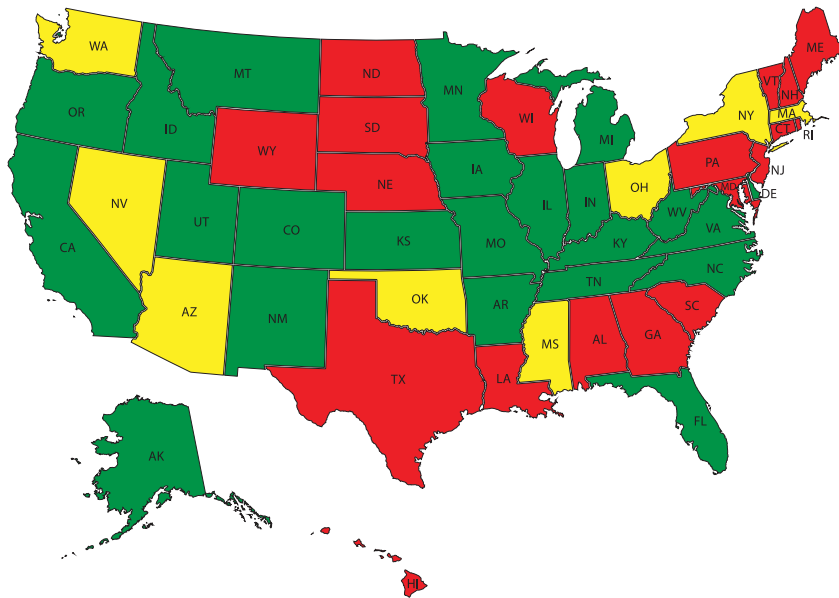


The ‘Test and Treat’ Shift: 2026

■ Alan A. Ayers, MBA, MAcc

WHERE PHARMACISTS CAN TEST AND TREAT



- **Direct Open Market:** Pharmacists can test a patient and prescribe medication (eg, antibiotics) on their own without a physician partner.
- **Active Battlegrounds:** States with active legislation in the House or Senate to authorize test-and-treat services.
- **Restricted Markets:** States where a pharmacist can only test and treat if they have a signed contract with a local physician.

“Test and treat” legislation at the state level is transforming pharmacists from dispensers into providers, authorizing them to diagnose and prescribe for conditions like flu, strep, and COVID-19 without physician oversight. As the map illustrates, this model is now active in more than 20 “direct open market” states (green), with legislation pending in key “battleground” states (yellow). *JUCM* first reported this disruption in 2015, and now the strategic intent is finally meeting regulatory reality.¹

As retail pharmacy declines, major chains are repurposing their highest-value resource—pharmacists—potentially using AI-automated dispensing as the catalyst. Many of these laws have passed under the radar in the last 3

years to solidify this new revenue channel.

However, significant concerns exist among urgent care clinicians:

- **Fails rural health:** The transformation ignores true primary care shortages, merely duplicating access already provided by urgent care and telemedicine.
- **Erodes safety:** Bypassing physical exams and differential diagnoses lowers the standard of care and risks antibiotic misuse.
- **Fragments care:** It encourages episodic “quick fixes” rather than integrated chronic disease management.
- **Ethical conflict:** It directs vulnerable patients into retail environments designed to cross-sell alcohol, tobacco, and lottery tickets rather than promote holistic health. ■



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Reference

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