CALIFORNIA HIV / AIDS POLICY RESEARCH CENTERS

Policy Potential for Expanding Pharmacist-Initiated PrEP in California

Almost 5,000 people in California are newly diagnosed with HIV each year with a disproportionate burden of new infections among men who have sex with men and Black and Latine people.[1] Although HIV pre-exposure prophylaxis (PrEP) has been available in the U.S. since 2012, only 36% of people with indications for PrEP were prescribed it in 2022.[2] However, the PrEP landscape is undergoing a radical shift with the introduction of new long-acting injectable (LAI) PrEP medications to the market (Apretude in 2021 and Yeztugo in 2025).[3,4] Many current and potential PrEP users may prefer LAI PrEP to oral PrEP due to greater ease of adherence compared to daily pill use and LAI PrEP's demonstrated superiority to oral PrEP for HIV prevention.[5–8] Accordingly, LAI PrEP has been heralded as a potential "game changer" for the HIV epidemic if made broadly accessible.[9]

Regardless of formulation, PrEP uptake remains limited by inequities in healthcare access and other barriers such as low awareness, stigma, and medical mistrust.[10,11] Pharmacy-based PrEP delivery may reduce some obstacles to PrEP access by virtue of pharmacies' widespread locations, extended hours, and availability of a wide range of non-HIV-related health services.[12,13] Pharmacists are highly trained healthcare professionals, many of whom are in frequent contact with patients and already provide primary prevention services (e.g., vaccinations, contraception) within their communities.[13,14] Positioning pharmacies as status-neutral entry points for HIV services may reduce stigma-related barriers to uptake.[15] Multiple studies have documented strong support for and interest in pharmacist-initiated PrEP among both pharmacists and current or potential PrEP users.[16–18] To leverage this potential, California policymakers have sought to advance HIV prevention efforts by authorizing the expansion of PrEP services in pharmacies.

Summary of Findings

- Given California's recent policy efforts to enable and expand pharmacist-initiated PrEP and the introduction of long-acting injectable (LAI) PrEP medications, large-scale implementation research is important to assess whether state legislation has achieved its desired impact.
- In 2025, we generated the first statewide estimate of the availability of pharmacist-initiated oral and LAI PrEP services using a mystery client caller approach in a stratified random sample of California community pharmacies.
- Of 910 pharmacies surveyed, 31 (weighted prevalence: 2.4%) reported offering pharmacist-initiated PrEP services of which only 5 (weighted prevalence: 0.5%) offered LAI PrEP.
- Pharmacist-initiated PrEP implementation was low across all geographic subregions and was limited to a subset of Albertsons-owned chain pharmacies, small chain or franchise pharmacies, and independent pharmacies.
- Additional research is needed to inform policy or regulatory changes that could facilitate broader implementation and to identify strategies for targeted implementation in pharmacies that serve communities with the greatest unmet need for HIV prevention services.

California Policy: Senate Bill 159 & Senate Bill 339

With Senate Bill 159 (2019), California was the first state to pass legislation authorizing pharmacists to independently prescribe ("furnish") up to 60 days of oral PrEP medication.[19,20] However, relatively few pharmacies have adopted this service since implementation began in late 2020.[17,21–23]

In February 2024, Senate Bill 339 was signed into law to address several key barriers to PrEP delivery in pharmacies.[24,25] SB 339 expands pharmacist PrEP provision to include current and future formulations recommended by the CDC for HIV prevention and enables pharmacists to furnish up to 90 days of PrEP medication (and beyond under specified conditions). SB 339 strengthens requirements that public and private health plans cover the cost of PrEP services and any related testing delivered by pharmacists, addressing a critical implementation challenge identified in our 2022 study and others.[17,21,26] While these changes are promising, parity in payment for pharmacist services remains elusive, and little was known about whether SB 339 has amplified equitable access to PrEP since its enactment.

In light of California's evolving policy environment and the ongoing rollout of new LAI PrEP medications, large-scale implementation research in a broad sample of California pharmacies holds tremendous value for understanding the extent to which recent legislation has achieved its intended and potential impact and identifying the next steps to enhance LAI PrEP access through pharmacies, particularly among underserved communities. California's experiences also have broader national relevance: since the passage of SB 159, many other states have passed legislation expanding pharmacists' role in PrEP provision.[27] Thus, in 2025, we conducted the first statewide representative cross-sectional survey to evaluate the availability of pharmacist-initiated oral and LAI PrEP services in community pharmacies.

California Community Pharmacies

We identified 5,149 community (retail) pharmacies in California using publicly available pharmacy licensing data.[28,i] Nine in ten (92%) were in metropolitan core areas.[29] A majority (69%) were in one of the eight California counties prioritized for HIV prevention efforts by the Ending the HIV Epidemic in the U.S. (EHE) initiative,[30] with 31% in Los Angeles County alone (**Figure 1**). Half were owned by large corporate chains with more than 50 pharmacy locations in California, most commonly CVS (21%), Walgreens (10%), or Albertsons (7%; including Safeway, Vons, Pavilions).

