

	has diabetes, unless OD notifies the physician treating the patient's diabetes in writing of any changes in the patient's glaucoma. The physician shall provide written confirmation of these notifications.		
	Prohibits treatment of glaucoma caused by diabetic complication if consulting Eye M.D. or physician determine that a referral is required.	NV;TX	2
Age Limitations	Prohibits treatment of infantile or congenital glaucoma	FL;NE;RI;VA	4
	Requires referral to Eye M.D. or other physician if faced with pediatric glaucoma	CT	1
	Prohibits treatment of glaucoma in persons under 18 years.	CA; NH	2
	Prohibits treatment of glaucoma in persons under 16 years.	NV;TX;VT	3
Secondary	Requires OD to refer patient to an Eye M.D. if requested by the patient, if indications of secondary glaucoma develop.	CA	1
	Requires referral to Eye M.D. or other physician in case of secondary glaucoma	CT	1
	Requires referral within 30 days to Eye M.D. physician in case of secondary glaucoma.	NH	1
Co-management Period	Prohibits independent glaucoma treatment, unless OD co-manages 50 glaucoma patients for a period of 2 years for each patient. Afterwards, OD must be certified by board to treat open angle glaucoma. The original patients may treated independently after OD has received certified by the board, with written consent of the patient.	CA	1
	Prohibits independent glaucoma treatment, unless OD co-manages 20 cases over a 2 year period; recent grads may be exempted.	KS	1
	Prohibits independent glaucoma treatment, unless OD provides evidence of 20 glaucoma referrals to MDs and 30 glaucoma consultations with MD. New graduates may be exempted.	ME	1
	Prohibits glaucoma treatment, unless OD comanages 25 glaucoma patients, including up to 5 established patients, during a period of not less than 18 months for each patient. New graduates; DVA, DOD, and NIHS ODs credtialed to treat glaucoma for 12 months; ODs from another state credtialed to treat glaucoma treatment for 12 moths; ODs who have completed a 12 month OD residency program – may be exempted.	NH	1
	For the purposes of comangement, a Joint	NH	1

	pharmaceutical formulary and credentialing committee of 3 ODs and 3 Eye MDs must meet quarterly to review glaucoma reporting forms and develop prescription drug protocols; develop a reporting form and patient consent form; determine which combination medication shall be considered one medication for glaucoma treatment; and determine which optometrists have successfully completed the comanagement training regimen. A glaucoma credentialing reporting form must be submitted to the committee upon 18 months of treatment for each patient during the comanagement period..		
	Prohibits glaucoma treatment unless OD consults on 15 patients with Eye M.D. for at least 1 year.	NV	1
	Prohibits independent glaucoma and ocular hypertension treatment, unless OD co-manages 75 cases or co-manages for three years; recent grads may be exempted.	NY	1
	Prohibits independent glaucoma treatment, unless OD co-manages 20 cases for at least a 1 year period or until the patients have stabilized whichever is longer; new grads may be exempted.	RI	1
Initial Consultation	Prohibits treatment until OD makes a provisional diagnosis of glaucoma and the OD and the patient identifies a collaborating Eye MD during co-management period.	CA	1
	Prohibits treatment until OD makes a provisional diagnosis of glaucoma during comanagement period.	NH	1
	Prohibits treatment until OD makes a provisional diagnosis of glaucoma during 2 year post-comanagement period.	NH	1
	Prohibits treatment until OD transmits relevant documentation from the provisional examination along with the treatment plan to the collaborating Eye MD during co-management period.	CA	1
	Prohibits treatment until OD transmits relevant information from the provisional examination and history of the patient along with the treatment plan to the collaborating Eye MD during co-management period.	CA	1
	Prohibits glaucoma treatment w/o prior consultation with physician.	DC;OR	2
	Prohibits glaucoma treatment unless OD consults with Eye M.D. w/i 72 hours of	ND	1

	initiating treatment.		
	Prohibits glaucoma treatment, w/o written consultation with MD when diagnosis made; during co-management period.	NY	1
Confirmation of Diagnosis	Prohibits treatment unless Eye MD confirms the diagnosis during co-management period. Eye MD shall refute or confirm the diagnosis w/l 30 days by performing a physical examination of the patient.	CA	1
	Prohibits glaucoma treatment, unless Eye M.D. confirms diagnosis during co-management period.	KS;ME;NH;NV;RI;NY	6
	Prohibits glaucoma treatment, without confirmation of diagnosis by Eye M.D.	MD;TX	2
	Prohibits glaucoma treatment, unless Eye M.D. confirms diagnosis w/l 30 days of initial diagnosis for a period of 24 months after the end of the comanagement period.	NH	1
Treatment Plan	Prohibits treatment, unless OD develops treatment plan which considers target intraocular pressures, optic nerve appearance, visual field testing, and an initial proposal for therapy.	CA	1
	Prohibits treatment unless Eye MD approves the treatment plan in writing during co-management period.	CA	1
	Prohibits glaucoma treatment, unless consultation with Eye M.D. to develop written treatment plan during co-management period.	KS;ME;NY;RI	4
	Prohibits glaucoma treatment, unless OD jointly and promptly develops written treatment plan with Eye M.D. and can only be changed by joint agreement of OD and Eye M.D.	MD	1
	Prohibits glaucoma treatment unless OD and Eye M.D. develop treatment plan in accordance with the currently accepted standard of care.	ND	1
	Prohibits treatment unless ophthalmologist reviews proposed OD treatment plan during comanagement period.	NH	1
	Prohibits glaucoma treatment unless Eye MD, OD and patient mutually agree to and document a treatment plan during comanagement period.	NH	1
	Prohibits glaucoma treatment, unless Eye M.D. reviews treatment for a period of 24 months after the end of the comanagement period.	NH	1

	Prohibits glaucoma treatment, unless consultation with Eye M.D. w/i 30 days of diagnosis to develop treatment plan.	TX	1
Target Pressure	Requires referral to Eye M.D. or other physician if interocular pressure exceeds 35	CT	1
	Requires referral to Eye M.D. if target pressure is not met in 60 days.	SC	1
	Requires consultation with Eye M.D. if target pressure in treatment plan is not reached.	MD	1
	Requires referral to Eye M.D. if not progress achieved in realizing the selected pressure range considered unlikely to cause further optic nerve damage or result in further visual field loss.	ND	1
	Requires optometrist to consult with the co-managing ophthalmologist if target pressure is not reached within 90 days and the patient is experiencing optic nerve damage and visual field loss or the patient develops angle-closure or other secondary glaucoma.		
	Requires consultation and/or referral to Eye M.D. if patient does not respond to target pressure which is 80% of initial intraocular pressure.	TX	1
Review of Patient's Progress	Requires OD to notify Eye MD in writing if there is any change in medication used to treat the patient during co-management period.	CA	1
	Requires OD to annually provide a written report to Eye MD about the achievement of goals contained in the treatment plan during co-management period. The Eye MD shall acknowledge receipt of the report in writing w/10 days.	CA	1
	Permits the Eye MD to periodically examine the patient at his or her discretion during co-management period.	CA	1
	Prohibits glaucoma treatment w/o periodic review of the patient's progress by Eye M.D.	TX	1
	Prohibits glaucoma treatment, unless Eye M.D. examines the patient once a year.	MD	1
	Requires referral to Eye M.D. or other physician if no substantial improvement in condition.	CT	1
	Requires consultation with Eye M.D. if there is worsening in a patient's visual field or optic nerve head.	MD	1
	Requires consultation within 30 days with Eye M.D. if there is worsening in a patient's visual field or optic nerve head upon maximum tolerated therapy.	NH	1

	Requires consultation with Eye M.D. if patient does not have expected response to treatment.	MD;ND	2
	Requires tests or photos to be provided to Eye M.D. for his or her review	MD	1
Notice to Patient	Requires OD, during co-management period, to provide the following information to the patient in writing: nature of the working suspected diagnosis, consultation evaluation by Eye MD, treatment plan goals, expected follow-up care, and a description of the referral requirements. The document shall be dated by both the OD and Eye MD and maintained in their files.	CA	1
	Requires OD to inform patient of seriousness of glaucoma.	FL	1
	Require patient to agree to treatment plan with the Eye MD and the OD during the comanagement period.	NH	1
	Requires OD to inform patient that disease will be confirmed and co-managed by Eye M.D. and must post notice in office; recent grads may be exempted	NY	1
	Requires OD to inform patient that disease will be confirmed and co-managed by Eye M.D.	TX	1
	Requires ODs to describe OD and ophthalmology education and state that they will refer to an ophthalmologist when collaboration is not enough and must be signed by patient.	VT	1
Education	Prohibits glaucoma treatment, unless OD completes 24 hour course in treatment and co-management of open angle glaucoma; new grads may be exempted.	CA	1
	Prohibits orals unless OD completes 44 hours of continuing education in glaucoma and use of oral drugs	IA	1
	Prohibits glaucoma treatment, unless OD completes 24 hour course in treatment and co-management of open angle glaucoma	KS	1
	Prohibits glaucoma treatment, unless OD completes 24 hour course in treatment of ; glaucoma; new grads may be exempted. Six hours of continuing education in glaucoma annually to be sunsetted after 10 years.	MO	1
	Prohibits glaucoma treatment unless OD completes additional education requirements determined by the board; new grads exempted, but may be waived for those graduating after 2002.	NE	1

	Prohibits glaucoma treatment unless OD completes 40 hours of classroom education approved by interdisciplinary committee, but may be waived for those graduating after 2002..	NH	1
	Prohibits glaucoma treatment unless OD passes exam based on classroom glaucoma education approved by interdisciplinary committee.	NH	1
	Prohibits glaucoma treatment unless OD completes a minimum of 10 hours in glaucoma specific education of continuing education. 7 & hours must be by participation in formal courses and 3 hours may be by independent study	NH	1
	Prohibits glaucoma treatment, unless OD completes 100 hours of clinical training; recent grads and ODs independently treating for five years in another state exempted.	NY	1
	Prohibits glaucoma treatment, unless OD complete 18 hours of continuing education in glaucoma.	PA	1
	Prohibits glaucoma treatment, unless OD completes 4 hours of continuing education upon license renewal.	PA	1
	Prohibits glaucoma treatment, unless OD completes 24 hour course in use of therapeutics, including 14 hours on glaucoma.	RI	1
Oversight	Corroborating proof of completion of co-management requirement shall be supplied by Eye MD. before OD can be certified to treat open angle glaucoma independently by OD board.	CA	1
	Requires interprofessional committee to review evidence of glaucoma consultations	ME	1
	Requires interprofessional committee to set clinical training and education requirements for treatment of glaucoma and must be approved by Medical Board	TX	1

Prohibitions on the Use of Controlled Substances¹

Index	Provision	State	No.
General Provisions	Prohibits General Anesthesia	CT, OR	2
	Prohibits oral sedative-hypnotics	WY	1
	Prohibits Conscious sedation	OR	1
	Prohibits Deep Sedation	OR	1
Schedule I	Prohibits all Schedule I Controlled	AK;AL;AR;AZ;CA;CO;CT;DE;FL;GA;HW	40

	Substance	;IL;IN;KY;LA;MA;MD;MI;ME;MN;MS; ND;NE;NH;NJ;NM;NV;NY;OK;PA;PR;RI; SC;TX;UT;VA;UT;WA;WV;WY	
	Prohibits Schedule I oral analgesics	MO	1
	Prohibits Schedule I controlled substances unless oral analgesic	DC;IA;KS;	3
	Prohibits Schedule I controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
Schedule II	Prohibits all Schedule II Controlled Substances	AK;AL;AR;AZ;CA;CO;DE;FL;GA;HW;IN; KY;LA;MA;MD;ME;MI;MN;MS;ND;NE; NH;NJ;NV;NM;NY;OK;PA;PR;RI;SC;TX; UT;VA;VT;WA;WV;WY	38
	Prohibits Schedule II Oral Analgesics	MO	1
	Prohibits Schedule II controlled substances unless oral analgesic	DC;IA;KS;	3
	Prohibits Schedule II Controlled Substances, unless limited to 72 hour supply.	CT	1
	Prohibits Schedule II controlled substances unless non-narcotic oral analgesic	IL	1
	Prohibits Schedule II controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
Schedule III	Prohibits Schedule III Controlled Substances	AK;DE;FL;HW;IN;MA;MD;MN;MS;ND;N Y;PR;RI;	12
	Prohibits Schedule III pharmaceutical agents that are not narcotic analgesics or that do not contain Dihydrocodeinone, ("Hydrocodone") for more than 96 hours.	AL	1
	Prohibits Schedule III controlled substances, unless oral analgesic	AZ;DC;IA;KS;NE;NM;SD	7
	Prohibits Schedule III Controlled Substances except those used for ocular pain and inflammation.	CO	1
	Prohibits Schedule III Controlled Substances, unless limited to 72 hour supply.	CT;KY;UT	3
	Prohibits Schedule III controlled Substances except oral analgesics; narcotic oral analgesic limited to 72 hours.	WV	1
	Prohibits Schedule III narcotic Controlled Substances	DE;	1
	Prohibits Schedule III controlled substances, unless oral analgesics but requires consultation with physician after 72 hours	GA	1
	Prohibits Schedule III controlled substances, unless non-narcotic analgesic	IL	1
	Prohibits Schedule III Controlled substances	LA	1

	for more than 48 hours and one additional 48 hour prescription is warranted by a follow-up		
	Prohibits Schedule III oral analgesics, unless OD consults w/ or refers to Eye M.D. after 48 hours	MO	1
	Prohibits Schedule III controlled substances except acetaminophen with thirty milligrams of codeine	ND	1
	Prohibits Schedule III controlled substances, unless oral analgesic but excludes treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris. Specific analgesics must be approved by interprofessional committee.	NH	1
	Prohibits Schedule III controlled substances except Tylenol with codeine	VT	1
	Prohibits Schedule III controlled substances, except analgesics with hydrocodone with compounds or codeine with compounds if OD limits dose to 3 days with referral to Eye M.D. if pain persists.	CA	1
	Prohibits Schedule III controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
	Prohibits Schedule III controlled substances. except analgesics with hydrocodone with compounds, codeine with compounds or propoxyphene with compounds if OD limits dose to 72 hours with no refill.	NV	1
	Prohibits Schedule III analgesics for more than 7 days without consultation from a physician.	OR	1
	Prohibits Schedule III analgesics for more than 7 days for a single trauma, episode, or incident without consultation from a physician.	WA	1
	Prohibits Schedule III controlled substances, except for seven day supply of oral analgesic.	SC	1
	Prohibits Schedule III controlled substances, except for one three-day supply of an analgesic.	ME;TX	2
	Prohibits Schedule III Controlled Substances, except oral analgesics	VA	1
Schedule IV	Prohibits Schedule IV Controlled Substances	AK;AZ;DE;FL;HW;IN;MA;MD;NY;PR;R!	11
	Prohibits Schedule IV Controlled Substances that are not narcotic analgesics.	AL	1
	Prohibits Schedule IV Controlled Substances except those used for ocular pain an	CO	1

	inflammation.		
	Prohibits Schedule IV Controlled Substances, unless limited to 72 hour supply.	CT;KY	2
	Prohibits Schedule IV Controlled Substances except oral analgesics; narcotic oral analgesic limited to 72 hours.	WV	1
	Prohibits Schedule IV narcotic Controlled Substances	DE;	1
	Prohibits Schedule IV controlled substances for more than 48 hours and one additional 48 hour prescription is warranted by a follow-up	LA	1
	Prohibits Schedule IV controlled substances, unless oral analgesics but requires consultation with physician after 72 hours	GA	1
	Prohibits Schedule IV oral analgesics, unless OD consults w/ or refers to Eye M.D. after 48 hours	MO	1
	Prohibits Schedule IV controlled substances, except for oral analgesic.	DC;IA;KS;MS;NM;NE;	6
	Prohibits Schedule IV controlled substances, unless non-narcotic analgesic	IL	1
	Prohibits Schedule IV controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
	Prohibits Schedule IV controlled substances, unless oral analgesic but excludes treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris. Specific analgesics must be approved by interprofessional committee.	NH	1
	Prohibits Schedule IV controlled substances, except analgesics with hydrocodone with compounds or codeine with compounds if OD limits dose to 3 days with referral to Eye MD is pain persists.	CA	1
	Prohibits Schedule IV controlled substances, except analgesics with hydrocodone with compounds, codeine with compounds or propoxyphene with compounds if OD limits dose to 72 hours with no refill.	NV	1
	Prohibits Schedule IV controlled substances, except for seven day supply of oral analgesic.	SC	1
	Prohibits Schedule IV controlled substances, except for one three-day supply of an analgesic.	ME;TX	2
	Prohibits Schedule IV Controlled Substances, except oral analgesics	VA	1
	Prohibits Schedule IV analgesics for more	WA	1

	than 7 days for a single trauma, episode, or incident without consultation from a physician.		
Schedule V	Prohibits Schedule V Controlled Substances	AK;AZ;DE;FL;GA;HW;IL;IN;MA;MD;NE;NH;NY;PR;RI;	15
	Prohibits Schedule V Controlled Substances that are not narcotic analgesics.	AL	1
	Prohibits Schedule V Controlled Substances except those used for ocular pain and inflammation.	CO	1
	Prohibits Schedule V Controlled Substances, unless limited to 72 hour supply.	CT;KY	2
	Prohibits Schedule V Controlled substances for more than 48 hours and one additional 48 hour prescription is warranted by a follow-up	LA	1
	Prohibits Schedule V oral analgesics, unless OD consults w/ or refers to Eye M.D. after 48 hours	MO	1
	Prohibits Schedule V controlled substances that are not oral analgesics codeine, propoxyphene, hydrocodone, and dihydrocodeine, alone or in combination with nonscheduled or nonregulated drugs	MT	1
	Prohibits Schedule V Controlled substances except oral analgesics; narcotic oral analgesic limited to 72 hours.	WV	1
	Prohibits Schedule V controlled substances, except for oral analgesic.	DC;IA;KS;MS;NM;	5
	Prohibits Schedule V controlled substances, except analgesics with hydrocodone with compounds or codeine with compounds if OD limits dose to 3 days with referral to Eye MD is pain persists.	CA	1
	Prohibits Schedule V controlled substances, except analgesics with hydrocodone with compounds, codeine with compounds or propoxyphene with compounds if OD limits dose to 72 hours with no refill.	NV	1
	Prohibits Schedule V controlled substances, except for seven day supply of oral analgesic.	SC	1
	Prohibits Schedule V controlled substances, except for one three-day supply of an analgesic.	ME;TX	2
	Prohibits Schedule V Controlled Substances, except oral analgesics	VA	1
	Prohibits Schedule V analgesics for more than 7 days for a single trauma, episode, or incident without consultation from a physician.	WA	1

1. Generally, there are no topical controlled substances. Topical cocaine is an exception that is uncommonly used by ophthalmologists and usually in connection with surgery involving the nose.

