultural safety and improving health outcomes, and support the development of skills that enable the provision of culturally safe care.	n/a
	Criterion 6.2 Aboriginal and Torres Strait Islander Peoples have input into curriculum design and management.	n/a
	Criterion 6.3 Staff delivering the program have the knowledge, expertise and cultural capability to guide and support student learning about Aboriginal and Torres Strait Islander cultures, cultural safety and improved health outcomes.	n/a
	Criterion 6.4 The education provider promotes and supports the recruitment, admission, participation, retention and completion of the program by Aboriginal and Torres Strait Islander Peoples.	n/a

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Current Prescribing standards (2023)	Proposed Draft revised Standards	Reason for change
	Criterion 6.5 Staff and learners work and learn in a culturally safe environments that are free from racism.	n/a
	Criterion 6.6 Learners have authentic practice-based learning experiences that enable them to apply culturally safe care for Aboriginal and Torres Strait Islander Peoples.	n/a

Appendix D

Patient and consumer health and safety impact statement

April 2026

Statement purpose

This Health impact statement has been developed to accompany APC's preliminary consultation paper for the revised *Accreditation Standards for Pharmacist Prescriber Education Programs* and in accordance with Ahpra guidance. It's purpose is to assess the potential effects of the proposed changes on patient and consumer health and safety, particularly for vulnerable members of the community and Aboriginal and Torres Strait Islander Peoples.

The four key components considered in this Statement:

1. The potential impact of the proposed revised Standards on the health and safety of patients and consumers, particularly vulnerable members of the community, including approaches to mitigate any potential negative or unintended effects.
2. The potential impact of the proposed revised Standards on the health and safety of Aboriginal and Torres Strait Islander Peoples, including approaches to mitigate any potential negative or unintended effects.
3. Engagement with patients and consumers about the proposal, particularly vulnerable members of the community.
4. Engagement with Aboriginal and Torres Strait Islander Peoples about the proposal.

The Statement aligns with the *National Scheme's* *Aboriginal and Torres Strait Islander Cultural Health and Safety Strategy 2020–2025*, *National Scheme engagement strategy 2020–2025*, *National Scheme Strategy 2020–2025* and reflects key aspects of the revised consultation process in the Procedures for the development of registration standards, codes and guidelines and of accreditation standards.

Below is our initial assessment of the potential impact of the proposed revised Standards for Pharmacist Prescriber Education Programs (the Standards) on the health and safety of patients, and consumers, particularly vulnerable members of the community, and Aboriginal and Torres Strait Islander Peoples. This statement will be updated after consultation feedback.

1. How will this proposal affect patient, client and consumer health and safety, particularly vulnerable members of the community? Will the impact be different for vulnerable members compared to the general public?

The Standards support the paramount principle of protecting the public and maintaining public confidence in the safety of services provided by health practitioners by ensuring that learners from APC accredited pharmacist prescriber education programs are competent and qualified to prescribe medicines according to their scope of practice as authorised under State and Territory legislation.

The proposed revision of the Standards has the potential to positively impact patient, client, and consumer health and safety by supporting more consistent, high quality prescribing practices. Strengthened accreditation requirements may improve clinical decision-making, promote safe and appropriate use of medicines, and enhance continuity of care. The revised standards will ensure the high quality of training required for pharmacists to support the Pharmacy Board's work to progress an endorsement for pharmacist prescribing.

Appendix D

For the general public, the proposal will help improve access to quality health care services delivered by pharmacists for minor ailments and the management of chronic and ongoing conditions (in accordance with state and territory legislation relating to prescribing). This will benefit members of the public, including vulnerable members of the community, Aboriginal and Torres Strait Islander Peoples, and people living in remote and rural areas who do not always have access to a wide range of health professionals.

APC estimates that the proposed revised Standards will have minimal, if any, adverse impacts on the health and safety of patients, clients and consumers, particularly people vulnerable to harm within the community or Aboriginal and Torres Strait Islander Peoples. The Standards will promote the health and cultural safety of Aboriginal and Torres Strait Islander Peoples by building the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples. However, our engagement through the consultation process will help us to better understand possible outcomes and meet our responsibilities to protect patient safety and healthcare quality.

2. How will consultation engage with patients, clients and consumers, particularly vulnerable members of the community?

In line with Ahpra's consultation processes, a range of opportunities for stakeholders, patients and consumers, the public and the profession to provide input into the development of the revised Standards will be provided. The consultations will include a targeted preliminary phase with specific key stakeholders and a public phase which will be open for all to contribute by providing feedback, including the public.

APC will ensure that the consultation is wide-ranging to capture feedback on the proposed revised Standards from patients, clients and consumers, peak bodies, communities and other relevant organisations to gain input, including from people vulnerable to harm within the community.

