Federal Judge Overturns Missouri COVID-Era Law Restricting Pharmacist Speech on Ivermectin and Hydroxychloroquine

A federal judge has struck down a Missouri law that barred pharmacists from proactively disputing doctors' COVID-19 prescriptions for drugs like ivermectin and hydroxychloroquine—a decision that critics warn undermined the authority of treating physicians and prioritized pharmacists' individual viewpoints over the integrity of the doctor-patient relationship.

The law, enacted during the tumult of the pandemic in 2022, prohibited pharmacists from contacting patients or physicians to challenge the efficacy of ivermectin or hydroxychloroquine unless the doctor or patient asked the pharmacist about the drug's efficacy first.

Missouri lawmakers who supported the measure described it as a safeguard for physician autonomy and a bulwark against what they viewed as pharmacist overreach into clinical decisions—especially at a time when treatments for COVID-19 were both rapidly evolving and deeply politicized.

However, in a March 28 order, U.S. District Judge Greg Kays ruled the law violated the First Amendment rights of pharmacists by restricting them from engaging in viewpoint-based speech. In the opinion, Kays characterized the statute as a "gag order" and emphasized that even factual, non-controversial information—such as the U.S. Food and Drug Administration's revocation of emergency use authorization—could not be conveyed under the law unless a pharmacist was explicitly asked.

Supporters of the ruling, including attorneys at the Hamilton Lincoln Law Institute who represented pharmacist Ashley Stock in the case, celebrated the decision as a victory for speech and scientific dissent. But the broader implications are more complex—and to many in the medical community, deeply troubling.

At the heart of the debate is a question that transcends partisan skirmishes over COVID-19 and reaches into the foundational structure of American health care: who should speak with authority in a patient's care?

Physicians, who spend years developing clinical acumen and cultivating one-on-one relationships with patients, are traditionally regarded as "learned intermediaries"—professionals uniquely positioned to contextualize treatment options within the broader landscape of a patient's health history, comorbidities, and lifestyle. In both legal and medical ethics contexts, this doctrine recognizes that a physician—not a pharmacist or drug manufacturer—is best equipped to evaluate the risks and benefits of a medication and communicate those to the patient

in a personalized manner. The Missouri statute was, in large part, an effort to preserve that central role.

The idea that a pharmacist—trained in pharmacology but often disconnected from the nuances of an individual patient's medical picture—could independently reach out to a patient and contradict their physician's judgment introduces serious risks, opponents of the ruling argue. While pharmacists play a vital role in ensuring safe dispensing practices and flagging contraindications, the Missouri law attempted to draw a line between legitimate pharmacist functions and unsolicited interventions that could erode trust in medical advice.

"The law wasn't about silencing dissent," one health policy attorney familiar with the case said. "It was about establishing appropriate boundaries. If a pharmacist has a concern, the proper avenue is a conversation with the prescribing physician—not direct engagement with the patient, which can feel like undermining or second-guessing the doctor's authority."

Those defending the law point to the unique nature of COVID-19 and the cultural environment in which these drugs became flashpoints. Ivermectin and hydroxychloroquine, both approved for other uses, became symbolic battlegrounds during the pandemic, with physicians caught in the crossfire between federal agencies issuing warnings and patients demanding access to alternative treatments they believed were being unfairly suppressed.

Missouri lawmakers who backed the law said they were responding to a flood of complaints from constituents whose access to treatment had been disrupted after pharmacists raised objections to doctor-issued prescriptions. In some cases, patients were told by pharmacists that their doctor's recommendations were "dangerous" or "irresponsible," according to testimony presented during legislative hearings. For lawmakers in Jefferson City, the issue was not whether the

drugs were effective, but whether pharmacists had the right—or the duty—to intervene in medical decisions without an invitation.

“We trust doctors to make these calls,” one source told The Vault Project. “If the FDA has concerns, they can communicate them to the public and to physicians. But pharmacists are not gatekeepers of truth in medicine—they’re part of a care team. This law was about preserving order in that team, not censorship.”

However, the federal court disagreed, siding with Ashley Stock, a Missouri pharmacist who said the law prevented her from fulfilling her professional and ethical obligations. Stock argued that she needed to be free to voice concerns about medications such as ivermectin and hydroxychloroquine, which she considered ineffective or harmful, particularly when scientific consensus or regulatory agencies advised against them.

The Missouri Board of Pharmacy, responsible for enforcing the law, has indicated that the ruling is under review. It remains unclear whether the state will appeal the decision. In the interim, pharmacists in Missouri are free to engage in unsolicited dialogue with patients, regardless of the physician’s guidance.

That change has sparked alarm among some physicians and medical associations, who fear the ruling could invite confusion and erode patient confidence in their doctors. Several doctors expressed concern that patients might now be more likely to abandon physician-prescribed treatments or question their care plans based on advice from a pharmacist unfamiliar with the complete medical profile.

“This is a victory for lawyers, not patients,” said one internist practicing in rural Missouri. “What patients need is clarity, trust, and continuity of care—not to be caught

between professionals giving conflicting messages about what to take and why.”

Moreover, the decision may open the door for broader legal challenges to professional speech restrictions across various medical and regulatory fields. While proponents of free speech herald the ruling as part of a broader trend toward deregulating discourse in medicine, others warn it could signal a retreat from consensus standards in patient care.

Still, defenders of ivermectin and hydroxychloroquine say the statute was never about truth—it was about power. They argue that the medical establishment rushed to discredit early treatment protocols and silenced clinicians who strayed from CDC guidance, leaving patients with fewer options during a time of crisis. From this view, pharmacists who challenged those narratives weren’t undermining care—they were participating in it.

Yet, even accepting that view, the question remains whether pharmacists should unilaterally intervene in the patient-doctor relationship. In most states, pharmacists can already refuse to fill prescriptions they believe are unsafe or illegal. The Missouri statute didn’t remove that right; it simply prohibited pharmacists from initiating unsolicited conversations about the doctor’s judgment, unless invited. Now that restriction is gone.