I. Prohibitions and Limitations on the Use of Topical and Oral Steroids, Immunosuppressives, Antimetabolites, and Anti-Inflammatories (See also Ocular Inflammations)

Topical and Oral Steroids	Prohibits Topical and Oral Steroids	PA;PR	2
Topical Steroids	Prohibits topical steroids for the treatment of ocular allergies, unless OD consults with Eye MD if patient's condition worsens 72 hours after diagnosis.	CA	1
	Prohibits topical steroids for the treatment of ocular allergies, unless OD consults with Eye M.D. if the inflammation is still present three weeks after diagnosis.	CA	1
	Prohibits topical steroids for the treatment of ocular allergies for more than six weeks after diagnosis after which OD must refer to Eye MD	CA	1
	Prohibits topical steroids for the treatment of ocular allergies for more than six weeks after diagnosis after which OD must refer to Eye MD	CA	1
	Prohibits topical steroids for the treatment of ocular allergies if condition recurs after six months after which OD must refer to Eye MD	CA	1
	Prohibits topical steroids for the treatment of unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis, unless OD consults with an Eye MD if the patient's condition worsens 72 hours after the diagnosis.	CA	1
	Prohibits topical steroids for the treatment of unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis, unless OD consults with an Eye MD if the patient's condition has not resolved within three weeks of diagnosis.	CA	1
	Prohibits topical steroids for the treatment of unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis if the patient is still receiving medication for the condition six weeks after diagnosis, after which a referral	CA	1
	Under no circumstances can OD treat	CA	1

	peripheral corneal inflammatory keratitis if it is Moorens or Terriens diseases.		
	Prohibits topical steroids for the treatment of peripheral corneal inflammatory keratitis, unless OD consults with an Eye MD if the condition worsens 48 hours after diagnosis.	CA	1
	Prohibits topical steroids for the treatment of peripheral corneal inflammatory keratitis if patient is still receiving medication two weeks after diagnosis, after which OD must refer patient to Eye MD.	CA	1
	Prohibits topical steroids for the treatment of traumatic iritis if condition worsens 72 hours after diagnosis, unless OD consults with Eye MD	CA	1
	Prohibits topical steroids for the treatment of traumatic iritis if patient condition has not resolved one week after diagnosis, after which OD must refer patient to Eye MD.	CA	1
	Prohibits Topical Steroids, if OD does not consult physician after 5 days; this requirement must be posted in OD's office.	NY	1
	Prohibits topical steroids, unless a collaborative practice protocol is established by the optometry board in consultation with an MD subject to the approval of the State Board of Physicians	MD	1
	Prohibits Topical Steroids, unless OD consults with Eye M.D. after 14 days and refers after 21 days	RI	1
	Prohibits Topical Steroids, unless OD consults with Eye M.D. during first 10 days and refers after 21 days	SC	1
	Prohibits Topical Steroids, unless OD refers to Eye M.D if patient has not improved in 10 days and must consult with ophthalmologist before prescribing.	NH	1
Oral Steroids	Prohibits Oral Steroids	AK;AZ;CA;DC;DE;FL;GA;IL;IN;LA;MA;ME;MD;MI;MN;MS;ND;NE;NH;NM;NV;NY;PR;RI;PA;SC;TX;WA;WY	29
	Prohibits oral steroids, unless consultation with Eye M.D.	KS	1
	Prohibits oral steroids, if used for more than 14 days.	IA	1
	Prohibits oral steroids for more than 7 days without consultation from a physician.	OR	1
	Prohibits oral steroids, if used for more than 6 days.	WV	1
	Prohibits oral steroids beyond 14 days if patient's primary care physician is not notified.	VT	1

	Prohibits oral steroids without consultation with a physician.	SD	1
Immunosuppressives	Prohibits Oral Immunosuppressives	AK;AZ;FL;GA;IL;LA;MA;MD;MS;NE;NM;NY;PR;RI;VT;WA;WY	17
Anti-Metabolites	Prohibits Antimetabolites	AK;AZ;CA;DC;FL;GA;IL;LA;KS;MA;MD;ME;MS;ND;NE;NH;NM;NV;NY;PR;RI;SC;VT;WA;WY	25
	Prohibits Oral Methotexrate	IA	1
	Prohibits Imuran	IA	1
	Prohibits antineoplastics	OR	1
Nonsteroidal Anti-inflammatory	Prohibits nonprescription nonsteroidal anti-inflammatory agents, if dose exceeds maximum dose for prescription counterpart.	AZ	1
	Prohibits prescription nonsteroidal anti-inflammatory agents	AZ	1
	Prohibits prescription nonsteroidal anti-inflammatory agents for more than 3 days, after which if not resolved must refer to Eye MD	CA	1
	Prohibits prescription nonsteroidal anti-inflammatory agents, unless approved by interprofessional committee (10 have been approved)	NH	1
	Prohibits more than one seven-day supply of oral nonsteroidal anti-inflammatories	ME;TX	2
	Prohibits oral nonsteroidal anti-inflammatory agents	AK;CO;FI;DE;GA;IL;LA;MA;MD;NY;PR;RI	12

VII. Additional Prohibitions on the Use of Topical Therapeutic Pharmaceutical Agents

Index	Provision	State	No.
Topicals Generally	Prohibits all topical drugs	PR	1
	Prohibits topicals on Children less than 1 YR	CA;MD	2
	Prohibits the dispensing of more than 72 hour supply of topical drug	MD	1
Miotics	Prohibits Miotics for treatment purposes other than emergency relief of eyeball pressure buildup.	SC	1
Anti-Biotics (See Also Ocular Infections)	Prohibits specifically formulated or fortified ocular antibiotics	MD	1
	Prohibits use of topical antibiotics, sulfonamides which are topically administered, excluding treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris, approved by interprofessional committee	NH	1
Antivirals	Prohibits use of topical antivirals for more than 3 weeks.	CA	1

	Prohibits topical antivirals unless an optometrist informs the patient that if the condition does not improve in 5 days, a physician will be notified. Also requires optometrist to post office sign.	NY	1
	Prohibits Topical Steroids, unless OD refers to Eye M.D if patient has not improved in 10 days.	NH	1
	Prohibits topical antivirals unless an optometrist consults with an Eye M.D. after more than 14 days of treatment.	OR	1
Antifungals	Prohibits antifungals	CA;MD	2
Anti-parasitics	Prohibits antiparasitics	MD	1
Referral	Requires OD to communicate with patient to determine response of topical ocular agent as soon as practicable after 72 hours from the time the agent was administered or prescribed. If patient has not responded, OD must consult with Eye M.D.	MD	1
Adverse reactions	ODs and MDs must report adverse topical drug reactions with a report on adverse drug reactions filed with the legislature annually. Requires emergency plan for management and referral for adverse drug reactions	MN	1
	Pharmacy board must file complaints on administration of topicals to OD Board	MN	1
Education	Prohibits topicals, unless OD completes 60 classroom hours in ocular and clinical pharmacology, therapeutics, and anterior segment disease and 60 hours of clinical training.	CO	1
	Prohibits topicals, unless OD completes 6 month internship, 24 hours continuing education every 2 years (12 in pharmacology).	DE	1
	Prohibits topicals, unless OD completes 110 hour transcript quality course work and clinical training in general and ocular pharmacology and one year in supervised diagnosis of eye disease or disorders.	FL	1
	Prohibits topicals, unless OD competes 20 hours of continuing education biennially	IA	1
	Prohibits topicals, unless OD completes 1 year of clinical training in diagnosis of eye disease	FL	1
	Prohibits topicals, unless OD completes 90 hours didactic and 30 supervised clinical education in therapeutics.	MA	1
	Prohibits topical, unless OD completes 60 hours in general and ocular pharmacology; 100 hours in treatment of eye condition with	MN	1

	topical drugs, 2 year of supervised clinical experience in diagnosis of eye disease or disorder or 1 year experience and 10 year actual clinical experience as licensed OD.		
	Prohibits topicals, unless OD completes 100 classroom course, including 60 hours clinical training in eye disease management.	NE	1
	Prohibits topicals, unless OD completes 100 classroom-clinical course hours in ocular and general pharmacology	NM	1
	Prohibits topicals unless 300 hours of clinical training in ocular disease other than glaucoma and ocular hypertension. Recent grads exempted.	NY	1
	Prohibits topicals, unless OD completes 72 hours of clinical therapeutic training in the direct therapeutic management of ocular disease in an internship with Eye M.D. The ratio of Eye M.D. to optometrists in the clinical training shall not exceed 1:4. The training shall include 50 eyelid, 50 conjunctiva, and 50 cornea disease cases. Prohibits glaucoma and anterior uveitis, unless OD completes 24 more hours of classroom study for amplified privileges to treat glaucoma and anterior uveitis	RI	1
	Prohibits topicals, unless OD completes 150 hours of classroom education and 40 hours of clinical training, and 5 hours of continuing education annually in ocular pharmaceuticals	SD	1
	Prohibits topicals, unless OD completes 75 hours of didactic and clinical instruction in general and ocular pharmacology.	WA	1

VIII. Additional Prohibitions on the Use of Oral Therapeutic Drugs

Index	Provision	State	No.
Orals Generally	Prohibits All Orals	AK;FL;MA;NY;PR;RI;	6
	Prohibits All oral drugs except tetracyline	MD	1
	Prohibits All oral drugs, except specified oral analgesics	GA;	1
	Prohibits All oral drugs, except over the counter agents and nonnarcotic analgesics	IL	1
	Prohibits orals drugs, unless OD communicate with the patient's primary care provider, or with a physician skilled in eye disease, when it is medically appropriate, as determined by the OD	VT	1
Age Limitations	Prohibits oral drugs to persons less than six years of age	KS	1
	Prohibits oral drugs to persons less than one	CA;MD	2

	year of age.		
	Prohibits oral drugs to persons less than twelve years of age.	SD	1
Oversight	Prohibits orals not specified in statute or not approved by interprofessional committee and approved by medical board	TX	1
	Requires consultation with a treating Eye M.D. for 90 days following surgery if an oral drug is used by the optometrist.	WA	1
Antibiotics (See also Ocular Infections)	Prohibits Oral Antibiotics	AK;FL;GA;IL;MA;NY; PR;RI	8
	Prohibits Oral Antibiotics to Persons under 6	AZ	1
	Prohibits use of antibiotics except tetracycline and derivatives cephalosporins, penicillin and derivatives, and erythron. cin. azithromycin, and clarithromycin, but limited to 72 hours for other than blepharitis and 10 days for blepharitis. If no improvement is shown in condition the OD must consult with PCP for referral to specialist is required	AZ	1
	If after the normal treatment period the condition is not resolved, the optometrist shall request that the primary care or family physician refer the patient to a specialist.	AZ	1
	Prohibits use of oral antibiotics except tetracyclines, dicloxacillin, amoxicillin, amoxicillin with clavulanate, erythromycin, clarythromycin, cephalexin, cephadroxil, cefaclor, trimethoprim with sulfamethoxazole, ciprofloxacin, azithromycin. Azithromycin shall be limited to the treatment of eyelid infections and chlamydial disease manifesting in the eyes	CA	1
	Prohibits Central Corneal Ulcer when the condition has not improved w/i 24 hour of diagnosis, unless OD consults with Eye MD.	CA	1
	Prohibits Central Corneal Ulcer when condition has not improved w/i 48 hours of diagnosis, after which OD shall refer patient to Eye MD.	CA	1
	Prohibits Central Corneal Ulcer if patient is still receiving antibiotics 10 days after diagnosis after which OD shall refer patient to Eye MD.	CA	1
	Prohibits treatment of corneal peripheral inflammatory keratitis if recurring within one year of initial occurrence, unless OD consults with Eye M.D.	CA	1
	Prohibits treatment of preseptal cellulitis if	CA	1

	the condition has not improved after 72 hours, after which OD must refer to Eye MD		
	Prohibits treatment of dacryocystitis if the condition has not improved after 72 hours, after which OD must refer to Eye MD	CA	1
	Prohibits treatment of preseptal cellulitis if the patient is still receiving oral antibiotics after 10 days, after which OD must refer to Eye MD	CA	1
	Prohibits treatment of dacryocystitis if the patient is still receiving oral antibiotics after 10 days, after which OD must refer to Eye MD	CA	1
	Prohibits Blepharitis if the condition has not improved w/i six weeks after which OD must consult with Eye MD.	CA	1
	Prohibits use of prescription oral drugs except for tetracycline and its derivatives for treatment of meibomitis and seborrheic blepharitis.	MD	1
	Prohibits more than one 10-days supply of oral antibiotics	ME	1
	Prohibits use of oral antibiotics, sulfonamides which are orally administered, excluding treatment of lacrimal drainage system, lacrimal gland, or structures posterior to the iris, approved by interprofessional committee	NH	1
	Prohibits more than one 10-day supply of oral antibiotics	TX	1
Antivirals	Prohibits Antivirals	AK;AZ;DC;DE;FL;GA;IL;LA;MA;MD;NV; NY;PR;RI;WV	13
	Prohibits oral Acyclovir for treatment of conditions other than herpes simplex viral keratitis, herpes simplex viral conjunctivitis, periocular herpes simplex viral dermatitis, varicella zoster viral keratitis, varicella zoster viral conjunctivitis, periocular varicella zoster viral dermatitis.	CA	1
	Prohibits oral acyclovir for the treatment of herpes simplex keratitis or varicella zoster viral keratitis if condition has not improved 7 days after diagnosis, after which OD must refer patient to Eye MD	CA	1
	Prohibits oral acyclovir for the treatment of herpes simplex keratitis or varicella zoster viral keratitis if condition has not resolved 3 weeks after diagnosis, after OD must refer patient to Eye MD	CA	1
	Prohibits oral acyclovir for the treatment of herpes simplex viral conjunctivitis, herpes	CA	1

	simplex viral dermatitis, varicella zoster viral conjunctivitis, varicella zoster viral dermatitis, if condition has worsened after 7 days after diagnosis, OD must consult with Eye MD.		
	Prohibits oral acyclovir for the treatment of herpes simplex viral conjunctivitis, herpes simplex viral dermatitis, varicella zoster viral conjunctivitis, varicella zoster viral dermatitis, if condition has not after 3 weeks of diagnosis, after which OD must refer to Eye MD.	CA	1
	Prohibits more than one 10 day supply of oral antivirals	MN	1
	Prohibits more than one 10 day supply of oral antivirals with referral to a physician.	ME	1
	Prohibits acyclovir, valacyclovir, or famciclovir, unless the OD consults a physician.	OH	1
	Prohibits anti-virals. except for acyclovir, valacyclovir, or famciclovir.	NH;VT, PA	3
Antifungals	Prohibits Antifungals	AK;AZ;CA;CO;DC;DE;FL;GA;IL;KS;LA;MA;MD;MS;NH;NM;NV;NY;PR;RI;VT;WV;WY	22
Antiparasitics	Prohibits Antiparasitics	AK;CA;DE;FL;GA;HW;IL;MA;MD;MN;NY;PR;RI;VT	14
Anti-histamines	Prohibits Antihistamines	AK;FL;GA;HW;IL;MA;MD;NY;PR;RI;	10
	Prohibits antihistamines, except for 7 day supply of cetirizine, loratadine, fexofenadine, but requires OD to get referral from MD.	AZ	1
	Prohibits oral antihistamines after two weeks, after which OD must refer to Eye MD.	CA	1
	Prohibits more than one 72-hour supply of oral antihistamines	ME;TX	2
	Prohibits oral decongestants	AK;CA;FL;GA;HW;IL;MA;MD;NY;PR;RI;SD;	12
	Prohibits oral mast-cell stabilizers	AK;CA;FL;GA;HW;IL;MA;MD;NY;PR;RI;SD; WV	13
Education	Prohibits any orals, unless OD completes education requirements specified by the board.	AZ;WV	2
	Prohibits orals unless OD completes 44 hours of continuing education in glaucoma and use of oral drugs	IA	1
	Prohibits orals, unless OD completes 15 hour course in the use of orals; recent grads exempted.	KS	1
	For persons without a therapeutic license, prohibits advance therapeutics unless OD completes 100 hour course is ocular	ME	1

	therapeutics, including at least 25 hours of supervised clinical training and another 25 hours devoted primarily to pharmacology and glaucoma. For person with a therapeutic license, prohibits advance therapeutics unless OD completes 25 hours course devoted primarily to pharmacology and glaucoma and 3 didactic hours on antiglaucoma agents.		
	Prohibits orals, unless OD completes 10 hours of TPA in orals every two years	NJ	1
	Prohibits orals, unless OD completes 20 course in clinical pharmacology, including systemic pharmacology.	NM	1
	Requires interprofessional committee to set clinical training and education requirements for use of oral and must be approved by Medical Board	TX	1
	Requires completion of instructional clinical review course before orals	TX	1
	Prohibits oral drugs unless OD completes 16 hours of didactic and 8 hours of supervised clinical education that is certified by an institution of higher learning.	WA	1

IX. Specific Limitations on the Ordering of Tests

Index	Provision	State	No.
X-Rays	Prohibits X-Rays	AK;CT	2
Cultures	Prohibits ordering of tests, except for a conjunctival culture.	MD	1
CLIA	Prohibits ordering or performing of tests, if tests are not CLIA-waived clinical tests	AZ	1
	Authorizes commissioner of health to regulate laboratory practice of ODs to ensure that they are in full compliance w/CLIA.	TN	1
Costs	Requires ODs to disclose laboratory costs	LA	1
Topicals	Prohibits ordering of tests not related to the use of topical pharmaceutical agents	HW	1