Questions 5 – 7 in the preliminary consultation paper specifically ask whether the proposed changes will impact Aboriginal and Torres Strait Islander Peoples; patient, client and consumer health and safety; and particularly any impacts on people vulnerable to harm within the community. Responses will help us better understand possible outcomes and address them.

3. What might be the unintended impacts for patients, clients and consumers, particularly vulnerable members of the community? How will these be addressed?

APC has considered what the possible unintended impacts of the proposal might be. Consulting with relevant organisations and people vulnerable to harm within the community will help us to identify any other potential impacts. We will consider and take actions to address any potential negative effects for patients, clients and consumers that may be raised during consultation, particularly for people vulnerable to harm within the community.

4. How will this proposal affect Aboriginal and Torres Strait Islander Peoples? How will the impact be different for Aboriginal and Torres Strait Islander Peoples compared to non-Aboriginal and Torres Strait Islander Peoples?

APC has considered potential impacts of the proposal on Aboriginal and Torres Strait Islander Peoples. The proposed revised Standards are not expected to have a greater impact on Aboriginal and Torres Strait Islander Peoples. APC Accreditation Standards consider and explicitly refer to and support the development of culturally responsive program graduates. However, the consultation feedback will help us understand if there anything that may require addressing.

Appendix D

5. How will consultation about this proposal engage with Aboriginal and Torres Strait Islander Peoples?

APC has considered the Aboriginal and Torres Strait Islander Cultural Health and Safety Strategy 2020–2025, which focuses on achieving patient safety for Aboriginal and Torres Islander Peoples as the norm, and on the inextricably linked elements of clinical and cultural safety.

We have ensured that there is Aboriginal and Torres Strait Islander Peoples representation in the Governance Group for this project, as well as in our Accreditation Committee, to guide the project and the development of APC Accreditation Standards. In addition, APC is committed to engaging with our Indigenous Health Strategy Group (IHSG) to ensure we incorporate Indigenous ways of knowing, being and doing. This approach aligns with APC's values and strategic plan, the guiding principles of the National Scheme, and the Ahpra Indigenous Health Strategy.

As part of our consultation process, we will explore the best ways to continue to meaningfully engage with Aboriginal and Torres Strait Islander Peoples.

6. What might be the unintended impacts for Aboriginal and Torres Strait Islander Peoples? How will these be addressed?

APC has considered the unintended impacts for Aboriginal and Torres Strait Islander Peoples and do not believe that there will be any. However, continuing to engage with relevant organisations and Aboriginal and Torres Strait Islander Peoples will help us to identify any potential impacts that have not yet come to light. We will consider and take actions to address any potential negative impacts for Aboriginal and Torres Strait Islander Peoples that may be raised during consultation.

7. How will the impact of this proposal be actively monitored and evaluated?

APC and the Pharmacy Board have procedures for regularly reviewing standards, codes and guidelines. If approved, the proposed Standards will be reviewed at least every five years.

APC may review the Standards earlier, if required, in response to any issues that arise or new evidence that emerges to ensure the standards' continued relevance, workability and maintenance of public safety. In particular, it will review the standards earlier if unintended consequences arise for the health and safety of the public, vulnerable members of the community or Aboriginal and Torres Strait Islander Peoples.

Appendix E

Statement of assessment against Ahpra's Procedures for the development of accreditation standards

Preliminary consultation on the of the Accreditation Standards for Pharmacist Prescriber education

Introduction

Section 25 of the Health Practitioner Regulation National Law as in force in each state and territory (the National Law) requires the Australian Health Practitioner Regulation Agency (Ahpra) to establish procedures for the purpose of ensuring that the National Registration and Accreditation Scheme (the National Scheme) operates in accordance with good regulatory practice.

The Ahpra *Procedures for the development of accreditation standards* (2023) is available at on the Ahpra Resources webpage.

Under the National Law, proposed new or revised accreditation standards are submitted by the accreditation authority to the relevant National Board/s for approval.

Context

At the Health Ministers' Meeting held in June 2025, Ministers noted that the jurisdictional expansion of community pharmacist's scope of practice was at differing stages and approaches, and there were risks associated with states and territories progressing these trials independently. Following the outcomes of the meeting, the Pharmacy Board of Australia (the Board) began its work in September 2025 to progress an endorsement for scheduled medicines for pharmacists, with the intent to support a consistent, safe, and nationally coordinated approach to pharmacist prescribing.

To support this important initiative, the Australian Pharmacy Council (APC) is reviewing the Accreditation Standards for Pharmacist Prescriber programs as requested by Health Ministers through the Board.