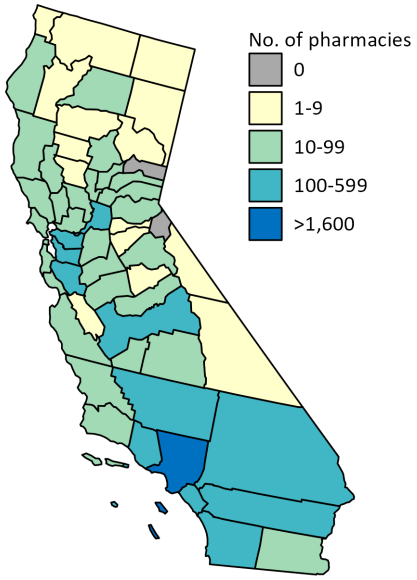


Figure 1. Geographic distribution of community pharmacies by county.

Survey Findings

We randomly sampled 1,100 pharmacies, stratifying sampling by census region,[31] urbanicity,[29] and pharmacy chain category.[ii] From July to November 2025, trained research assistants called these pharmacies to assess the availability of

[i] We restricted the data to active retail pharmacy licenses and excluded Rite Aid pharmacies (due to widespread closures expected during the study) and pharmacies that served a limited patient population or only provided specialty services.

[ii] We oversampled pharmacies outside of metropolitan centers to ensure broad geographic representation and undersampled large chain pharmacies with little or no evidence of implementation at the chain level, with the exception of Albertsons which was known to have implemented in some locations.[22,32]

pharmacist-initiated PrEP services ("Hi, I was wondering if I can get PrEP drugs for HIV prevention from your pharmacy without a prescription from a doctor?"), following a mystery client approach adapted from other U.S. pharmacy studies.[21,22,33–37] Overall, 910 eligible pharmacies were surveyed and retained in analyses (**Table 1**).[iii] Estimates of the proportion of pharmacies that provided PrEP services (prevalence) were weighted to be representative of community pharmacies statewide.

Table 1. Characteristics of California community pharmacies surveyed about the availability of pharmacist-initiated PrEP services, July–November 2025.

	Unweighted n (%)	Weighted %
All pharmacies	910 (100.0)	100.0
Ending the HIV Epidemic in the U.S. (EHE) initiative priority jurisdiction*		
EHE county	488 (53.6)	68.2
Non-EHE county	422 (46.4)	31.8
Rural-Urban Commuting Area (RUCA) category**		
Metropolitan core (primary code: 1)	653 (71.8)	92.2
Metropolitan high/low commuting (primary codes: 2–3)	92 (10.1)	2.7
Micropolitan and rural (primary codes: 4–10)	165 (18.1)	5.2
Census region		
1 - Superior California	98 (10.8)	7.8
2 - North Coast	56 (6.2)	2.3
3 - San Francisco Bay Area	71 (7.8)	12.9
4 - Northern San Joaquin Valley	68 (7.5)	3.8
5 - Central Coast	71 (7.8)	5.7
6 - Southern San Joaquin Valley	99 (10.9)	6.0
7 - Inland Empire	99 (10.9)	11.3
8 - Los Angeles County	206 (22.6)	31.4
9 - Orange County	76 (8.4)	10.9
10 - San Diego - Imperial	66 (7.3)	7.9
Pharmacy chain category		
Albertsons	110 (12.1)	7.1
CVS	30 (3.3)	20.8
Walgreens	29 (3.2)	9.9
Walmart	30 (3.3)	5.3
Other large chains (>50 locations)	30 (3.3)	5.2
Small chains or franchises (4–50 locations)	85 (9.3)	6.2
Independent or unclassified small chains (<4 locations)	596 (65.5)	45.4

*Indicator of whether pharmacy located in one of eight California counties prioritized for HIV prevention efforts by the EHE initiative: Alameda, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, and San Francisco.[30]