X. Specific Limitations on Superficial Foreign Body Removal

Index	Provision	State	No.
Depth	Prohibits superficial foreign body removal below the Bowman's Layer;	CT;HW;TX;WI	4
	Prohibits superficial foreign body removal below anterior stroma	CA	1
	Prohibits perforating superficial corneal foreign body removal	CA	1
	Prohibits superficial foreign body if foreign body has penetrated the globe	FL	1
	Prohibits superficial foreign body removal	UT	1

	deeper than the anterior one-half of cornea		
	Prohibits foreign body removal from within the tissue of the eye	NY	1
	Prohibits superficial foreign body removal below the conjunctiva	WI	1
Visual Axis	Prohibits the use of sharp instruments if superficial foreign body is w/i central 3mm of cornea	CA	1
	Prohibits superficial foreign body removal w/i 2.5mm of visual axis.	MD	1
	Prohibits superficial foreign body removal w/i 3mm of visual axis, if body has penetrated deeper than the corneal epithileum	NH	1
Instruments	Prohibits superficial foreign body removal unless removed with cotton-tipped applicator or blunt spatula.	MD	1
	Prohibits superficial foreign body removal requiring surgical repair upon removal.	CA	1
Referral	Requires OD to refer to Eye M.D. to remove foreign bodies that are not superficial ocular or ocular adnexal foreign bodies.	SC	1

XI. Prohibitions on the Use of Injections

Index	Provision	State	No.
Types of Injections	Prohibits all Injectable Drugs	AK;CO;DE;FL;GA;HW;IL;KS;MA;MI;MS;MO;NC;NE;NM;NV;NY;OH;PA;PR;RI;SC;WV;WY	24
	Prohibits Intravenous Drugs	AZ;CT;MA;ME;MN;NH;SC	7
	Prohibits Injections into the Eyeball	AL	1
	Prohibits use of needles	TX	1
	Prohibits Botox Injections	OR;VT	2
	Prohibits Intramuscular injections	MA;MN;ME	2
	Prohibits Intraocular injections	OR;VT	2
	Prohibits Subdermal injection	MA;ME	2
	Prohibits Retrobulbar injections	OR;MA;ME;VT	4
	Prohibits Subcutaneous injections	MA;VT	1
	Prohibits Subtenon injections	OR;VT	2
	Prohibits Ketamine (IM) for an infant's examination under anesthesia	VT	1
	Prohibits Infusions	WA	1
Specific Conditions	Prohibits the removal of benign skin lesions involving subcutaneous injections	VT	1
	Prohibits the management of skin and conjunctival neoplasms	VT	1
Anaphylactic Shock	Prohibits Subcutaneous injections, except for an injection to counter anaphylactic shock	ME	1
	Prohibits injectable drugs, except for epinephrine auto-injectors to counter	AZ	1

	anaphylactic shock and must maintain supportive equipment and supplies, including oxygen equipment, airway maintenance equipment or other necessary equipment.		
	Prohibits injectable drugs, except for a automatic injectors	CA	1
	Prohibits injectable drugs, except for a automatic injectors and epi-pens followed by immediate referral to the nearest emergency facility	MS	1
	Prohibits injectable drugs, except for a automatic epinephrine injectors	LA	1
	Prohibits Injectable Drugs except for an injection to counter anaphylactic shock	AR;CT;DC;IA;KY;MN;NH;NJ	8
	Prohibits Injectable Drugs except for an epinephrine injection to counter anaphylactic shock	MD;VA;WA	3
	Prohibits Injectable Drugs except for an injection to counter anaphylactic shock and then must refer immediately to physician.	TX	1
	Prohibits Injectable Drugs except for an injection to counter anaphylactic shock, unless board approves individual ODs.	TN	1
	Prohibits Injectable drugs except for injections appropriate for the emergency stabilization of a patient.	VT	1
Diagnostic Agents	Prohibits Invasive diagnostic agents	HW	1
	Prohibits Indocyanine green angiography	VT	1
Education	Requires interprofessional committee to set clinical training and education requirements for use of parenteral drugs and must be approved by Medical Board	TX	1
	Prohibits injections for anaphylaxis unless OD gets an extra 4 hours of didactic and clinical education.	WA	1

XII. Prohibitions on Surgery

Index	Provision	State	No.
Surgery Generally	Prohibits Surgery	AK;AZ:CA;CO;CT;DC;DE;FL;GA;HW;IA;IL;IN;KS;KY;LA;MD;MN;MI;MO;MS;MT;NC;NE;NH;NJ;NM;NV;NY;OH;PA;PR;RI;SD;TX;UT;VA;VT;WA;WV;WI;WY	42
	Prohibits Invasive Surgery or Procedures	AK;AZ;AL;CO;CT;FL;HW;ID;MA;MI;ME;MS;ND;NY;OH;RI;VA	17
	Prohibits Surgery using anything other than topical anesthetic (but also prohibits lasers, cataract surgery, and RK)..	AR;TN	2
	Prohibits procedures that require presence or	SC	1

	assistance of a nurse anesthetist or anesthesiologist (but also prohibits lasers, and instruments requiring closure))		
Instruments	Prohibits Lasers	AL;AR;AZ;CA;CO;CT;DC;DE;FL;GA;HW;IA;ID;IN;KS;KY;LA;MD;ME;MI;MN;MO;MS;MT;ND;NH;NY;OH;OR;PA;SC;NE;TN;TX;UT;VT;WA;WY	39
	Prohibits Use of Cryoprobe	AZ;LA	2
	Prohibits X-rays	AK;CT	2
	Prohibits Use of Ionizing Radiation	AZ;CA;LA;MI;NH;NY;OH;TX;UT	10
	Prohibits Use of Scalpel	AZ;LA;TX	3
	Prohibits Use of Needles	TX	1
	Prohibits Use of therapeutic ultrasound	CA;MI;NH;NY;OH;VT;WA	7
	Prohibits Use of Electrical Cautery	AZ;LA	2
	Prohibits Thermal or Electrical Cautery, except when performing electrolysis.	VT	1
	Prohibits use of mechanical means to cut, alter, infiltrate... tissue	CA;HW;NH;LA;NY;OH;TX;VT;WA	9
	Prohibits penetration by manual operation into the intraocular tissues or spaces for healing diseases, deformations, or injuries.	WY	1
Punctal Plugs	Prohibits use punctal occlusion, by laser, cautery, diathermy, cryotherapy, or other means constituting surgery.	CA	1
Irrigation	Prohibits lacrimal irrigation and dilation below age 12	CA	1
	Prohibits lacrimal irrigation and dilation, unless OD Board certifies an OD to perform procedure after completing 10 procedures under supervision of Eye MD	CA	1
	Prohibits nasal lacrimal irrigation	CA	1
Procedures	Prohibits Refractive Surgery	HW;ID;WA	3
	Prohibits photorefractive keratectomy	ID	1
	Prohibits LASIK	OK	1
	Prohibits Radial Keratotomy	AL;AR;DC;MD;TN	5
	Prohibits Cryosurgery	AL;MD;DC	3
	Prohibits procedures using instruments that require closure by suturing, clamping or other device	SC;TX	2
	Prohibits Cosmetic Surgery	WA	1
	Prohibits Cosmetic Lid Surgery with Laser	OK	1
	Prohibits eyelid procedures, except epilation of eyelash with forceps	MD	1
	Prohibits procedures that require an incision	MI	1
	Prohibits Muscle Surgery	AL	1
	Prohibits Extraocular Muscle Surgery	CT	1
	Prohibits Cataract Surgery	AL;AR;DC;TN	4
	Prohibits Retinal Surgery	AL	1
	Prohibits Retinal Surgery with Laser	OK	1
	Prohibits Surgical Treatment of Glaucoma	CT	1

	Prohibits Cutting or Opening of the Globe	CT	1
	Prohibits Enucleation of the Eye	CT	1
	Prohibits removal of interocular foreign bodies	OH	1
	Prohibits surgery to treat eye disease	WA	1
Board Powers	Prohibits Board from issuing rules pertaining to use of cosmetic or therapeutic lasers.	CO	1

XIII. Additional Requirements for Education Related to Prescribing Therapeutic Drugs and License Renewal

Index	Provision	State	No.
Therapeutics Generally	Prohibits therapeutic drugs, unless OD completes 20-25 hours of continuing education half of which must relate to eye disease management.	AL	1
	Prohibits therapeutic drugs, unless OD completes internship under supervision of Eye M.D., including 100 hours of clinical training in examination, diagnosis, and treatment.	AR	1
	Prohibits advanced therapeutics, unless OD completes 75 classroom and 51 clinical hours in the study of advanced Optometric care.	CT	1
	Prohibits therapeutics, unless OD completes 55 classroom hours, including 15 hours in general pharmacology, 20 hours in ocular pharmacology, 20 hours of clinical laboratory.	DC	1
	Prohibits therapeutics, unless OD attains 40 hours of clinical experience with OD, MD, or DO. New OD must complete six month internship with OD, MD, DC.	DE	1
	Prohibits topicals, unless OD completes 100 hour course, 100 hour preceptorship with Eye M.D., 36 hours of continuing education biennially on ocular and systemic diseases	HW	1
	Prohibits therapeutics, unless OD completes 100 hours of education: 40 didactic and 60 clinical.	IA	1
	Prohibits therapeutics, unless OD completes 20 hours of continuing education in ocular pharmacology; new grads may be exempted.	IN	1
	Prohibits therapeutics, unless OD completes 6 hour course in general and ocular pharmacology and 2 hours of continuing education in ocular therapy annually..	KY	1
	Prohibits therapeutics unless OD completes 110 hour TPA course; recent grads exempted	MD	1
	Prohibits therapeutics, unless OD completes	MO	1

	course in general and ocular pharmacology, including 100 hours of clinical training supervised and approved by Eye M.D.		
	Prohibits therapeutics unless OD completes educational requirements established by optometry board.	NC	1
	Prohibits therapeutics, unless OD completes 76 hours of didactic education and 24 hours of clinical education on ocular disease management.	ND	1
	Prohibits therapeutics, unless OD completes 250 hours on continuing education every three years, at least 60 hours shall be in courses approved and supervised by the board.	NH	1
	Prohibits therapeutics, unless OD completes 30 hours of general pharmacology, pharmacokinetics, special populations, prescription writing, appropriate and ethical uses of off-label medications; adverse drug reactions, systemic side effects and medication errors, addiction recognition, CPR, record-keeping.	NJ	
	Prohibits therapeutics, unless OD completes 46 hours of didactic education and 34 hours of supervised clinical education, including courses in glaucoma in postoperative care.	LA	1
	For persons without a therapeutic license, prohibits advance therapeutics unless OD completes 100 hour course in ocular therapeutics, including at least 25 hours of supervised clinical training and another 25 hours devoted primarily to pharmacology and glaucoma. For person with a therapeutic license, prohibits advance therapeutics unless OD completes 25 hours course devoted primarily to pharmacology and glaucoma and 3 didactic hours on antiglaucoma agents.	ME	1
	Prohibits therapeutics, unless OD completes 100 hour course in diagnosis and treatment of the human eye and adnexa in a program supervised by a board certified ophthalmologist.	MO	1
	Prohibits therapeutics, unless OD completes 64 hours of didactic education and 80 hours of clinical training with the advice of the State Medical Board and Pharmacy Board on treatment of eye conditions	MS	1
	Prohibits therapeutics, unless OD completes 100 hour course in prescription and administration of therapeutics	PA	1
	Prohibits therapeutics unless OD completes	TN	1

	150 hours classroom hours and 40 hours of clinical experience relative to diagnosis and treatment of ocular disease.		
	Prohibits therapeutics unless OD completes 10 hours of continuing education annually.	TN	1
	Prohibits therapeutics w/o didactic and clinical training approved by board.	VA	1
	Prohibits therapeutics w/o less than 50 percent of his or her continuing ed in the use of pharmaceuticals, including complication arising from their use, and the treatment of glaucoma.	VT	1
	Prohibits therapeutics w/o CPR certification as a condition of initial certification of license renewal.	VT	1
	Prohibits therapeutics and superficial foreign body removal w/o 100 hours study in therapeutic drugs and the removal of foreign bodies.	WI	1
License Renewal	Prohibits OD license renewal without 48 hours of continuing education	AK	1
	Prohibits OD license renewal without continuing education in pharmaceuticals as determined by the board	AZ	1
	Prohibits OD TPA license renewal without 50 hours of continuing education every two years in order to renew his or her certificate. 12 hours on glaucoma; 10 hours on ocular infections; five hours on inflammation and topical steroids; six hours on systemic medication and two hours on the use of pain medications.	CA	1
	Prohibits OD license renewal, unless OD completes 12 hours of continuing education every 2 years.	DE	1
	Prohibits OD license renewal, unless OD completes 30 hour course, including 6 hours in pharmacology and ocular disease, every two years.	FL	1
	Prohibits license renewal, unless OD completes continuing education requirements specified by the board.	HW;OR;WY	3
	Prohibits OD license renewal, unless OD completes 2 day course annually.	IA	1
	Prohibits OD license renewal, unless OD completes 30 hours of continuing education	IN	1
	Prohibits OD license renewal without 8 hours of continuing education annually.	KY	1
	Prohibits license renewal without 24 hours of continuing education with five hours on pharmacology, therapeutics annually.	KS	1
	Prohibits license renewal, unless OD	MA	1

	completes 18 hours of continuing education annually		
	Prohibits license renewal without 50 hours of continuing education, 30 hours of which are in therapeutics for TPA certified ODs every 2 years	MD	1
	Prohibits license renewal without 8 hours of continuing education annually	MO	
	Prohibits license renewal for therapeutic practitioners, unless OD completes 25 hours of continuing education including 15 hours in ocular disease	ME	1
	Prohibits license renewal, unless OD completes 50 hours of continuing education every 2 years, at least 30 devoted to TPA and 10 of those hours devoted to orals.	NJ	1
	Prohibits license renewal, unless OD completes two days of continuing education annually, including six credit hours in ocular therapeutic pharmacological agents.	NM	1
	Prohibits license renewal, unless OD takes up to 25 hours of continuing education annually.	NC;NH	2
	Prohibits license renewal without reasonable amount of continuing education per three year period as determined by the board.	ND	1
	Prohibits license renewal for therapeutic practitioners, unless OD completes 36 hours of continuing education every three years in ocular disease and pharmacology	NY	1
	Prohibits license renewal, unless OD biennially completes 30 hour course, 6 on therapeutics. No credit for courses in office management or practice building.	PA	1
	Prohibits license renewal without an annual continuing education course.	RI	1
	Prohibits license renewal for therapeutic practitioners, unless OD completes 20 hours of continuing education including 8 hours in pharmacology.	SC	1
	Prohibits license renewal w/o 45 hours of continuing education every 3 years	SD	1
	Prohibits license renewal w/o 30 hours of continuing education every 2 years	UT	1
	Prohibits license renewal w/o 16 hours of continuing education	LA	1
	Prohibits license renewal w/o 16 hours of continuing education	VA	2
	Prohibits license renewal w/o 20 hours of continuing education	VT	1



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SPECIALIZING IN

Cataract Surgery and
Laser Vision Correction

April 11, 2007

Honorable Representative Kurt Olson
House Labor and Commerce Committee

Re: Committee Substitute for HB 113

Dear Representative Olson,

As a Physician and Surgeon who began medical service in rural Alaska in 1983, I am writing in support of your Committee Substitute for HB 113 that will expand optometrists' use of oral and injectable medications.

I believe I am uniquely qualified to comment on this legislation because of my long term relationship with rural Alaskan medical practice, my prior experience in academic medicine and my close association with optometric physicians in a consultative role. From 1983 through 1986, I served as a general medical officer with the US Public Health Service in Bethel, Alaska. There, prior to my training as a surgeon, I assisted optometric physicians with therapeutics prescribing issues prior to the advent of any optometric therapeutics privileges in the state of Alaska. Then, as now, I was impressed with the educational level, skill and competence of my optometric colleagues. The advent of optometric topical medical therapeutics privileges in Alaska, as in other Northwestern states in which I practice, has been a tremendous benefit to patients not only in rural areas but in our larger cities as well.

From 1995 to 1999, after completing my residency in ophthalmology and a fellowship in cornea and external disease, I taught as Assistant Professor of Ophthalmology at Johns Hopkins University. Because I was involved in the daily clinical teaching of the resident surgeons in our training program, I have a broad perspective on the range of skills demonstrated by clinicians from a wide range of educational backgrounds. Optometric Physicians have already demonstrated the ability to responsibly prescribe and administer medical therapy, to recognize diseases and complications for which additional consultation is required, and to seek that consultation where appropriate.

Optometrists serve as primary eye care providers for a large number of patients in Alaska and, as such, they serve as the front line in this effort. This is especially true in rural Alaska where transportation issues are even more difficult than in nearly every other state. In view of these issues, the addition of oral and injectable medications to their armamentarium is very appropriate and would improve the delivery of effective eye care to all Alaskans.

Some who oppose this legislation may claim that since optometrists have not had training as medical or osteopathic doctors they are somehow less qualified or deficient in the necessary training to prescribe oral medicines or administer injectable medications for ocular disorders. Such a claim is simply not supported by the

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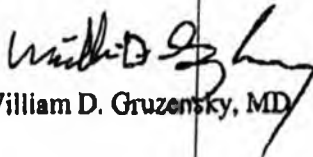
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evidence. Every day we expect nurse practitioners, physician's assistants, and even paramedics to administer medications within the scope of the diseases that they treat. Likewise we expect them to refer patients beyond the scope of their skills to qualified physicians and surgeons. In my many years of experience acting as a consultant for Optometric Physicians, I know that I can expect the same from each of them.

Because I have worked in more than one state, I have experience working with optometrists who have oral and injectable medication privileges. I have yet to see a complication from the prescription of an oral medication by an optometrist that I could attribute to an inappropriate use of these privileges.

Optometric Physicians are an important resource for the delivery of eye care in Alaska and their efforts would be made much more efficient by enabling them to deliver this care at their maximum potential. Towards this goal, I support the effort to expand optometrist's use of oral and injectable medications.

With kindest regards,


William D. Gruzensky, MD

Sponsor Statement for House Bill 113

“An Act relating to the prescription and use of pharmaceutical agents, including controlled substances, by optometrists.”