APC's accreditation standards and processes are critical for ensuring pharmacists are equipped with the education and competencies required to safely and effectively prescribe medicines under evolving legislative frameworks. National consistency in pharmacist prescribing will be underpinned by our work.

Assessment

Below is the APC assessment of Accreditation Standards for Pharmacist Prescriber Education Programs (the Standards) taking account of the Ahpra procedures.

1. Describe how the proposal

1.1 takes into account the paramount principle, objectives and guiding principles in the National Law[1]

1.2 draws on available evidence, including regulatory approaches by health practitioner regulators in countries with comparable health systems

The APC proposal takes into account the National Scheme's paramount principle of protecting the public and maintaining public confidence in the safety of services provided by health practitioners by ensuring that graduates from APC accredited pharmacy prescriber education programs are competent and

[1] See section 3 and section 3A of the National Law

qualified to prescribe medicines according to their scope of practice as authorised under State and Territory medicines poisons legislation.

The proposal to review the Standards has considered and will ensure that the following National Law objectives are met:

- 2(b) to facilitate workforce mobility across Australia by reducing the administrative burden for health practitioners wishing to move between participating jurisdictions or to practise in more than one participating jurisdiction. While different jurisdictions will continue to have their own legislation and prescribing requirements, pharmacists will benefit from consistent training standards across all jurisdictions.

- 2(c) to facilitate the provision of high-quality education and training of health practitioners. Education providers are required to map course content to the revised Standards. The Proposed Standards are aligned with the National Prescribing Competency Framework (3rd Edition)[2] which describes the practice of safe and effective prescribing regardless of profession. In addition, the proposal has considered alignment with documents that are currently being finalised, which are Accreditation Standards for Pharmacy Programs and the Pharmacist Capability Framework, current contemporary workforce requirements, and emerging public health expectations.

- 2(ca) to build the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples. The Standards consider, explicitly refer to and support the development of culturally responsive graduates.

- 2(e) to facilitate access to services provided by health practitioners in accordance with the public interest. Successful roll out of the Urinary Tract Infection Pharmacy Pilot – Queensland (UTIPP-Q) saw 87% of 6531 women across Queensland with minor UTIs access pharmacy services and be successfully treated by pharmacists.[3] This paved the way for other pilots, such as the Queensland community pharmacy pilots with the primary aim to improve healthcare access and allow pharmacist prescribing by suitably trained practitioners for certain conditions in some jurisdictions.[4,5] Literature has also shown that pharmacist prescribing in other countries improves patient access to services, as well as clinical effectiveness, safety, and overall economic outcomes.

- 2(f) to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and to enable innovation in the education of, and service delivery by, health practitioners by ensuring the Standards reflect contemporary practice, support an adaptable workforce by considering emerging practice settings and technologies in the Standards, and considers the broader context of regulatory and educational developments across the National Scheme.

The review of the Standards supports the National Scheme to operate in a transparent, accountable, efficient, effective and fair way by ensuring standards are clearly articulated, regularly reviewed, and developed in partnership with stakeholders, including education providers, practitioners, and consumers.

The draft Standards are underpinned by an extensive Literature Review that has been undertaken by APC. The Literature Review consisted of three parts:

- Part A evaluated the available evidence published between 2023 and 2025 regarding pharmacist prescribing
- Part B examined the grey literature review specifically across identified prescribing accreditation standards in midwifery, nursing, optometry, pharmacy, physiotherapy, and podiatry
- Part C reviewed international accreditation standards for pharmacist prescribing programs.

[2] Department of Health, Disability and Ageing. National Prescribing Competencies Framework- Embedding quality use of medicines into practice (3rd edition). September 2025. [Internet] Accessed April 8, 2026.
[3] Nissen, Lisa, Lau, Esther, & Spinks, Jean. The management of urinary tract infections by community pharmacists: A state-wide trial: Urinary Tract Infection Pharmacy Pilot - Queensland (Outcome Report). [Internet]
[4] Queensland Government. MEDIA STATEMENT: Delivering Easier Access to Health Services at the pharmacy [Internet]. 2025
[5] Queensland Government. About the Pilot. [Internet]. 2025

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2. Outline steps that been taken to:

- achieve greater consistency within the National Scheme (for example, by adopting any available template, guidance or good practice approaches used by National Scheme bodies)
- meet the wide-ranging consultation requirements of the National Law

The review of the Standards has been informed by the Guidance on embedding good practice in health practitioner education: clinical placements, simulation-based learning and virtual care, Principles to strengthen the involvement of consumers in accreditation, Interprofessional Collaborative Practice Statement of Intent and Glossary of accreditation terms. Utilising these guidance documents ensures the Standards remain consistent with the National Scheme.