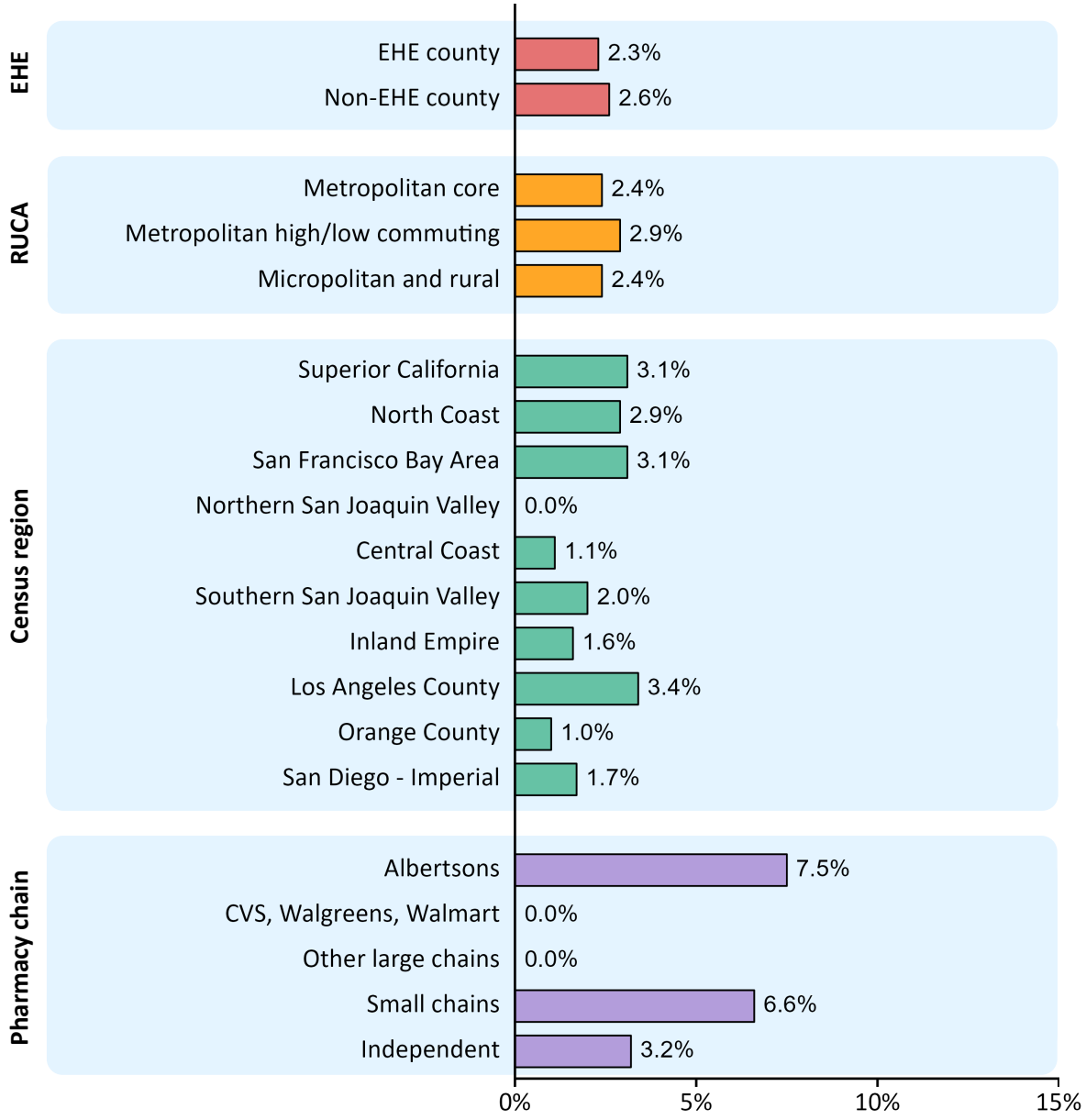
**Classified based on pharmacy ZIP code using 2020 USDA RUCA primary codes.[29]

[iii] The remaining pharmacies were identified as ineligible (n=156 ineligible pharmacy type, n=8 no working phone number, n=8 permanently closed, n=3 not yet open to the public, n=1 duplicate) or could not be reached after three phone calls (n=14).

Of 910 pharmacies, 31 (weighted prevalence: 2.4%) reported offering pharmacist-initiated PrEP services. These services were largely limited to oral PrEP; only 5 pharmacies (weighted prevalence: 0.5%) reported offering both oral and LAI PrEP.

Across all census regions and rural-urban and EHE county classifications, less than 4% of pharmacies reported providing pharmacist-initiated PrEP services (**Figure 2**). A subset of Albertsons-owned chain pharmacies had implemented PrEP services (n=11; weighted prevalence among Albertsons: 7.5%). Other implementing pharmacies were independently owned (n=17; weighted prevalence: 3.2%) or associated with small chains or franchises (n=3; weighted prevalence: 6.6%).

Figure 2. Prevalence of pharmacist-initiated PrEP services in California community pharmacies stratified by pharmacy characteristics.



EHE: Ending the HIV Epidemic in the U.S. initiative; RUCA: Rural-Urban Commuting Area. All percentages weighted to account for the sampling scheme.

Discussion

We evaluated the implementation of pharmacist-initiated PrEP services in California pharmacies in 2025, five years after implementation began under SB 159 and more than one year after SB 339 was enacted to address key implementation barriers. We estimated that fewer than 3% of community pharmacies statewide offered these services. Implementation was low across all geographic regions, including counties prioritized for the scale up of HIV prevention services due to a greater burden of HIV incidence.