House Bill 113 would allow optometrists to prescribe systemic (oral) medications to treat a patient's eyes or for an allergic shock reaction. Currently Alaskan optometrists are limited to prescribing only topical medications, while optometrists in 45 states, the District of Columbia and Guam are able to prescribe systemic (oral) medications.

The course of study that optometrists undergo is comparable or exceeds that required of their peers in the health care professions who are already granted the ability to prescribe medications. Optometry programs include several semesters of pharmacology, in addition to studies in human anatomy, physiology and biochemistry. Optometrists, like dentists and podiatrists, attend four years of graduate school after receiving their undergraduate degree, while nurse practitioners and physician assistants only complete two years of graduate school. Yet of these professions, only optometrists are limited to prescribing topical agents.

Regulations are already in place to ensure that only qualified optometrists may prescribe systemic medications. Optometrists must pass an exam, such as the “Treatment and Management of Ocular Disease” from the National Board of Examiners in Optometry, and must show that they have completed the necessary continuing education in pharmacology each year in order to prescribe any medications authorized under statute.

Increasing optometrists' prescribing authority will be of benefit to Alaskan patients, preventing those who require oral or injectible prescriptions from having to visit a general practitioner in addition to their regular optometrist. This will save patients time and money, and allow optometrists greater participation in their patients' care.

HB113 v. CSHB113()

CS for HB113()

Contains the following provisions that were not included in HB113

Section 1

Clarifies that the endorsement allows prescription of pharmaceutical agents if the applicant:

- 1) Passes exam on ocular pharmacology
- 2) Completes 23 hours in approved nontopical therapeutic pharmaceutical agent course
- 3) Completes 7 hours in injections course

Section 2

Adds new subsection

Endorsement renewal requirements (each 4 years)

- 1) 8 hours continuing education concerning use and prescription of pharmaceutical agents.
- 2) 7 hrs continuing education concerning injections.
- 3) Meets other board requirements.

Section 3

Defines what endorsement allows licensee to prescribe controlled substance

- 1) "is prescribed and used for the treatment of ocular disease or conditions, ocular adnexal disease or conditions, or emergency anaphylaxis.
- 2) Not schedule 1, 2 or 6 (HB113 only listed 1)
- 3) Not prescribed for more than 4 days of use
- 4) Not injected into eyeball
- 5) Licensee must have physician-patient relationship
- 6) Must have DEA registration number.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION



Rev. 6/98

Central Microfilm Services
Department of Education & Early Development
State of Alaska

HB113 v. CSHB113()

CS for HB113()

Contains the following provisions that were not included in HB113

Section 1

Clarifies that the endorsement allows prescription of pharmaceutical agents if the applicant:

- 1) Passes exam on ocular pharmacology
- 2) Completes 23 hours in approved nontopical therapeutic pharmaceutical agent course
- 3) Completes 7 hours in injections course

Section 2

Adds new subsection

Endorsement renewal requirements (each 4 years)

- 1) 8 hours continuing education concerning use and prescription of pharmaceutical agents.
- 2) 7 hrs continuing education concerning injections.
- 3) Meets other board requirements.

Section 3

Defines what endorsement allows licensee to prescribe controlled substance

- 1) "is prescribed and used for the treatment of ocular disease or conditions, ocular adnexal disease or conditions, or emergency anaphylaxis.
- 2) Not schedule 1, 2 or 6 (HB113 only listed 1)
- 3) Not prescribed for more than 4 days of use
- 4) Not injected into eyeball
- 5) Licensee must have physician-patient relationship
- 6) Must have DEA registration number.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB135-DHSS-FMA-03-19-07
 Bill Version: HB 135
 () Publish Date: _____
 Dept. Affected: Health & Social Services
 RDU: Departmental Support Services
 Component: Off Faith-Based & Community Initiatives

Revision Date/Time (Note if correction): _____
 Title: TUITION FOR CERTAIN CHILDREN

Sponsor: STOLTZE
 Requester: HOUSE (HES)

Component No. 2849

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services	21.4	21.4	21.4	21.4	21.4	21.4
Travel						
Contractual	20.0	20.0	20.0	20.0	20.0	20.0
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	41.4	41.4	41.4	41.4	41.4	41.4

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES (0)						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	41.4	41.4	41.4	41.4	41.4	41.4
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	41.4	41.4	41.4	41.4	41.4	41.4

Estimate of any current year (FY2007) cost: _____

Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

SB 76 creates a higher education savings program for eligible children who have been placed in out-of-home care by the Department of Health and Social Services.

The Office of Faith-Based and Community Initiatives is responsible for administration of the ASPIRE (Alaska Youth Succeed When People Invest Resources in Education) program to encourage investment in the higher education of eligible children in the state.

(cont. on page 2)

Prepared by: Stephanie Wheeler, Executive Director
 Division: Office of Faith Based & Community Initiatives
 Approved by: Karleen Jackson, Commissioner
 Agency: Department of Health and Social Services

Phone: 269-8016
 Date/Time: 03/07/2007
 Date: 03/19/2007

FISCAL NOTE
FN #

STATE OF ALASKA
2007 LEGISLATIVE SESSION

ANALYSIS CONTINUATION
(cont. from page 1)

The office estimates that it will take 25% of the time of an existing program coordinator (Range 18) located in Juneau or Anchorage to administer the program. The position will be responsible for management of the broader Alaska Partnership for Healthy Communities (APHC) initiative designed to improve collaboration among government agencies and communities through projects that promote integrated services for Alaskans. The ASPIRE program fits well with the position's broader responsibilities.

Contractual funds in the amount of \$20.0 per year are requested to create and print brochures and to support a very modest television and radio promotional effort to publicize ASPIRE.

FISCAL NOTE

STATE OF ALASKA
2007 LEGISLATIVE SESSION

Fiscal Note Number: HB113-COM-OL-03-16-07
 Bill Version: HB 113
 () Publish Date: _____

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
 Title Optometrists Use of Pharmaceuticals RDU Corp, Bus & Prof Licensing (117)
 Component Corp, Bus & Prof Licensing
 Sponsor Samuels et al
 Requester House HES Component No. 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2007) cost: 0.0
 Mark this box (X) if funding for this bill is included in the Governor's FY 2008 budget proposal:

POSITIONS

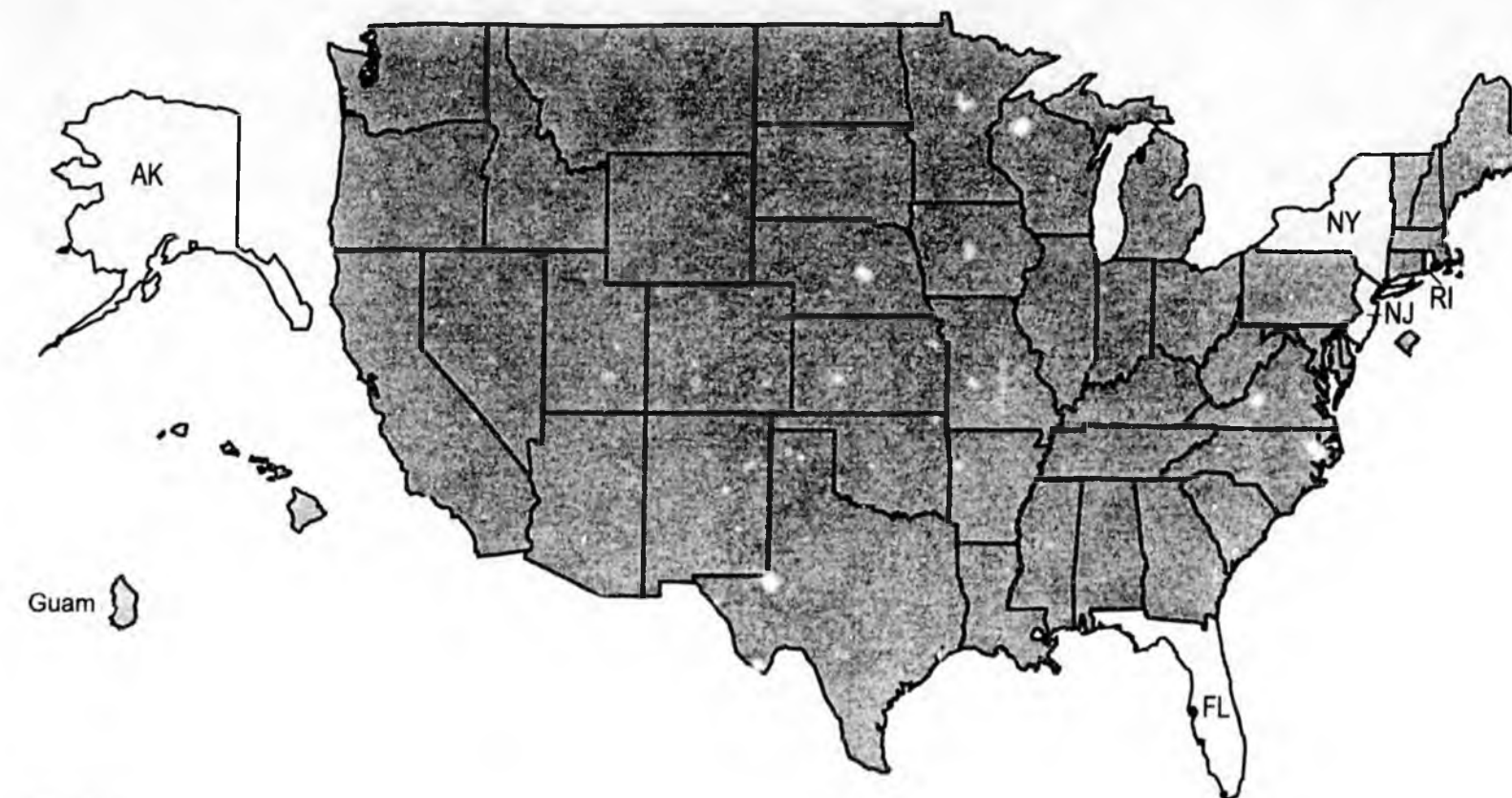
Full-time						
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

This legislation amends various provisions of AS 08.72 Optometrists and Use of Pharmaceutical Agents, including adding specifications for controlled substances. This is not expected to result in the need for additional funds to implement the provisions.

Prepared by: Chris Wyatt, Administrative Manager Phone (907) 465-2572
 Division Corporations, Business, and Professional Licensing Date/Time 3/16/07 2:09 PM
 Approved by: Emil Notti, Commissioner Date 3/16/2007
 Agency Commerce, Community, and Economic Development

The Prescription of Systemic Medications By Optometrists To Treat Eye Disease



 **Some/All Systemic Medications**

September, 2006



Frequently Asked Questions

Do optometrists have sufficient education, training, and experience to use systemic drugs?

Yes. Courses in pharmacology, physiology, and pathology are an integral component of the core curriculum in optometry school, using the same medical model as taught in dental and medical schools. Optometry schools are fully accredited by nationally-recognized agencies. Circa 1970, all optometry schools elevated their education level to a 4 year professional program identical to the medical and dental model. Optometrists have been safely prescribing systemic drugs in other states since 1977, and currently 45 states allow all or some systemic treatment of eye diseases. Licensed optometrists are required to take continuing education courses in this area to stay current in their knowledge and training. This is not new ground, Alaska is far behind the curve in eye care access and delivery.

Does HB 113 allow optometrists to administer pharmaceuticals by injection and infusion?

Yes. The route of administration of a drug is not the primary factor. In fact, injectable drugs are generally not a class of separate drugs. Optometrists are fully educated and competent to use any drug regardless of its route of administration. Optometrists currently use needles every day routinely for removing corneal foreign bodies, and needle-type cannulas for irrigating tear ducts, so that is not a factor.

Are there potential risks associated with prescribing systemic drugs?

Absolutely. The prescribing of any drug is very serious, that is why doctors of optometry, dentistry, and medicine educate a minimum of 8 years and are state licensed. In Alaska, advanced nurse practitioners safely prescribe all the systemic drugs unrestricted with currently less education. Optometrists go through rigorous training on all types of prescriptive medicines for the whole body plus the eye, including contraindications and side effects. HB 113 restricts optometrists to treating ONLY the eye and surrounding tissues. When systemic medications are indicated for certain and emergent conditions they are absolutely necessary. Optometrists use their professional judgment to decide whether to treat or to refer a patient to a more specialized provider.

Do ophthalmologists have more education and training than optometrists?

Yes. Optometry school consists of four years of post-graduate, doctoral-level study concentrating on the eye, vision and associated systemic disease with an optional one-year residency. This education is the same medical model as medicine, dentistry & podiatry. Ophthalmology is a 3 year residency above and beyond medical school. This additional three-year residency prepares the ophthalmologist to be an eye surgeon and tertiary-level specialist. This is the same as cardiology, orthopedics, or ear, nose, throat specialists. Patients see a primary care provider for their general health needs and are referred to a specialist when necessary. This system increases access to care and holds costs lower. Optometrists routinely refer patients to ophthalmologists for advanced eye care or surgery, the same as family doctors refer to needed specialty consultation. The critical factor is that there are optometrists in a vast number of Alaskan communities, while the specialty ophthalmologists are only in a few large cities.

Who benefits from HB 113?

Patients. This bill will allow patients to receive prescriptive treatment in-office or go straight to a pharmacy with a prescription written by the patient's primary eye doctor, instead of having to schedule another doctor's visit simply to get the prescription for the medicine the optometrist has already determined they need. Optometrists gain no additional income by expanding their drug authority, as the patient is charged for the office visit, not which drug is prescribed.

Will HB 113 put Alaskans at risk?

No. Often times, legislators must make difficult decisions based on assumptions. Fortunately, with HB 113, there are no assumptions necessary because we can look at facts. Similar legislation has passed in 45 other states throughout the last 30 years with none ever repealed and no reported problems. In fact, the Alaska Medical Board surveyed medical boards throughout the Nation to find out if there were any problems in states where similar legislation had passed. Not one medical board reported any problems.

Alaska Optometric
Association

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Statement for Optometric Practice Under this Legislation

As optometric physicians, our intent for expanding our statutes to include oral pharmaceuticals is to provide better and more complete eye care to Alaskans.

Currently, we are limited in the treatment of eye diseases we see on a routine basis. Diseases such as acute allergic reactions, ocular Herpes and ocular Herpes Zoster, chronic lid diseases, and infectious conjunctivitis and lid diseases, would benefit from the help of oral medications.

109 optometric physicians 85 different locations currently serve the Alaskan population spanning from Barrow to Juneau.

Optometric physicians are often the only eye care physicians available in rural areas throughout Alaska. **Our specialty is in primary and preventative eye care. We are educated and trained in the use of oral therapeutics.** This legislation is not adding to the profession but enabling optometric physicians to practice at the level they are trained and needed.



Current and Proposed Therapeutic Pharmaceuticals Legislation for Optometric Physicians

Current legislation for optometry and the use for pharmaceutical agents:

A licensee may prescribe and use a pharmaceutical agent in the practice of optometry if

1. a pharmaceutical agent is a drug **topically applied** to the human eye and its appendages; and
2. the person holds a license endorsement issued by the board authorizing the prescription and use of pharmaceutical agents.

A licensee may not purchase, possess, prescribe, or use a pharmaceutical agent unless the licensee has obtained a license endorsement under AS 08.72.175.

Proposed change to legislation for optometry and the use for pharmaceutical agents:

A licensee may prescribe and use a pharmaceutical agent, including a controlled substances, in the practice of optometry if

1. the pharmaceutical agent is not included on schedule 1A* under AS11.71
2. the pharmaceutical agent is prescribed and **used for the treatment of ocular disease and ocular adnexal disease or conditions or for emergency anaphylaxis** [a drug topically applied to the human eye and its appendages]; and
3. [(2)] the person holds a license endorsement issued by the board authorizing the prescription and use of pharmaceutical agents.

**Schedule 1A are those that have no accepted medical use in the United States and that have high abuse potential, including LSD, heroin, marijuana, and may include investigational controlled substances.*



Scope of Optometry Practice

The practice of optometry includes:

(The following is a sample of what is included in the scope of optometry and does not list every disease or disorder that is treated in the practice of the profession.)

A complete analysis of the following components of the eye and visual system:

The health of the ocular tissue including the eyelids, lashes and the surrounding tissues, conjunctiva, cornea, anterior chamber, iris, lens, vitreous, retina and optic nerve.

The ocular vascular systems including the eyelids and surrounding tissues, cornea, conjunctiva, optic nerve and retina.

The intraocular pressures and blood pressure.

Pupil responses, extraocular muscles and eye lid muscle responses.

The ability for the eye to see with and without correction.

Diagnosis, treatment and management of ocular diseases:

Conjunctivitis including viral, bacterial and allergic corneal inflammation, ulcers, degeneration and dystrophy, keratoconus, abrasions, foreign body removals, uveitis, glaucoma, macular degeneration, retinitis pigmentosa, macular edema, retinitis, vitreal disorders, cataracts, retinal melanomas and masses, and other ocular tissues including eye lids.

Pre and post surgical care for variety of ocular surgeries.

Diagnosis of ocular disease and related systemic diseases*:

Hypertensive retinopathy and hypertension, arteriosclerotic plaques and arteriosclerosis, vascular incidences including central retinal and branch vein occlusions, central retinal artery occlusions, ischemic optic neuropathy and diabetic retinopathy and diabetes.

Neurological evaluation involving the visual system related systemic conditions:

Optic neuritis and multiple sclerosis, pseudo-tumor cerebri secondary to increased intracranial pressure, retrobulbar optic neuritis, brain tumors involving the visual pathway, pupillary response defects which can be secondary to a lesion or mass along the neuropathway.

**An optometric physician manages the ocular manifestations of the disease and the patient is referred to the appropriate physician to treat the systemic portion of the disease.*



Doctorate Degree Education and Training for Optometric Physicians

There are between **200 to 300 classroom hours** assigned to the specific area of pharmacology and **two years of clinical applications** of systemic and ocular agents in the treatment of ocular disease.