The National Law requires wide-ranging consultation on the proposed standards. The National Law also requires accreditation authorities to consult each other on matters of shared interest. APC develops and maintains accreditation standards in accordance with the Ahpra Procedures for the development of accreditation standards and the Principles to strengthen the involvement of consumers in accreditation. This ensures effective and broad stakeholder consultation via preliminary and public consultation phases, and accreditation standards that align with best practice and contemporary design. In line with the guidance, APC will provide a range of opportunities for stakeholders, including the public and the profession, to provide input into the development of the Standards.

Preliminary consultation is the first step in the consultation process and will be progressed with key stakeholders via one-on-one interviews, targeted stakeholder meetings, and email submissions.

The APC will ensure that there is the opportunity for broader public feedback via a six-week public consultation. This includes publishing a public consultation paper and relevant documents on the Consultation on Standards for Pharmacist Prescriber programs | Australian Pharmacy Council webpage and informing health practitioners and the community of the review via email, newsletters, social media posts and Media Releases.

The APC will consider all feedback received and prepare advice to the National Board to help inform the review of the Accreditation Standards for Pharmacist Prescriber Education Programs.

3. Address the following principles:

a. whether the proposal is the best option for achieving the proposal's stated purpose and protection of the public

The following options and rationale for consideration are as follows:

Option one – status quo. This option means that APC is to not take any action now and to keep the current existing Accreditation Standards for Pharmacist Prescriber Education Programs 2023.

Option two – revising and updating the Standards. Updating the Standards will ensure that they are contemporary.

The preferred option is option two. The expansion of pharmacist prescribing is occurring at different stages and approaches across jurisdictions, creating a risk of inconsistency in practice. Option two is to progress with the revision of the Standards now, as this will support a nationally consistent, safe and contemporary framework that reflects evolving scope of pharmacist prescribing. This option will also align with the Pharmacy Board's request for the revision and support their work in progressing a national endorsement for pharmacist prescribing to help achieve greater consistency across the jurisdictions.[6]

[6] Pharmacy Board of Australia. Development of a proposal for an endorsement for scheduled medicines for pharmacists [Internet].2025

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b. whether the proposal results in an unnecessary restriction of competition among health practitioners or education providers

The proposal is unlikely to restrict competition as it provides transparency and clarity in relation to education requirements to support any education provider to develop and seek accreditation to deliver a pharmacist prescriber program, increasing the opportunity for competition in the sector.

c. whether the proposal results in an unnecessary restriction of consumer choice

The proposal is unlikely to restrict consumer choice as it is not expected to reduce the number of accredited pharmacist prescriber education programs, the number of registered pharmacists or restrict their professional practice.

d. whether the overall costs of the proposal to members of the public and/or education providers and/or registrants and/or governments are reasonable in relation to the benefits to be achieved

The APC has considered the potential costs associated with the proposal during the development of this consultation paper.

APC does not consider this proposal will have a more than minor impact on education providers who currently deliver an accredited program who will be required to review their programs for alignment with the new Standards, as this work will be undertaken as part of their established quality improvement processes/cycles. However, this will be tested with education providers as part of a targeted consultation and feedback will be sought.

APC considers the overall costs for the development of the Standards to be reasonable and notes that the Board funding has been cross-subsidised by APC through the contribution of additional funds to reduce the overall costs to the National Scheme.

e. whether the proposal's requirements are clearly stated using 'plain language' to reduce uncertainty, enable the public to understand the requirements, and enable understanding and compliance by registrants, and

The APC is committed to using plain English and structuring the revised standards clearly to support understanding and implementation by education providers and learners. A plain language review will be undertaken prior to finalisation. The inclusion of consumer representation in the Governance Group for the revision of the Standards will provide us with valuable feedback into the readability of the document that will continue until the final version is delivered.

f. whether the Accreditation Authority/National Board has procedures in place to ensure that the proposed standard remains relevant and effective over time.

The Pharmacy Board of Australia has procedures in place to support a review of the Standards at least every five years as good regulatory practice.

However, the Board has asked APC to review the Accreditation Standards for Pharmacist Prescribing Education Programs earlier, in response to the outcomes from the Health Minister's meeting held in June 2025, that the jursidicational expansion of communicty pharmacsits practice is at varying stages and approaches. As a result, Pharmacy Board was requested to establish a proposal for an endorsement for pharmacist prescribing.

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4. Closing statement

APC will provide any further regulatory impacts identified during the consultation process and/or in developing the revised Standards (via an updated Statement of assessment against Ahpra's Procedures for the development of accreditation standards), to the Pharmacy Board of Australia to inform decision-making.

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