To our knowledge, this study provides the first representative statewide estimate of pharmacy-level implementation. In an online survey conducted in 2022, we found that one in ten (11%) California pharmacists and pharmacy students reported working in a pharmacy that offered pharmacist-initiated PrEP under SB 159.[17] However, that survey relied on a non-representative convenience sample of individuals recruited through professional organizations and, with its opt-in design, likely overestimated the availability of these services at the pharmacy level. To more robustly assess SB 159 implementation, several other studies have surveyed pharmacies using a mystery client approach, reporting regional implementation estimates ranging from 1.7% (in Los Angeles County community pharmacies in 2023)[23] to 7.9% (in San Francisco Bay Area independent community pharmacies in 2024).[21,22] The present study builds on these methods to produce an estimate using a representative statewide sample (2.4%) that falls within the range of prior regional estimates.

This study is also the first to assess the implementation of LAI PrEP in pharmacies, finding that less than 1% of community pharmacies offered this service in 2025. Notably, pharmacists are already key providers of other injectables (including more than half of COVID-19 vaccines in the U.S.[14]), and half of pharmacists in our 2022 survey reported being *willing* to provide LAI PrEP under enabling conditions,[26] underscoring the potential for pharmacist-initiated LAI PrEP to address gaps in HIV prevention. Efforts to realize this potential are especially pressing in 2026 as the first twice-yearly subcutaneous LAI PrEP medication (Yeztugo) continues its national rollout.

Our findings suggest that the expansion of pharmacists' scope of practice under SB 159 and SB 339 has yet to deliver on the vision of pharmacies as broadly accessible sources of PrEP services. Although legislation requires many public and commercial health plans to reimburse PrEP-related pharmacist services, there is little evidence that payment for services has been operationalized in practice, and anecdotal reports from pharmacist stakeholders indicate that reimbursement challenges remain a major barrier. Pharmacies face high upfront medication costs, declining reimbursement rates, and complicated or inadequate systems to bill for services.[21,26,38] The U.S. Centers for Medicare and Medicaid Services has yet to universally recognize pharmacists as independent healthcare providers, limiting reimbursement opportunities for clinical services beyond dispensing and immunizations under many health plans.

Low public awareness of and demand for pharmacist-initiated PrEP services is also an important barrier. The financial sustainability of pharmacy-based service provision depends on sufficient consumer demand, which may necessitate strategic implementation in pharmacies serving a high volume of potential PrEP users and/or investment in demand creation efforts. These financial realities are compounded by other logistical constraints (e.g., limited distribution of LAI PrEP medications via specialty pharmacies) that make PrEP stocking and provision infeasible for many pharmacies.

Adding to this complexity, California policy has continued to evolve since SB 339. In October 2025, Governor Newsom signed legislation that shifted pharmacist practice to a standard of care model (Assembly Bill 1503)[39] and increased regulation of pharmacy benefit managers (PBMs; SB 41).[40] At the same time, he vetoed legislation that would have required commercial health plans to cover all forms of FDA-approved PrEP medication without cost sharing, prior authorization, or step therapy and enabled pharmacists to bill a commercial plan or health insurer's outpatient prescription drug (pharmacy)

benefit for LAI PrEP (AB 554).[41] The implications of these changes for pharmacy practice are yet to be seen. A robust understanding of the state and national policy landscape and other systemic factors that underlie low implementation (including the interplay between pharmaceutical companies, PBMs, and health plans that drives medication cost, reimbursement, and payment for services) is needed to generate effective policy solutions that enable broader implementation.

Given the low level of implementation observed in the present study, universal implementation of pharmacist-initiated PrEP services is unlikely to be a realistic goal. Instead, targeted implementation may represent a more efficient pathway to impact by prioritizing and funding pharmacies that serve populations with the greatest unmet need for HIV prevention services. Preliminary evidence suggests that pharmacist-initiated PrEP may increase uptake overall yet risks perpetuating persistent racial and ethnic disparities in access if implemented without a clear focus on equity.[42–44] To reduce inequities in who benefits from pharmacist-initiated PrEP, key next steps include identifying high-priority pharmacy implementation sites and developing culturally responsive implementation models that center the needs and preferences of communities who are underserved by existing PrEP delivery channels.

In summary, community pharmacies and pharmacists remain underutilized to advance HIV prevention goals despite the increasingly favorable policy environment in California (and beyond), willingness of pharmacists and consumers to provide and receive pharmacist-initiated PrEP, and availability of more diverse PrEP formulations. Additional research is needed to identify policy or regulatory changes that could overcome existing barriers to facilitate broader implementation. Strategies should be developed and tested for targeted implementation in pharmacies that serve communities with unmet PrEP needs.

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