General pharmacology 1 & 2 cover **systemic pharmacology** of agents in each drug class, pharmacokinetics, and the quantitative and qualitative aspects of pharmacodynamics and the drug and patient relationship variables. This includes the topics of autonomic nervous system agents, cardiovascular drugs, renal pharmacology, gastrointestinal drugs, respiratory pharmacology, anti-inflammatory agents, chemotherapeutic agents, neuropharmacologic agents, anesthetics, hormones and hormone antagonists, pain pharmacology, toxicology and the toxicology of poisons.

Ocular pharmacology and ocular pharmacological therapies includes ocular and systemic pharmacological agents related to the treatment and management of ocular disease the pharmacokinetics and pharmacodynamic. This includes the **use of topical, oral and injectable medications in the treatment of eye and the associated structures.**

Related required classes and labs:

Human anatomy	Neuroanatomy	Histology
Human physiology	Neurophysiology	Embryology
Human pathology	Neurobiology	Biochemistry
Ocular anatomy	Ocular physiology	Ocular pathology
Ocular disease	Ocular emergencies	Immunology
Clinical medicine	Clinical emergencies	Patient Care

Clinical Education

There are **at least 2,000 patient contact hours** in a variety of optometric clinical settings examining diverse patient populations. This includes clinical, hospital and emergency experience.

Please see the attached examples of the course work required by optometry schools.

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY

Doctor of Optometry Degree
2005 - 2006 Curriculum

FIRST PROFESSIONAL YEAR: 2005-2006

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
501	Geometric Optics with Lab	4.0	502	Physical Optics with Lab	3.0
516	Clinical Experience I	0.5	503	Visual Optics and Ocular Motility with Lab	4.0
531	Ocular Anatomy, Physiology and Biochemistry with Lab	4.5	517	Clinical Experience II	0.5
535	Functional Neuroanatomy and Neurobiology	3.0	532	Anatomy of the Visual System with Lab	3.0
536	Pharmacological Principles and Autonomic Agents	3.0	533	Microbiology, Genetics and Immunology; Pharmacology of Anti-Infective Drugs; Diseases of the Lid and Lacrimal System	3.0
546	Clinical Procedures: Non-refractive Diagnostic Tests with Lab	3.0	534	Laboratory Procedures for Assessment of Ocular Disease	1.0
562	Behavioral Optometric Science with Lab	4.0	537	Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications I	1.0
			547	Clinical Procedures: Binocular Testing and Optics with Lab	2.0
	Total Semester Credits	22.0		Total Semester Credits	20.5
					Total First Year Credits
					42.5

SECOND PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
601	Ophthalmic Optics	3.0	617	Optometric Case Analysis	4.0
602	Sensory-Motor Interactions in Vision with Lab	4.0	618	Theory and Practice of Spherical Rigid and Soft Contact Lenses with Lab	3.0
616	Theory and Methods of Refraction	3.0	621	Clinical Experience IV	0.5
620	Clinical Experience III	0.5	633	Diagnosis and Treatment of Posterior Segment Diseases	3.0
631	Diagnosis and Treatment of Anterior Segment Diseases	2.0	634	Detection, Assessment and Treatment of Posterior Segment Diseases	1.0
632	Detection, Assessment and Treatment of Anterior Segment Diseases	1.0	638	Etiology, Diagnosis and Management of Systemic Diseases with Lab; Pharmacology of Systemic Medications III	2.0
637	Etiology, Diagnosis and Management of Systemic Diseases; Pharmacology of Systemic Medications II	2.0	648	Clinical Procedures: Phorometry and Ocular Health with Lab	4.0
646	Clinical Procedures: Refractive Error Measurement with Lab	2.0	662	Visual Information Processing and Perception with Seminar	4.0
647	Ophthalmic Dispensing Procedures with Lab	2.0			
648	Physiological, Psychological and Cognitive Changes During the Lifespan	2.0			
	Total Semester Credits	21.5		Total Semester Credits	21.5
					Total Second Year Credits
					43.0

THIRD PROFESSIONAL YEAR: 2005 - 2006

OPT#	Summer Semester:	Credits	OPT#	Fall Semester:	Credits	OPT#	Spring Semester:	Credits
715	Patient Care: First Session	1.0	718	Advanced Optometric Case Analysis with Lab	4.0	723	Patient Care: Third Session Assessment and Mgt of Strabismus and Amblyopia with Lab	2.0
716	Theory and Practice of Specialty Contact Lenses with Lab	4.0	720	Vision Therapy for Binocular and Oculomotor Dysfunction with Lab	4.0	725	Evaluation and Mgt of Patients with Perceptual Problems with Lab	3.0
721	Clinical Experience V	0.5	722	Patient Care: Second Session Pediatric and Developmental Optometry	2.0	727	Applied Ocular Therapeutics	1.0
726	Normal and Abnormal Visual Perception	2.0	724	Assessment and Mgt of the Partially Sighted Patient	2.0	762	Communication in Optometric Practice with Lab	2.0
761	Public Health Optometry	2.0	728	Assessment and Mgt of Ocular Disease Patients	2.0	764	Optometric Economics and Practice Electives*	4.0
763	Environmental, Occupational and Recreational Vision	2.0	733	Electives				
791	Optometric Thesis: Orientation and Planning Electives*	1.0						
	Total Semester Credits	12.5		Total Semester Credits	16.0		Total Semester Credits	16.0
*Students are required to complete at least 4 credit hours of electives during third year.								
								Total Third Year Credits (Including Electives)
								48.5

FOURTH PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Semester:	Credits	OPT #	Spring Semester:	Credits
	<u>Preceptorships:</u>			<u>Internal Clinic Rotation:</u>	
814	Patient Care VIII: Preceptorship Session 1	11.0	817	Patient Care XI: Internal Clinic Rotation	5.0
815	Patient Care IX: Preceptorship Session 2	11.0	818	Vision Therapy Patient Care	2.0
816	Patient Care X: Preceptorship Session 3	11.0	819	Low Vision Patient Care	1.0
892	Optometric Thesis: Completion	1.0	820	Contact Lens Patient Care	1.0
			821	Clinical Rounds	1.0
			822	Pediatric Patient Care	1.0
			832	Ocular Disease and Special Testing Patient Care	1.0
					Total Fourth Year Credits
					46.0

ILLINOIS COLLEGE OF OPTOMETRY

Doctor of Optometry Degree
2005 - 2006 Curriculum

FIRST PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Quarter 1.1	Credits	OPT #	Winter Quarter 1.2	Credits	OPT #	Spring Quarter 1.3	Credits	
114	Human Anatomy	5.0	106	Histology and Embryology	4.0	111	Neuroanatomy and Neurophysiology	4.0	
116.1	Human Physiology and Pathology I	4.0	107	Applied Ocular Anatomy	6.0				
120.1	Geometric and Theoretical Optics I	4.0	116.2	Physiology and Pathology II	2.0	116.3	Physiology and Pathology III	4.0	
140.1	Sensory Aspects of Vision I	4.0	120.2	Geometric and Theoretical Optics II	4.0	140.2	Sensory Aspects of Vision II	5.0	
150.1	Biochemistry I	4.0				162.3	Optometry 1.2	3.0	
162.1	Introduction to Optometric Procedures	1.0	150.2	Biochemistry II	4.0	170	Physiological Optics I	3.0	
			162.2	Optometry 1.1	3.0	194	Health Promotions	1.0	
	Total Quarter Credits	22.0		Total Quarter Credits	22.0		Total Quarter Credits	20	
								Total First Year Credits	64.0

SECOND PROFESSIONAL YEAR: 2005 - 2006

OPT #	Fall Quarter 2.1	Credit	OPT #	Winter Quarter 2.2	Credit	OPT #	Spring Quarter 2.3	Credit	
212	Ocular Physiology	4.0	245	Color Vision and Developmental Neurobiology	4.5	222	Theoretical and Physical Optic Immunology	2.0	
244	Binocular Vision and Ocular Motility	5.0	246	Visual Perception	2.0	256	Ocular Pharmacology and Therapeutics	4.0	
254.1	General Pharmacology I	4.0	248	Perspectives on Behavioral Disorders	1.5	261	Physical Diagnosis	2.0	
262.1	Optometry 2.1	4.0	254.2	General and Ocular Pharmacology	4.0	263.2	Ocular Disease II	3.0	
270.1	Ophthalmic Optics I	4.0				262.3	Optometry Seminar	3.5	
			262.2	Optometry 2.2	3.5	262.4	Introduction to Binocular Vision Disorders	1.0	
			263.1	Ocular Disease I	2.0	266	Microbiology	1.0	
			270.2	Ophthalmic Optics III	3.0				
	Total Quarter Credits	21.0		Total Quarter Credits	20.5		Total Quarter Credits	16.5	
								Total Second Year Credits	58.0

THIRD PROFESSIONAL YEAR: 2005 - 2006

OPT #	Summer 3.1 & Fall 3.2 Quarters	Credit	OPT #	Winter 3.3 & Spring 3.4 Quarters	Credit	
363.1	Ocular Disease III	4.0	360.2	Clinical Medicine II	2.0	
365.1	Contact Lenses I	6.0	363.3	General & Ocular Emergencies	1.0	
380.1	Patient Care	6.0	367	Low Vision Rehabilitation	3.0	
390	Evidenced Based Health Care	1.0	376.1	Strabismus and Amblyopia I	4.0	
360.1	Clinical Medicine	2.0	380.3	Patient Care	6.0	
363.2	Ocular Disease IV	3.0	364	Neuro-Ophthalmic Disorders	4.0	
365.2	Contact Lenses II	3.0	376.2	Strabismus and Amblyopia II	3.0	
375	Binocular Vision Disorders	3.5	379	Infant & Child Development and Management	3.0	
380.2	Patient Care	6.0	380.4	Patient Care	6.0	
390	Evidenced Based Health Care	1.0	391	The Business of Optometry	2.0	
	Total Semester Credits	35.5		Total Semester Credits	34.0	
					Total Third Year Credits	69.5

FOURTH PROFESSIONAL YEAR: 2005 - 2006

OPT #	Summer 4.1, Fall 4.2, Winter 4.3, & Spring 4.4 Quarters	Credit
403	Independent Study	3.0
400	Patient Care	16.0
	Or	
	Patient Care Externship	20.0
Total Fourth Year Credits		19 / 23

SAME

FILE

CONTINUES



Alaska Optometric Association

Alaska's Authority on Primary Eye & Vision Care

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Kevin Berg, OD
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Tracy Oman
Executive Director

March 19, 2007

The Honorable Peggy Wilson
Chair, Health, Education & Social Services
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Representative Wilson;

On behalf of the frontline eye care providers serving patients in communities across our state, the Alaska Optometric Association would like to voice our support of your committee substitute for House Bill 113.

Optometrists across the United States have been safely diagnosing and treating eye conditions with topical and systemic medications since 1977 with no problems, and with topical medications in Alaska since 1992, with zero complaints to the Board. HB 113 simply elevates Alaska optometry scope of practice to include systemic medications.

Optometrists are fully educated and trained on all types of prescriptive medicines for the whole body plus the eye, including contraindications and side effects. They pass comprehensive National Board Examinations covering these topics. This education and training fully prepares them to diagnose and treat eye conditions appropriately or refer patients to a more specialized provider when necessary.

The purpose of this bill is to allow patients to receive prescriptive treatment from their primary eye-care provider, instead of having to schedule another doctor's visit simply to get the prescription for the medicine the optometrist has already determined they need. Optometrists gain no additional income by expanding their drug authority, it simply benefits the patients by providing better access to eye care throughout Alaska.

Alaska is far behind the curve in eye care access and delivery. HB 113 elevates optometry's scope of practice in line with the 45 other states throughout the nation that have been successfully prescribing systemic medications for the past 30 years with no reported problems. In addition, it lowers health care costs for Alaskans and provides better incentives to bring the best qualified doctors of optometry to Alaska.

Please review the enclosed "Frequently Asked Questions" for more details.

Sincerely,

Tracy Oman
Executive Director

Enclosure

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Anchorage, AK 99501
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Toll Free: 877-693-2562
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Frequently Asked Questions

Do optometrists have sufficient education, training, and experience to use systemic drugs?

Yes. Courses in pharmacology, physiology, and pathology are an integral component of the core curriculum in optometry school, using the same medical model as taught in dental and medical schools. Optometry schools are fully accredited by nationally-recognized agencies. Circa 1970, all optometry schools elevated their education level to a 4 year professional program identical to the medical and dental model. Optometrists have been safely prescribing systemic drugs in other states since 1977, and currently 45 states allow all or some systemic treatment of eye diseases. Licensed optometrists are required to take continuing education courses in this area to stay current in their knowledge and training. This is not new ground, Alaska is far behind the curve in eye care access and delivery.

If HB 113 is enacted, would optometrists in Alaska have one of the most expansive scopes of practice in the Country ?

No. Optometrists in 45 other states in the country are allowed to prescribe oral medication, but levels of authority vary slightly from state to state based on the authority granted by each state legislature. Alaska is currently far behind other states scope of practice laws. Even if enacted, there are many states that would still have more expansive scopes of practice. In fact, optometrists currently perform laser surgeries in one state.

Does HB 113 allow optometrists to administer pharmaceuticals by injection and infusion?

Yes. The route of administration of a drug is not the primary factor. In fact, injectable drugs are generally not a class of separate drugs. Optometrists are fully educated and competent to use any drug regardless of its route of administration. Optometrists currently use needles every day routinely for removing corneal foreign bodies, and needle-type cannulas for irrigating tear ducts, so that is not a factor.

Are there potential risks associated with prescribing systemic drugs?

Absolutely. The prescribing of any drug is very serious, that is why doctors of optometry, dentistry, and medicine educate a minimum of 8 years and are state licensed. In Alaska, advanced nurse practitioners safely prescribe all the systemic drugs unrestricted with currently less education. Optometrists go through rigorous training on all types of prescriptive medicines for the whole body plus the eye, including contraindications and side effects. HB 113 restricts optometrists to treating ONLY the eye and surrounding tissues. When systemic medications are indicated for certain and emergent conditions they are absolutely necessary. Optometrists use their professional judgment to decide whether to treat or to refer a patient to a more specialized provider.

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Who benefits from HB 113?

Patients. This bill will allow patients to receive prescriptive treatment in-office or go straight to a pharmacy with a prescription written by the patient's primary eye doctor, instead of having to schedule another doctor's visit simply to get the prescription for the medicine the optometrist has already determined they need. Optometrists gain no additional income by expanding their drug authority, as the patient is charged for the office visit, not which drug is prescribed.

Will HB 113 put Alaskans at risk?

No. Often times, legislators must make difficult decisions based on assumptions. Fortunately, with HB 113, there are no assumptions necessary because we can look at facts. Similar legislation has passed in 45 other states throughout the last 30 years with none ever repealed and no reported problems. In fact, the Alaska Medical Board surveyed medical boards throughout the Nation to find out if there were any problems in states where similar legislation had passed. Not one medical board reported any problems.

Dr. Bill Faulkner, Optometrist
400 L Street, Suite 104 Anchorage, Alaska 99501
(907) 276- 1984
Fax (907) 276- 1981

Honorable Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

This is a very simple issue. Optometrists in Alaska would like to join their colleagues in 45 other states in being able to provide a higher level of care to our patients.

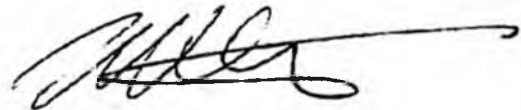
With regard to eye care, Optometry takes care of most of the problems most of the people have, most of the time. The circumstances that would require our use of systemic agents might not occur for a week, or we might have three patients in one day that would benefit from this service. We just never know from day to day.

I have recently activated my Oregon Optometric license. It is interesting to note that in the State of Oregon, by the 2009 licensing cycle, it will be an absolute requirement for all licensed Optometrists to have their systemic medication certification. If it is not obtained, then you cannot practice in that State. This is how "mainstream" this certification has become in our profession.

When Optometrists have tried to enhance our level of care in the past, organized Ophthalmology has demonstrated a history of mistruths, half truths and distortions in their opposing testimony. This surely must be based on ego, not logic. Please do not be fooled by their self serving claims.

Alaskan Optometrists simply want to join with the rest of the profession in the United States in being better able to care for our patients.

Thank you for your time and attention to this matter.



William D. Faulkner, O.D.
Cc: Alaskan Optometric Association

Alaska State Medical Association

Homer Eye Care Center
Boyd L. Walker, O.D.

3726 Lake Street, Suite A
Homer, Alaska 99603

907 235-7745
FAX 907 235-7710

3/19/2007

Honorable Representative Peggy Wilson
Chair, House HESS Committee

Dear Representative Wilson:

I am writing in support of your committee substitute for House Bill 113.

For optometric physicians, HB113 changes the current statutes to include systemic (oral and injectable) pharmaceuticals to provide better and more complete eye care to Alaskans. Currently in Alaska, optometric physicians are limited in the treatment of eye diseases to the use of medications that are applied topically. 45 of the 50 states allow optometric treatment of some or all eye disease utilizing systemic medications. Alaska is far behind the rest of the nation with respect to eye care access and delivery.

Optometric physicians are often the only eye care physicians available in rural areas throughout Alaska. Their specialty is in primary and preventative eye care. Optometric physicians are educated and clinically trained in the use of systemic therapeutic agents. This legislation simply enables optometric physicians to practice at the level to which they are trained.

Thank you for your consideration of this important legislation.

Sincerely,

Boyd L. Walker, O.D.

cc: Representative Paul Seaton

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
2575 YORBA LINDA BOULEVARD
FULLERTON, CALIFORNIA

OFFICE OF THE PRESIDENT
(714) 449-7450 FAX (714)526-3907 EMAIL: leswalls@scco.edu

March 20, 2007

To: Members of the Alaska State Legislature

Re: HB 113 "An Act relating to the prescription and use of pharmaceutical agents, including controlled substances, by optometrists."

Members of the Alaska State Legislature:

First of all, thank you for the opportunity to write a letter explaining why I am testifying in support of HB 113. I understand the proposed legislation would allow the outstanding optometrists in your great State to utilize systemically prescribed medications for eye care related health issues including certain injections. It is indeed a pleasure to offer you my opinion on the appropriate role of the optometrist in the care of their patients which, in my opinion, includes the use of ocular related systemic medications.

As a licensed practitioner of both optometry and medicine, I write to support HB 113 as I believe with all my heart that Alaska's optometrists are well-trained and qualified to utilize the systemic medications included in the bill. Indeed, the medications included are widely utilized safely and appropriately by optometrists in many other states and have been for many years. I believe that the continuing education requirement in HB 113 is more than adequate to insure that the optometrists have the education and training required to safely utilize the medications outlined in the bill.

Let me offer some specific observations of my own regarding optometric and medical education.

Medical school traditionally prepares the student in general medical and surgical background for post-graduate training programs. Detailed anatomy and physiology of organs such as the eye is not emphasized during medical school. As well, during surgical rotation in medical school, it is uncommon to be exposed to ocular surgery. Because heart disease, cancer, and stroke are the biggest killers of the U.S. population, medical school clinical training is heavily devoted to general internal medicine, general surgery, obstetrics-gynecology, and pediatrics. There are usually fourth-year electives in 4 to 12 week blocks where a student may increase his/her exposure to subspecialty medical and surgical areas such as ophthalmology, ear/nose and throat, urology, pulmonary medicine, cardiology, etc. In my experience, a small minority of students choose ophthalmology as a clinical rotation.

By a small personal survey in the area of California in which I now reside, most primary care physicians (general practitioners, family practice, internists, and pediatricians) admit that they had from one to three weeks of medical school devoted to ophthalmological care. This includes both didactic course work and clinical experience. I do not need to remind you that these physicians may legally treat eye diseases on an unrestricted basis.

On the other hand, optometry school is mostly devoted to ocular training. There are courses in general pathology and ocular signs of systemic disease because the optometrist is responsible to detect systemic diseases with ocular manifestations and to make appropriate referrals. Included with the systemic disease education is the specific education and training in the use of systemic medications and medication interactions, especially in regard to medications utilized in the management of ocular conditions. The detailed ocular anatomy, ocular physiology, ocular pathology, and ocular pharmacology training in optometry school is far superior to the same ocular topics in any general medical school course in the country.

A Doctor of Optometry is a four year doctorate degree just as for dentistry, pediatry and medicine. During the course of study to become a doctor of optometry, there is detailed training in ocular diseases including the management of pre-operative and post-operative care for patients undergoing all forms of ocular surgery. For the optometrists in practice, continuing education courses and practical, hands-on clinical training with patients is the mechanism utilized for assuring that patients receive the highest quality of care possible. In fact, there is testing by the National Board of Examiners in Optometry that tests for these needed skills and graduates must pass these rigorous tests before becoming licensed to care for patients.

This is not to slight medical education; there is simply not enough medical school curriculum time to devote to the eye because of training in vital organ systems such as the heart, lung, vascular system, etc. Additionally, the prerequisites for optometry school meet or exceed the requirements for medical school admission and the Optometry Admission Test parallels that of the Medical College Admission Test. With all the prerequisites and the primary care doctoral program in optometry school, the graduate is trained to make professional judgments and is quick to consult with other health care providers when a patient requires needed services outside the scope of practice. Optometrists now routinely work with medical specialists and subspecialists in the interest of the highest quality patient care.

The clinical education of an optometrist does not have to parallel the education and training of an ophthalmologist anymore than the education and training of a family physician needs to parallel that of a surgeon. Just as family physicians can safely utilize medications that are also utilized by surgeons, so can optometrists utilize medications that are utilized by ophthalmologists. The education and training for an optometrist includes the safe, effective use of all pharmaceutical agents for ocular diseases in the clinical setting which includes subsequent follow-up.

I would like to point out that ophthalmologists are vitally needed. Patients would be in sad shape without their advanced expertise in the areas of severe ocular trauma, cataract surgery, retinal surgery, complicated ocular infections, etc. These are all vital secondary and tertiary care conditions which optometrists do not propose to treat. I do regret that the opposition resorts to "scare tactics" in this legislative issue. In my opinion, risk to the public is not an issue and the safe use of these therapeutic pharmaceutical agents by optometrists has been well documented in other states.

I also feel strongly that optometrists are vitally needed. There is no question but that the Alaska Board of Examiners in Optometry will protect the people of Alaska by insuring adequate education, continuing education and training for any optometrist allowed to utilize these systemic medications outlined in HB 113. In my opinion, it is unfair to patients and a waste of resources to prevent optometrists from providing care at the highest level of their education and training. Constraints on the profession undoubtedly contribute to an increase in health care costs.

Sincerely,

Lesley L. Walls, O.D., M.D., D.O.S.
President

March 20, 2007

David Karpik, OD
1001 Noble St, Ste 410
Fairbanks, AK 99701

Honorable Representative Peggy Wilson
Chair, House HESS Committee
Juneau, AK 99801

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

First of all, I am passionate about both Alaska and her people. I am a recent graduate of The Ohio State University College of Optometry. Following receiving my degree, I completed post-graduate specialty training: a residency in contact lens and family practice optometry through Pacific University. I now have the good fortune to be serving patients in Fairbanks.

It was quite a shock to come to a state in which so much of my training went underutilized due to restrictive legislation. My didactic and clinical training in pharmacology met or exceeded the quantity and caliber of my colleagues in Dentistry and Medicine at Ohio State. This is not to claim a superior education is provided at Ohio State; in fact a comparison between Illinois College of Optometry, Pacific University College of Optometry, Harvard College of Dental Medicine, and The Ohio State College of Medicine shows equivalency in pharmacology hours of education. This is by design. Optometry is a doctoral level program. The current legislation would make sense 2 generations ago, but does not today.

Additionally, competence with oral pharmaceuticals is confirmed through rigorous testing by the National Board of Examiners in Optometry (NBEO). This board certification consists of approximately 36 hours of testing, with 1 out of the 4 sections of board certification dedicated to treatment of ocular disease with systemic and topical pharmaceuticals. Passing all sections of NBEO examination is required to gain licensure in Alaska.

It is the patient who will gain the most from expansion of prescriptive privilege already in place in the lower 48 that matches the past 30 years of level of training received in an optometric education. No longer will delayed treatment for simple and well understood eye problems cause harm. No longer will public health dollars be wasted for duplicate office

visits to prescribe the medication that the optometrist has deemed necessary.

Sincerely,

David Karpik, O.D.

March 19, 2007

Steve Dobson, OD
1000 E Dimond Blvd
Anchorage, AK 99515

Honorable Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

HB113 would significantly *improve access* and *decrease cost* for the thousands of Alaskans in our state who each year seek quality *optometric medical eye care*. HB113 when enacted will allow patients to receive prescriptive treatment in-office or go straight to a pharmacy with a prescription written by the primary eye care doctor, instead of having to schedule another doctor's visit simply to get the prescription or the medicine the optometrist has already determined they need. Optometrists do not gain additional income by expanding their prescriptive authority, as the patient is charged for the office visit not which drug is prescribed.

Currently, optometrists in Alaska including myself, prescribe *antibiotics, anti-virals, anti-inflammatory, allergy, and steroid medications along with medications to treat glaucoma (beta-blockers, alpha-agonists, carbonic anhydrase inhibitors, prostaglandins)* on a routine basis when treating our patients for diseases of the eye and adnexa. Unfortunately, for those optometric patients residing in Alaska these medications are limited to topical (not so for the patients who seek optometric medical eye care throughout most of the United States).

Today, 45 other states allow optometrists to prescribe oral medications for their patients. Levels of authority vary slightly from state to state based on the authority granted by each state legislature. Even if HB113 were enacted, many states would still have more expansive scopes of practice. In fact, optometrists in one state currently perform laser surgeries.

Since 1970 all optometry schools have elevated their education level to a four year post-graduate, doctorate-level professional program along with extensive core curriculum course work in pharmacology, physiology and pathology using the same medical model as taught in dental and medical schools. As a result, optometrists have been safely prescribing systemic drugs in other states since 1977. *Alaska is unfortunately behind the curve in eye care access and delivery.*

When posed with the question whether Ophthalmologists have more education and training than the Optometrists the answer would be yes. The Optometric curriculum is

comprised of four years of post-graduate, doctorate-level study emphasizing the eye, vision and associated systemic disease with an optional one-year residency. This education is the same medical model as medicine, dentistry, and podiatry. Ophthalmology is a three-year residency beyond medical school. This additional three year residency prepares the Ophthalmologist to be an eye surgeon and tertiary-level specialist. This model is the same for other medical specialties such as cardiology, ENT's (ear, nose, and throat), nephrology, orthopedics etc. Patients routinely schedule appointments with their primary care provider and are referred to a specialist when necessary. This model *increases access* to care and helps to *control costs*. Optometrists refer patients frequently to Ophthalmologists for more advanced eye care or surgery the same as family doctors refer their patients for specialty consultations. General practitioners including Optometrists live and serve in many rural communities throughout our state. Other specialists including Ophthalmologists reside mostly in the more metropolitan communities.

HB113 will provide Alaskans with *additional access* to high quality medical eye care and help *control costs* associated with *unnecessary referrals* (lost wages due to time away from work, additional office visit fees). An important fact to realize is similar legislation has passed in 45 other states throughout the last 30 years with *none* ever repealed and no reported problems. In fact, the Alaska Medical Board surveyed medical boards throughout the nation to find out if there were any problems in states where similar legislation had passed. Not one medical board reported any problems. In addition, medical malpractice insurance premiums for optometrists did not rise in states where systemic medication (versus topical only) prescriptive authority legislation was approved

Sincerely,

Steven S Dobson O.D.
Past Chairman, Board of Examiners in Optometry

MARSH

Marsh Affinity Group Services
a service of Seabury & Smith, Inc.
1440 Renaissance Drive
Park Ridge, IL 60068-1400
847-803-3100
800-323-2106

January 26, 2007

Ms. Sherry L. Cooper, Manager
State Government Relations
American Optometric Association
243 N. Lindbergh Blvd., Floor 1
St. Louis, MO 63141

Dear Ms. Cooper:

On behalf of our client, the American Optometric Association (AOA), we ask that you please consider the following information regarding professional liability coverage available to licensed Optometrists practicing in all 50 States and the District of Columbia.

Marsh Affinity Group Services, a service of Seabury & Smith, Inc., has an uninterrupted 10+ year relationship with the AOA as their sponsored professional liability partner. Because of our long-term partnership with AOA, we believe Marsh currently represents the largest portfolio of Optometrist professional liability insurance in the country. We are very fortunate to have over 7,500 Optometrists depend on Marsh for this important liability coverage.

Our primary carrier for professional liability coverage is Chicago Insurance Company, a member of the Interstate National Corporation, one of the Fireman's Fund Insurance Companies. Chicago Insurance Company does not currently charge different rates based on the procedures performed or not performed by each Optometrist. In other words, the scope of optometric-related professional services does not increase or decrease the rate charged for each insured. Prescription authority granted to Optometrists in other states does not in any way impact the premium paid by individuals in those states.

Unfortunately, a small percentage of our insured Optometrists have experienced professional liability claims that they in turn have reported to Chicago Insurance Company. When allegations of professional malpractice have necessitated a defense, the carrier has responded by conducting a professional investigation of care and outcome. Chicago Insurance Company confirmed on January 25, 2007 that their very credible claim portfolio shows that prescription authority is not a significant cause of loss for Optometrists. As such, they also confirmed that they have no plans to change their underwriting guidelines or rates regarding prescriptive authority.

Marsh is not presently concerned with the overall financial health or performance of the AOA professional liability program, although we must acknowledge that we have not conducted an actuarial review of the adequacy of Optometrist rates. We rate the likelihood of Chicago Insurance Company remaining a professional liability market for Optometrists as "Excellent".

We appreciate your willingness to consider the above information. If any questions or concerns arise as a result of this letter, please contact us at your earliest convenience.

Sincerely,



Mark A. Brostowitz, Senior Vice President
Allied Healthcare Professional Liability
Mark.brostowitz@marshpm.com
847-493-4418

D.L. THANENPOHN, O.D.
P.N. REBER, O.D.
S.A. LENTER, O.D.
J.C. FALCONER JR., O.D.
L.M. NOLIN, O.D.



Alaska
EYE CARE CENTERS

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(907) 272-2557

WASILLA
(907) 376-5266

1345 W. 9th Ave.
Anchorage, Alaska 99501
(907) 272-2557
FAX (907) 274-4932

March 19, 2007

Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson,

I am writing to express my support for the committee substitute for House Bill 113. This bill will allow me to prescribe drugs other than those topically applied (drops and ointments) to my patients.

As an optometrist in Alaska, I am a health care provider who is not being utilized to his fullest capabilities. Optometrists have degrees from four year graduate institutions which include extensive education and training in the treatment of ocular disease and pharmacology. While the topical drugs which I can now prescribe are sufficient for treating many types of eye disease, there are many others in which alternative routes of drug administration are far superior or even essential. Some eye conditions that come into my office are accompanied by severe pain, and some are medical emergencies. It is inefficient and unnecessary to require them to see another doctor to get the prescription. And in Alaska, with many rural communities where the only eye doctor is an optometrist, this legislation is especially needed.

Forty-five states have already seen the wisdom in allowing optometrists prescribe oral drugs, and we still have one of the lowest malpractice rates in the health care industry. That gives you a measure of how much of a risk we are to our patients.

The people of Alaska expect their local eye doctor to be able to prescribe the treatment they need. Please let us do our jobs better.

Sincerely,

A handwritten signature in cursive script, appearing to read "James C. Falconer, Jr.".

James C. Falconer, Jr OD
President-Elect, Alaska Optometric Association

Dr. Bill Faulkner, Optometrist
400 L Street, Suite 104 Anchorage, Alaska 99501
(907) 276-1984
Fax (907) 276-1981

Honorable Representative Peggy Wilson
Chair, House HESS Committee

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

This is a very simple issue. Optometrists in Alaska would like to join their colleagues in 45 other states in being able to provide a higher level of care to our patients.

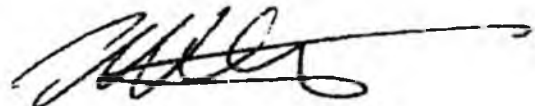
With regard to eye care, Optometry takes care of most of the problems most of the people have, most of the time. The circumstances that would require our use of systemic agents might not occur for a week, or we might have three patients in one day that would benefit from this service. We just never know from day to day.

I have recently activated my Oregon Optometric license. It is interesting to note that in the State of Oregon, by the 2009 licensing cycle, it will be an absolute requirement for all licensed Optometrists to have their systemic medication certification. If it is not obtained, then you cannot practice in that State. This is how "mainstream" this certification has become in our profession.

When Optometrists have tried to enhance our level of care in the past, organized Ophthalmology has demonstrated a history of mistruths, half truths and distortions in their opposing testimony. This surely must be based on ego, not logic. Please do not be fooled by their self serving claims.

Alaskan Optometrists simply want to join with the rest of the profession in the United States in being better able to care for our patients.

Thank you for your time and attention to this matter.



William D. Faulkner, O.D.
Cc: Alaskan Optometric Association

Alaska State Medical Association



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President, CEO

Debbie Eldridge
Executive VP, COO

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SPECIALIZING IN —
Cataract Surgery and
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March 20, 2007

**Honorable Representative Peggy Wilson
Chair, House HESS Committee**

Representative Wilson:

I am writing to support your committee substitute for House Bill 113.

This is legislation that is long overdue for the state of Alaska. Similar legislation has been adopted in 45 other U.S. states which has allowed Optometrists to provide more comprehensive care to their patients.

As you know Alaska is largely a rural state, consequently Alaskans don't have the same access to care that patients have in the lower-48. Optometrists outnumber ophthalmologists in Alaska and we better serve rural Alaska than does ophthalmology. This legislation would give Alaskans better access to more comprehensive eye care, and would eliminate the need for a patient to see another provider for a medication the Optometrist has already determined they need.

You may hear arguments against this legislation stating that Optometry does not have the training or the experience needed to prescribe systemic medications. These arguments simply do not hold water. An Optometric education consists of four years of post-graduate, doctoral-level training concentrating on the eye, visual system, and systemic diseases affecting vision. If we were not adequately trained and experienced 45 other states would not have already adopted this legislation.

This legislation would be good for Alaskans giving them better access to quality eye care.

Thank you for your time and attention to this important issue.

Sincerely,

A handwritten signature in black ink, appearing to read "Paul M. Barney".

Paul M. Barney, O.D.
Center Director
Pacific Cataract & Laser Institute
Anchorage, Alaska

Corporate Office

2517 E. Frisky Ave
Chitana, AK 99522-2420
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www.pcli.com



April 3, 2007

Chair Kurt Olson
House Labor & Commerce Committee
State Capitol
Juneau, AK 99801

Dear Representative Olson:

In the interest of patients, optometrists should communicate with medical doctors over circumstances requiring systemic medications. In the event of an ocular manifestation of a potentially systemic disease, the Alaskan optometrist should confer with local ophthalmologists. In the extremely unlikely event of an anaphylactic reaction in the optometrist's office, emergency services or local family medical doctors should be called.

Since 1989, I have practiced with some fine optometrists as collegial partners with subspecialty ophthalmologists. Their experience has been gleaned by decades of optometric practice adjacent to ophthalmic practice. There are optometrists, when covering cases that might benefit from systemic medications, easily contact ophthalmologists in or out of our practice, or directly with other medical physicians. They also clearly recognize that their individual familiarity with medical conditions has been mainly influenced by the years of adjacent practice with ophthalmologists rather than from their training in optometry school. I recommend we keep things as they are in Alaska and oppose HB 113, if the system is not broken, why meddle, especially when it comes to patient care.

The following information is written to clear up some misinformation expressed by several optometrists that occurred in House HESS, regarding the extent to which Alaskan ophthalmologists interact with rural patients.

After graduating from UAF in 1980, I trained at Yale Medical School and did an Internship and ophthalmology residency at the Mayo Clinic in Rochester, Minnesota. After completing an additional year of subspecialty training in pediatric ophthalmology in Indiana, I returned to Alaska to start a practice with Ophthalmic Associates. I have since conducted ongoing subspecialty clinics in Cordova, Homer, Kodiak, Wasilla, Bethel, Galena and the Koyukon region as well as a surgical practice in Anchorage covering both private hospitals, ANMC and Elmendorf. I have mentored a dozen premedical students one of the first of which is now Dr. Griff Steiner. At the request of Alaskan optometrists, I have offered education to many of them and to optometrist interns. Over arrange of experiences and skills, it is best for Alaskan eye patients, young and old, to have collegial communication between optometrists, local physicians and with general and subspecialty ophthalmologists who continuously cover the urgent and emergent cases.

The most common cause of vision impairment in children is Amblyopia; this disease can potentially be eliminated through early consistent screening and persistent,

accurate treatment. As a result, I have devoted over a decade and over \$300,000 to a cooperative, charitable vision screening program called the Alaska Blind Child Discovery (ABCD; www.abcd-vision.org). As you may know, the single most expensive component of the Alaska Medicaid travel budget has been for follow-up exams and glasses for children who are referred by non-specific wall-chart acuity screening. ABCD instead offers much more valid, and cost-effective objective screening to over 21,000 children through out the state, Ketchikan to Adak, from Kodiak to Barrow. No insurance or Medicaid yet pays for this new enhanced vision screening. The ABCD program carefully interprets objective screening results and recommends that referred children get a carefully defined Confirmatory Exam from the "nearest convenient eye doctor." ABCD then coordinates follow up over the years referred children are treated. ABCD has demonstrated a significant reduction in Alaskan amblyopia vision impairment cost-effectively.

This is one example of the extent to which ophthalmologists in Alaska are offering rural eye care. Please review our experiences offering this state-of-the-art pediatric vision screening free of charge to Alaskans at the State Fair(1), in the Koyukon region(2, 3), and state-wide(4-7).

Sincerely Yours,

Robert W. Arnold

Robert W. Arnold, M.D.

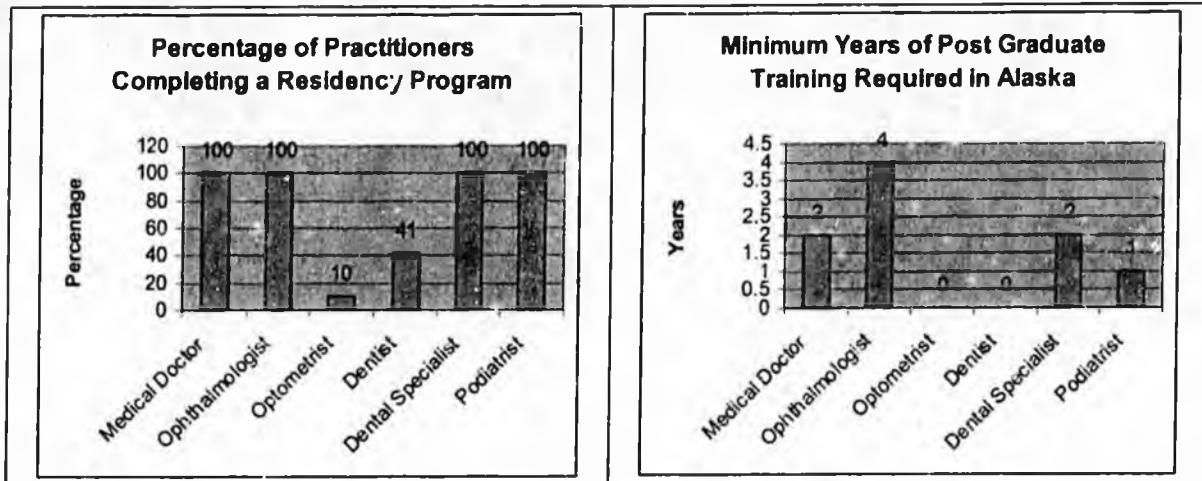
Cc: House Labor & Commerce Committee

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2. Lang DM, Arnold AW, Leman RE, Arnold RW. Validated portable pediatric vision screening in the Alaska Bush: A VIPS-like study in the Koyukon. *Alaska Med* 2007;49(1):2-13.
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Post Graduate Training Comparison Between Optometrists and Selected Professions

Ophthalmologists are medical doctors who specialize in the treatment of eye disease after three to four years of training after medical school and hospital residency. In arguing for expanded scope of practice to treat eye disease, optometrists, on the other hand, compare their education and training to podiatrists, dentists, and even medical doctors. However amongst the many significant differences between optometrists and these other professions is post-graduate training.



Medical Doctors

All medical doctors must complete at least a one year residency program upon graduation from medical school. In Alaska, the requirement is two years if the medical doctor graduated after 1995. http://www.labor.state.ak.us/research/dlo/phy_surg.htm

Ophthalmologists (EYE MDs)

In addition to the same one year residency program that all medical doctors must complete, to become an ophthalmologist, the medical doctor must also complete an additional three to four year residency training program that specializes in medical and surgical treatment of the eye. http://www.acgme.org/acWebsite/downloads/RRC_progReq/240pr106.pdf

Optometrists

Nationally, approximately 10 percent of all optometrists complete a one year residency program. *Optometric residencies are not required in Alaska or elsewhere by law or by professional standard.* <http://www.opted.org/teampublish/uploads/SpringStudentInterest.pdf>

Dentists

Nationally, approximately 41 percent of dental school graduates immediately enter into post-graduate training program. About 27 percent of all dentists enter a general dentistry residency program and an additional 14 percent enter a dental specialty program. www.adea.org/DEPR/Assocreptiune01.pdf

Dental Specialists

Completion of a two year post graduate program is a pre-requisite to be licensed as a dental specialist in Alaska. <http://www.labor.state.ak.us/research/dlo/dentist.htm>

Podiatrists

Alaska requires podiatrists to complete a one-year podiatric surgical residency program. Today, virtually all podiatry school graduates in the US complete a podiatric residency. It is now a licensing requirement in 41 states. <http://www.labor.state.ak.us/research/dlo/podiatrt.htm>

Compiled by the American Academy of Ophthalmology, The Eye M.D. Association

March 18, 2007

Alaska State House of Representatives
Health, Education & Social Services Committee

Re: HB 113


Dear Members of the Committee:

I am writing you today on House Bill 113, optometric scope of expansion. The treatment of ocular disease is very serious and requires a great deal of knowledge, education, and experience. After four years of medical school and another three to five years of residencies and internships, however, ophthalmologists are well suited for the task. They understand what drugs are needed, potential side effects, and how they might interact with other prescriptions. The over prescription of these drugs can lead to other health problems and of course addiction.

It is mind boggling to me that the Optometrists who are pushing this legislation, believe that they deserve to make these same kinds of decisions as an ophthalmologist without the same kind of education. Their education and training is not the same as Ophthalmologist, it's that simple, plain common sense

By voting "NO" on HB 113, you will help protect consumers of eye care by ensuring the quality of its providers.

Thank you for your time on this issue.


Tim Crumpton
22742 Oberg Road
Chugiak, Alaska 99567



March 17, 2007

House HESS(Health Education, & Social Services) Committee
State of Alaska

Re: HB 113

Dear Legislators:

In the interest of patients, optometrists should communicate with medical doctors over circumstances requiring systemic medications. In the event of an ocular manifestation of a potentially systemic disease, the Alaskan optometrist should confer with local ophthalmologists. In the extremely unlikely event of an anaphylactic reaction in the optometrist's office, emergency services or local family medical doctors should be called.

Since 1989, I have practiced with some fine optometrists as collegial partners with subspecialty ophthalmologists. Their experience has been gleaned by decades of optometric practice adjacent to ophthalmic practice. There are optometrists, when covering cases that might benefit from systemic medications easily contact ophthalmologists in or out of our practice, or directly with other medical physicians. They also clearly recognize that their individual familiarity with medical conditions has been mainly influenced by the years of adjacent practice with ophthalmologists rather than from their training in optometry school. I recommend we keep things as they are in Alaska and that you oppose HB 113. If the system is not broken, why meddle, especially when it comes to patient care.

Again, please consider your legislative role concerning medical care and oppose HB 113

Sincerely Yours,

Robert W. Arnold

Robert W. Arnold, M.D.



Tony Knowles, Governor

Department of Community and Economic Development

Division of Occupational Licensing

3601 C Street, Suite 722, Anchorage, AK 99503-5934

Telephone: (907) 269-8160 • Fax: (907) 269-8156 • Text Telephone: (907) 465-5437

Email: License@dced.state.ak.us • Website: www.dced.state.ak.us/occ/

ALASKA STATE MEDICAL BOARD Telephone: 907/269-8163 ♦ Fax: 907/269-8196

March 18, 2002

Barbara Gabier, Program Coordinator
Division of Occupational Licensing

MAIL BALLOT ON CSHB 215

Ms. Gabier, following is a compilation of the results of a mail ballot survey distributed to the medical board soliciting their opinions on CSHB 215. All eight board members have now responded to the mail ballot.

Table with 2 columns: QUESTION and VOTE. Contains 6 rows of survey questions and their respective vote counts.

ISSUE FOR CONSIDERATION: CSHB 215 Optometrists Prescribing Authority

Following this page is the complete text of CSHB 215 that makes changes to optometrists prescribing authority. You are being asked to provide your recommendations on this bill. Please vote and return your ballot to me as soon as possible. Please fax your completed ballots to me at 907/269-8196. Thank you for your continuing efforts in this matter.

April 27, 2000

Governor Tony Knowles
State of Alaska
Juneau AK 99811

In response to your request for an opinion, the State Medical Board, at its April 27, 2000, meeting unanimously voted to oppose the enactment of Senate Bill 78.

Although this legislation may have been passed by the House and Senate in an effort to improve patient access to care, the board believes that the potential for harm to Alaskans from optometrists prescribing and administering non-topical medications greatly exceeds the benefits. Optometrists do not have the clinical experience to safely administer eye injections, intravenous and intramuscular injections, and oral medications, including some narcotics. Reading about the effect and side effects of medications or attending seminars, does not prepare an optometrist for complications related to patients' other medical problems and chronic medications. The board's charge is to protect Alaskan patients; we believe that this legislation would endanger patients.

Sarah A. Isto, MD, Chair
Alaska State Medical Board

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 19, 2007

Honorable Peggy Wilson
State Capitol, Room 403
Juneau, AK 99801-1182

RE: HB113 – Optometrists Prescriptive Authority
Alaska State Medical Association Opposition

Dear Representative Wilson:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA opposes the enactment of HB113 which would allow optometrists to prescribe therapeutic drugs and medications. Optometrists are not physicians but often the general public mistakes them for the "EYE MD's" or Ophthalmologists. Optometrists do not have the education and training that a licensed physician and surgeon have. Ophthalmologists have additional training beyond their medical degree, generally at least a 4 to 5 year residency to further qualify them to use and prescribe therapeutic drugs. Many of these drugs have an impact not only on the eye, but interact with many body systems. We feel that if an individual wishes to practice medicine, he/she should be educated and trained as a physician. I hope you would agree that this philosophy would be in the best interest of the public.

This may sound like a "turf" issue. It is not. This is a quality of care issue. The physician community must advocate for patients and what is best for them, as you and the rest of the Legislature must also do. The bottom line is that the Legislature is the final arbiter of what constitutes quality of care for Alaska's citizens.

If the Legislature feels that some portions of what historically has constituted the practice of medicine can be performed by someone other than a licensed physician, then so be it. ASMA would hope that a legacy of less than optimum and quality care is a legacy for which you and your colleagues would not like to be remembered.

I am sure you will be getting more detailed information from the Ophthalmologists about this issue. ASMA feels that HB113 can be interpreted to presume that optometrists will be granted the authority to prescribe drugs by the sole determination of the Board of Optometry. No parameters are provided concerning the educational or post graduate training criteria that the Board of Optometry would apply.

ASMA urges you to vote against the passage of HB113. HB113 would not contribute to better care for Alaska's citizens. An appropriate litmus test is contained in the question - "Is this the practice of quality medical care?". ASMA believes that HB113 is not good medicine. We urge you to apply this same test and are confident that you will arrive at the same conclusion.

Please vote NO on HB113.

Sincerely,



By: Roland Gower, MD, President
For: The Alaska State Medical Association

To: Alaska Legislature
From: Carl Rosen, MD, President, American Academy of Ophthalmology,
Alaska Chapter
542 West Second Ave, Anchorage, Alaska 99501
907-276-1617, message: 907-563-8526
Re: Analysis of HB 113, Optometric Scope of Practice Legislation
Date: 2/1/07

What is Wrong with HB 113 – the Optometric Scope of Practice Legislation?

If this bill were enacted, optometrists in Alaska would have one of the most expansive scopes of practice in the country. Simply put, optometrists do not have sufficient education, training, or experience to use systemic drugs.

What would this bill do?

HB 113 would allow optometrists to:

- Administer pharmaceuticals by injection and infusion.
- Prescribe Controlled Substances, including narcotics and analgesics.
- Prescribe whole classes of oral drugs, including but not limited to steroids, antibiotics, and antivirals.

What are some of the problems associated with prescribing systemic drugs?

Here are just a few examples of the many side-effects that systemic drugs can cause:

- Extended use of steroids can lead to permanent damage of the joints and other parts of the body.
- The over-prescribing of antibiotics has already contributed to the significant problem of resistant micro-organisms, resulting in infectious diseases that are more difficult to treat.
- Controlled substances are not only subject to abuse but are rarely prescribed by ophthalmologists. When ophthalmologists do prescribe them, it is usually related to major eye surgery. A basic rule of thumb in ophthalmic care is that if you need a controlled substance, you missed the diagnosis.

A high percentage of the persons treated by ophthalmologists are seniors. Since seniors often have serious eye medical conditions as well as chronic illnesses for which they may be taking other drugs and less tolerance to drug side-effects, careful evaluation and close coordination by an ophthalmologist with other medical treatment is essential.

How does the education and training of an optometrist and ophthalmologist differ?

Optometrists go to four years of optometry school. This is not the same as the eight years of ophthalmology training and education. Not only do optometrists not possess a medical degree, they are not required to complete clinical rounds, internships and residencies that

focus on patients with serious eye disease. The typical training and experience of an ophthalmologist begins with four years of medical school. Afterwards, the medical school graduate must also complete an intensive one-year hospital residency, consolidating and honing knowledge and skills in the art of medicine. Only then does the physician begin a three-year ophthalmology residency in order to concentrate on the treatment of eye disease. As a result of this training, ophthalmologists graduate confident prescribing systemic drugs to patients who seek their help. Just as importantly, because of this education and training, their patients trust them to prescribe drugs safely and effectively.

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To: Representative Peggy Wilson, HESS Chair

I am writing to express my concern over HB113. Optometrists do not attend medical school and receive roughly half of the overall training and education of an ophthalmologist.

They are simply not qualified to safely carry out the new responsibilities that is Bill will produce.

Please vote "NO" on HB 113.

Sheryl Conners
P.O. Box 222
Hoonah, AK
99829

Karen B. Hindman
P.O. Box 604
Hoonah, AK. 99829

Feb. 28, 2007

Representative Peggy Wilson, HESS Chair
Capital Bldg. Room 403
Juneau, AK. 99801

Dear Representative Wilson:

I am writing to express my opposition to
HB 113.

Lowering long held medical standards to cater to the
isolated interests of a single profession is the wrong
policy for this state. Maintaining professional
standards is of the utmost importance in the
medical field where there is absolutely no room for
error.

This bill seeks to expand the role of optometry in
this state, disregarding the vast differences in
level of education and experience between
optometrists and ophthalmologists. Supporters of this
bill want to ignore the facts. Ophthalmologists go
to medical school and complete three to four years
of postgraduate residency and internship. Optometrists
are held to no such standard.

Thank you

Sincerely

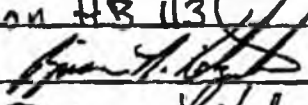
Karen B. Hindman

~~Karen B. Hindman~~

To: House Floor Committee (R) Wilson

My name is Brian N. Ketzek and I am writing
in a follow up to my phone call regarding HB 113
I want to vote "no" on this Bill. As a person who wears
both contacts and glasses I want a qualified doctor
who has the schooling to prescribe any and all medications.

Optometrists receive about half of the training and
they do not qualify to carry out their new responsibilities.
Please vote "no" on HB 113.


Brian N. Ketzek
P.O. Box 222
Hondoluk, AK

99829

cc. (R) Wilson

March 14, 2007

Representative/Chairman Peggy Wilson
House Health, Education and Social Services Committee
Capitol Building, Room #204
Juneau, Alaska 99801

Dear Representative Wilson:


A bill, House Bill 113, though well intentioned, may have devastating effects to uniformed patients.

Ocular diseases are very serious, often resulting in partial or complete loss of vision. In treatment, strong and potentially dangerous drugs are administered when necessary, and only under the most extreme circumstances. Ophthalmologists are well trained to recognize when systemic drugs are necessary and are qualified in the administration of these medications in coordination with other medications.

Optometrists have not been provided with this expertise. Their education and training is approximately one half of that of an Ophthalmologists and are traditionally qualified to center their concerns to defects in vision and the issuance of corrective lenses. Extending to them the right to work on the same level of Ophthalmologists would defy logic or responsibility.

Professional standards are crucial to the medical field; especially to the human eye, as any faulty determination can lead to loss of the patient's vision. For these reasons, and for the interests of all Alaskans, I respectfully request your "NO" vote on HB 113.

Thank you for your consideration


Joseph Bustamante
P.O. Box 201836
Anchorage, AK 99520

cc: House HESS Committee members

March 18, 2007

Honorable Representative Peggy Wilson, Chair
Health Education & Social Services Committee
Alaska State Legislature
State Capitol
Juneau, AK 99801

Dear Representative Wilson:

I am an Alaskan ophthalmologist and I strongly urge you to oppose HB 113. This bill would allow optometrists to prescribe oral medications to patients. This bill is touted as a convenience for patients, claiming that optometrists have the training and experience to prescribe narcotics, steroids, and all other classes of potentially lethal medicine to patients with eye conditions.

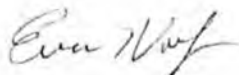
I believe that optometrists are often helpful in screening patients for eye disease and systemic problems. **But it would be very dangerous to allow the unsupervised "practice of medicine" by anyone who has no medical training.** Please understand that I have completed 11 years of intensive medical training since college, as compared to 4 years of optometry school. I became "board certified" by the Academy of Ophthalmology after two more years of work/study. I complete over 25 hours of accredited "continuing education" every year to maintain my medical license under the jurisdiction of the Alaska Medical Board.

As far as patient convenience, I have never turned down a patient or optometrist request for a same-day exam, usually with less than one hour waiting time. For routine exams, my "next available" appointment is only 2 weeks or so away. I work very hard to protect patients and to see them within a reasonable time period.

Perhaps like you, I grow weary of the annual "turf battles" that occur in state legislatures across the country. If optometrists want to be medical doctors (physicians) or even surgeons, there are plenty of openings in medical schools for qualified applicants.

Please reject this dangerous bill, this year and in the future.

Sincerely,



Evan Wolf, MD, PhD

Valley Eye Associates, PC
935 E Westpoint Drive
Wasilla, AK 99654

CC: Legislative members of the House HESS Committee

House of Representatives
State of Alaska
HESS Committee

March 19, 2007

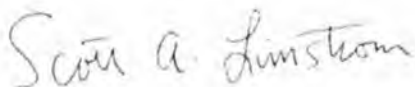
Dear Committee Members:

I am writing to you in opposition to House Bill 113. This bill would give Optometrists within the state of Alaska full authority to prescribe both oral and injectable pharmaceuticals. As such, the bill would allow Optometrists to use intravenous medications, give peri-ocular and intra-ocular injections. As an Ophthalmic surgeon specializing in retinal surgery, I perform intravenous angiograms and give intra and peri-ocular injections on a daily basis. Intra-ocular injections entail the risk of infection, retinal tear, retinal detachment, hemorrhage, blindness and death. An infection related to an intra-ocular injection is an absolute surgical emergency requiring surgical vitrectomy and injection of antibiotics to the eye. Only an Ophthalmic surgeon specializing in retinal surgery is capable of treating such an emergency. Only a retinal surgeon should be performing such procedures.

HB 113 would also give Optometrists the authority to use intravenous medications and perform procedures such as intravenous flourescein angiography in the office. This procedure entails numerous risks including: extravasation of the dye with skin necrosis, allergic reaction, anaphylaxis and death. In our office we keep a "crash cart", with all the medications and supplies necessary to treat an anaphylactic reaction, in the room where the procedure is performed. The treatment of anaphylaxis entails the use of medications and may require full resuscitation with intubation of the patient, placement of central venous access and treatment of cardiac arrhythmias and cardiovascular collapse. In spite of proper treatment, several people die in the U.S. each year as a result of anaphlyaxis related to the use of intravenous flourescein angiography.

As an Ophthalmic surgeon, I have completed four years of college, four years of medical school, one year of internship, 3 years of surgical residency, and 1 year of subspecialty fellowship training. This experience qualifies me to use intravenous medications and ocular injections. This experience qualifies me to treat the complications of the use of intravenous medications and ocular injections. Optometrists do not have the education or experience to use such medications. Optometrists do not have the education or experience to treat the complications related to the use of such medications. This bill is a danger to the residents of the state of Alaska. Please vote against HB 113.

Sincerely,



Scott A. Limstrom, M.D. -- Alaska Retinal Consultants, -- 3500 LaTouche, #250,
Anchorage, Ak 99508



STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sarah Palin, Governor
Emil Notti, Commissioner
Rick Urion, Director

Division of Corporations, Business and Professional Licensing

April 10, 2007

The Honorable Kurt Olson, Chair
Labor and Commerce Committee
House of Representatives
Alaska State Capitol, Room 408
Juneau, AK 99801

Dear Representative Olson:

Re: HB 113

Alaska State Board of Examiners in Optometry
Official Position Statement

House Bill 113, if enacted, would authorize qualified optometrists with a current license endorsement to prescribe additional classes of pharmaceutical agents including limited systemic drugs. The Board voted unanimously via mail ballot dated April 9, 2007 to fully support HB 113.

The Board's support of HB 113 is based upon the following points:

- Optometrists have been safely prescribing systemic drugs in other states since 1977. Similar legislation has been enacted in 45 other states throughout the last 30 years with no reported problems. With advancing research and technology, there are many new drug treatments introduced every year, and Alaska licensees with a therapeutic endorsement need to be able to prescribe the most advanced treatments.
- The Alaska Board of Optometry has received zero complaints involving drug prescriptions since the 1992 Alaska legislation was enacted authorizing therapeutic prescribing by optometrists. HB 113 expands this authority to include limited systemic medications for those licensees with a therapeutic endorsement.
- HB 113 restricts optometrists to treating ONLY the eye and surrounding tissues. Doctors of optometry complete comprehensive training on all types of prescriptive medicines for the whole body plus the eye, including contraindications and side effects. Optometrists are fully educated and competent to use any drug for treating the eye regardless of its route of administration.
- In 2001 the Alaska State Medical Board surveyed medical boards throughout the nation to find out if there were any problems in states where similar legislation had been enacted. Not one medical board reported any problems with optometrists prescribing.

PO Box 110806, Juneau, AK 99811-0806

Telephone: (907) 465-2534 Fax: (907) 465-2974 Website: www.commerce.state.ak.us/occ

Representative Kurt Olson

April 10, 2007

Page 2

- Optometrists take national board exams administered by the National Board of Examiners in Optometry (NBEO). HB 113 requires licensed optometrists to take additional continuing education courses to stay current in their knowledge and training. With Board of Optometry oversight, there are adequate safeguards in place to protect the public.
- HB 113 greatly improves access to quality eye care, as Alaska optometrists have excellent geographic distribution in many rural areas and often service remote areas. It will be beneficial in lowering health care costs by reducing unnecessary second referrals and reducing travel costs and lost work time for the patient.

Sincerely,

Jill Geering Matheson by JW

Jill Geering Matheson, OD, Chair
Board of Examiners in Optometry

Southcentral
Foundation



April 9, 2007

Representative Kurt Olson
State Capitol, Rm 408
Alaska State Legislature
Juneau, AK 99801-1182

RE: Support HB 113 - "An Act relating to Optometry"

Dear Representative Olson:

I am writing to urge support of HB 113, which would add additional prescriptive authority for licensed optometrists with a board endorsement, who obtain the additional educational requirements approved by the Alaska Board of Examiners in Optometry. Alaska optometrists already treat eye disease by prescribing medications, but this bill increases their scope by authorizing additional systemic medications with certain restrictions and requiring additional education.

Southcentral Foundation is a non-profit health care organization of Cook Inlet Region, Inc., which provides a wide range of health care and related services to Alaska Natives and American Indians in Anchorage, the Mat-Su Valley, and surrounding rural villages. When Southcentral Foundation was established in 1982, it consisted of 12 staff providing limited services in three program areas: optometry, dental, and social services. Today, after 25 years, optometry remains one of our core health care services, although we now have over 900 employees and provide health-related services to over 32,000 Alaska Natives through about 65 different programs.

We seek optimum health care for our Alaska Native clients, and view optometry with the respect that is due a profession of its caliber. Please vote "YES" on the passage of HB 113 to ensure quality optometry that is both cost-effective and accountable. This bill has been modified to comply with issues raised in earlier years, and now contains several added restrictions and requirements placed upon the license endorsements of qualified Alaska doctors of optometry.

Sincerely,
SOUTHCENTRAL FOUNDATION


Katherine Gottlieb, MBA
President/CEO

Chair Kurt Olson
House Labor and Commerce Committee
State Capitol
Juneau, AK 99801

April 2, 2007

RE: cshb 113

APP . 0 2007

Dear Representative Olson:

Expanding the scope of practice for optometrists through the legislature, especially as delineated in the current bill, would be a horrible mistake. We ophthalmologists have repeatedly delineated the vast educational differences, so I will not repeat them here. Mistakes made by other states do not constitute a safe precedent. It is very frustrating and dangerous that these bills keep coming before you. **At the end of the day it has to somehow make sense to you to pass a bill allowing optometrists to perform injections of the eyes of Alaskans, including your own eyes and the eyes of your children.** These are injections that ophthalmologists do hundreds of times in training under the supervision of other MDs - optometrists have never done them. Never. The injection itself requires skill and just as importantly the experience to know when to use them. Optometrists have none of this experience. Zero. Passage of this bill will be equivalent to allowing chiropractors to inject the spine because they swear up and down they have read as much as orthopedists or neurosurgeons. Even if they had read as much, which is manifestly false, this does not remotely qualify them to perform these injections.

Also relevant is that these injections are rarely necessary. What is the positive outcome of such a bill? Is the optometric agenda actually improved patient care? If a patient in a rural area has such a severe condition that it requires an eye injection, it is already beyond the scope of optometrists and the patient must see an ophthalmologist. Other milder conditions that might benefit from an injection, such as chronic sties, are rarely injected. I am a subspecialist in this area and I never inject them, using more conservative measures the vast majority of the time, with surgery only if these measures fail.

It is also well documented in other states that these absurd requests for increased procedural scope of practice (that can hardly enhance patient care) are actually designed as legislative stepping stones to later argue for surgical privileges.

As MDs, our most important oath is "First do no harm". Please help us help Alaskans by rejecting this bill. Please contact me at any time if you have any questions.

Sincerely,



Griff C. Steiner, MD (4th generation Alaskan and Stanford graduate)
Ophthalmologist subspecializing in Cornea/External disease.
542 W. 2nd Ave.
Anchorage, AK 99501
lbngriff@gci.net
907-276-1617 main office
907-264-2643 back line at office
907-350-4232 cell

cc: House Labor and Commerce Committee Members



APR 10 2007

April 3, 2007

Chair Kurt Olson
House Labor & Commerce Committee
State Capitol
Juneau, AK 99801 **Re: CSHB 113**

Dear Representative Olson:

In the interest of patients, optometrists should communicate with medical doctors over circumstances requiring systemic medications. In the event of an ocular manifestation of a potentially systemic disease, the Alaskan optometrist should confer with local ophthalmologists. In the extremely unlikely event of an anaphylactic reaction in the optometrist's office, emergency services or local family medical doctors should be called.

Since 1989, I have practiced with some fine optometrists as collegial partners with subspecialty ophthalmologists. Their experience has been gleaned by decades of optometric practice adjacent to ophthalmic practice. There are optometrists, when covering cases that might benefit from systemic medications, easily contact ophthalmologists in or out of our practice, or directly with other medical physicians. They also clearly recognize that their individual familiarity with medical conditions has been mainly influenced by the years of adjacent practice with ophthalmologists rather than from their training in optometry school. I recommend we keep things as they are in Alaska and oppose HB 113, if the system is not broken, why meddle, especially when it comes to patient care.

The following information is written to clear up some misinformation expressed by several optometrists that occurred in House HESS, regarding the extent to which Alaskan ophthalmologists interact with rural patients.

After graduating from UAF in 1980, I trained at Yale Medical School and did an Internship and ophthalmology residency at the Mayo Clinic in Rochester, Minnesota. After completing an additional year of subspecialty training in pediatric ophthalmology in Indiana, I returned to Alaska to start a practice with Ophthalmic Associates. I have since conducted ongoing subspecialty clinics in Cordova, Homer, Kodiak, Wasilla, Bethel, Galena and the Koyukon region as well as a surgical practice in Anchorage covering both private hospitals, ANMC and Elmendorf. I have mentored a dozen premedical students one of the first of which is now Dr. Griff Steiner. At the request of Alaskan optometrists, I have offered education to many of them and to optometrist interns. Over arrange of experiences and skills, it is best for Alaskan eye patients, young and old, to have collegial communication between optometrists, local physicians and with general and subspecialty ophthalmologists who continuously cover the urgent and emergent cases.

The most common cause of vision impairment in children is Amblyopia; this disease can potentially be eliminated through early consistent screening and persistent,

accurate treatment. As a result, I have devoted over a decade and over \$300,000 to a cooperative, charitable vision screening program called the Alaska Blind Child Discovery (ABCD; www.abcd-vision.org). As you may know, the single most expensive component of the Alaska Medicaid travel budget has been for follow-up exams and glasses for children who are referred by non-specific wall-chart acuity screening. ABCD instead offers much more valid, and cost-effective objective screening to over 21,000 children through out the state, Ketchikan to Adak, from Kodiak to Barrow. No insurance or Medicaid yet pays for this new enhanced vision screening. The ABCD program carefully interprets objective screening results and recommends that referred children get a carefully defined Confirmatory Exam from the "nearest convenient eye doctor." ABCD then coordinates follow up over the years referred children are treated. ABCD has demonstrated a significant reduction in Alaskan amblyopia vision impairment cost-effectively.

This is one example of the extent to which ophthalmologists in Alaska are offering rural eye care. Please review our experiences offering this state-of-the-art pediatric vision screening free of charge to Alaskans at the State Fair(1), in the Koyukon region(2, 3), and state-wide(4-7).

Sincerely Yours,

Robert W. Arnold

Robert W. Arnold, M.D.

Cc: House Labor & Commerce Committee

1. Arnold RW. Highly specific photoscreening at the Alaska State Fair: Valid Alaska Blind Child Discovery photoscreening and interpretation. *Alaska Med* 2003;45(2):34-40.
2. Lang DM, Arnold AW, Leman RE, Arnold RW. Validated portable pediatric vision screening in the Alaska Bush: A VIPS-like study in the Koyukon. *Alaska Med* 2007;49(1):2-13.
3. Arnold RW, Arnold AW, Stark L, Arnold KK, Leman RE, Armitage MD. Amblyopia detection by camera (ADBC): Gateway to portable, inexpensive, vision screening. *Alaska Med* 2004;46(3):63-72.
4. Arnold RW, Armitage MD, Gionet EG, et al. The cost and yield of photoscreening: Impact of photoscreening on overall pediatric ophthalmic costs. *JPOS* 2005;42(2):103-11.
5. Arnold RW, Donahue SP. The yield and challenges of charitable state-wide photoscreening. *Binocul Vis Strabismus Q* 2006;21(2):93-100.
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7. Leman R, Clausen MM, Bates J, Stark L, Arnold KK, Arnold RW. A comparison of patched HOTV visual acuity and photoscreening. *J Sch Nurs* 2006;22(4):237-43.

SPR



Robert Ford, MD
President, CEO

Debbie Blodgett
Executive VP, COO

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Jeffrey Grimes
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Michael Van Buren, OD

Sarah Williams, OD

Lee Youngman, OD

SPECIALISTS

Chief of Surgery and

Laser Vision Correction

April 9, 2007

Honorable Representative Kurt Olson
House Labor and Commerce Committee

Re: Support of Committee Substitute for HB 113

Dear Representative Olson,

I am writing to support your Committee Substitute for HB 113. As a licensed ophthalmologist in Alaska, I believe this expanded scope of practice will enable optometric physicians to better care for their patients.

As in many areas of our health delivery system, patients usually receive the best care when various health professionals are utilized to the full extent of their training and competency. I have worked along side optometric physicians in Alaska and a number of other western states. These doctors are generally conservative and careful, and I have great respect for the role they play as primary care practitioners. Their formal education is solid and thorough.

Forty-five other states have adapted similar legislation. But, because of the rural nature of our state, Alaskans may stand to gain more if family optometrists have access to a wider array of medications.

Sincerely yours,

Art Gabel, MD

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Cynthia Merrill, OD, MPH
OD Director

Gail Parnish
Site Director

Larry Roth, MS
Laser Vision
Quality Improvement

PHYSICIANS

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Paul Barney, OD
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Rick Burt, OD
Paul Chung, MD
Shauri Cunniff, OD
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Bruce Flint, OD
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SPECIAL ZING IN -

Cataract Surgery and
Laser Vision Correction

April 9, 2007

Honorable Representative Kurt Olson
House Labor and Commerce Committee

Re: Support of Committee Substitute for HB 113

Dear Representative Olson,

As a licensed ophthalmologist in Alaska, I am writing to express my support of your Committee Substitute for HB 113 that will expand optometrists' use of oral and injectable medications.

Optometric physicians are primary eye care specialists. As the front line of eye care, these practitioners should be allowed to incorporate the prescription and use of certain systemic medications in their treatment of ocular disease. Alaska optometrists have been prescribing drugs since 1992 and need a wider range of options for certain eye diseases to better treat their patients. This will particularly benefit people in rural and remote communities.

Over 2 decades, ophthalmologists within our organization have had the privilege of comanaging over one hundred thousand surgery patients with optometrists throughout Alaska and the Pacific Northwest. We have also worked hand-in-hand with these eye care professionals to assist in the care of all types of acute and chronic eye diseases. I have become familiar with the formal education optometric physicians receive. It is rigorous, extensive and more than adequate for them to safely and effectively prescribe systemic medications for treating eye diseases. I have also had the opportunity to observe their clinical skills on many, many occasions. Any claims of deficient education are simply untrue.

As a health care practitioner, I believe our overall benefit to society is maximized when each health professional is utilized to the fullest extent of his or her training and competency. I support the effort to expand optometrists' use of oral and injectable medications and am willing to testify in person on behalf of legislation that would make this possible.

Please contact me if I can clarify things or answer questions you may have.

With warm regards,

A handwritten signature in black ink that reads "R. Ford".

Robert O. Ford, MD
President and CEO

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- Michael Van Brock, OD
- Susan Williams, OD
- Lee Youngman, OD
- SPS - ASSISTANT IN
Cataract Surgery and
Laser Vision Correction

April 10, 2007

Honorable Representative Kurt Olson
House Labor and Commerce Committee

Re: Committee Substitute for HB 113

Dear Representative Olson,

The purpose of this letter is to share my support of Committee Substitute for HB 113. This important legislation will improve optometric physicians' ability to care for patients—enabling them to use a broader scope of eye-related drugs.

As you are undoubtedly aware, optometrists are the only eye care practitioners available to Alaskans in many outlying communities. Not being authorized to administer certain oral and injectable agents often limits these doctors' ability to provide optimum care.

The vast majority of other states have enacted similar laws and their residents now realize a fuller benefit from the eye care profession.

Although I am licensed to practice in Alaska, I have had the privilege of working in other states where optometric physicians are authorized to use oral and injectable medications. From first hand experience, I can assure you that this has benefited the public at large. In my surgical treatment of thousands of patients referred by family optometric physicians, I have seen nothing but positive results come from these doctors being enabled to use oral and injectable pharmaceutical agents.

I thank you for carefully considering the positive implications this proposed legislation has for the citizens of Alaska.

My best regards,

Paul Shenk, MD

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