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Arkansas State Board of Pharmacy News

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New Web Site – PharmacyBoard.Arkansas.Gov

The Arkansas State Board of Pharmacy has an updated Web site with a new Web address and a completely new look. The new Web site adds more functionality than the old Web site. It includes direct links from the homepage to find a pharmacist or pharmacy, file a consumer complaint, send comments to the Board of Pharmacy office, update address and employment information, and sign up for eNews by clicking on the radio tower icon. The new Web site also includes a section for Hot Topics of current interest and has dates for upcoming events. The previous Web address for the Arkansas State Board of Pharmacy will automatically direct you to the Board's new site. To see the Board's new Web site, visit *http://pharmacyboard.arkansas.gov.*

Newsletter/Notification Changes

The Arkansas State Board of Pharmacy periodically sends out updates, *Newsletters,* current topics, and notifications by mail and/or e-mail. Previously, using quarterly *Newsletters,* the Board had to have two to three months lead time in order to pre-announce issues for upcoming events. During the June 2012 meeting, the Arkansas State Board of Pharmacy discussed these challenges as well as the costs involved with the preparation and delivery of mailed *Newsletters.* With an updated system that enables the Board to reach an exponentially greater number of permit holders and licensees, the Board voted to phase out the mailing of *Newsletters* in favor of sending electronic reminders of current issues as well as links to the quarterly *Newsletter* as posted on the Arkansas State Board of Pharmacy Web site. As a part of this process, it is important to ensure that your contact information is current with the Arkansas State Board of Pharmacy office including your e-mail address as a point of contact.

If you would like to check your contact information you may do so through the Board Web site by clicking on the *License Maintenance* link. Once you reach that screen, enter your license number, which includes PD as a designator for pharmacists and PT for technicians followed by a five-digit number. If your license only has four numbers then you put a zero in front of those four digits such as PD01234 for the number 1234. Also, per pharmacy regulations, do not forget to update your information if you move or change jobs.

Operation Spring Cleaning – Arkansas's Fourth Prescription Drug Take-Back Day

During the April 28, 2012 Drug Enforcement Administration (DEA)-sponsored National Prescription Drug Take-Back event, Arkansans returned an astounding 10,556 pounds of unused medication through the efforts of law enforcement agencies throughout the state. This collection brought the Arkansas take-back event totals to over 33,845 pounds of unused medications. Nearly 17 tons of unused medication was collected in Arkansas throughout the four take-back events, which were held during a four-hour window each day. This weight represents an estimated over 50 million pills and dosage units of medication and Arkansas has also been recognized with the following statistics from its take-back events:

Through four take-back events for the DEA region consisting of Alabama, Arkansas, Louisiana, and Mississippi, **Arkansas** (even as the least populated state):

- Led in weight collected, sites, and agencies for each of the four events
- Led in weight collected, sites, and participants (agencies) for the four events combined
- Accounted for 66.08% of the total weight taken in by this four-state region for the four events combined
- Almost doubled the weight taken in by the other three states combined
- Accounted for 53% of the region's total sites for the four events combined
- Had more sites than the other three states combined:
  - Arkansas – 615 sites; Alabama, Louisiana, and Mississippi combined – 543 sites
- Had more participants (agencies) than the other three states combined:
  - Arkansas – 536 participants; Alabama, Louisiana, and Mississippi combined – 420 participants

Once again, through the efforts of our law enforcement and partner agencies in Arkansas, our state has made a tremendous effort to address the prescription drug abuse problems that we face, especially with our youth. The Board looks forward to future efforts in this endeavor and hopes that you will encourage law enforcement in your own area to continue working with the Arkansas prescription drug take-back initiatives and take a look at *www.artakeback.org* for more information. The next DEA Prescription Drug Take-Back Day is scheduled to take place on Saturday, September 29, 2012, from 10 AM to 2 PM.

Expedited Partner Therapy – Message from the Arkansas Department of Health and the Arkansas State Board of Pharmacy

The two most commonly reported communicable diseases in the United States are gonorrhea and chlamydia, and Arkansas consistently ranks in the top 10 states for incidence of these infections. For Arkansas Department of Health patients with chlamydia, fewer than 40%

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FDA Warned Medical Practices About Counterfeits in US and Risks to Patients

In April 2012, Food and Drug Administration (FDA) sent letters to medical practices in several states requesting that they stop administering drugs purchased from any foreign or unlicensed source. FDA's letters were sent in response to the discovery that the medical practices purchased medications from foreign or unlicensed suppliers that sold illegal prescription medications. FDA has advised that these medical practices are putting patients at risk of exposure to medications that may be counterfeit, contaminated, improperly stored and transported, ineffective, and dangerous.

In an FDA statement, the agency urges the health care community "to examine their purchasing practices to ensure that they buy directly from the manufacturer or from licensed wholesale drug distributors in the United States." Further, FDA reminds health care providers, pharmacies, and wholesalers/distributors that they are valuable partners in protecting consumers from the threat of unsafe or ineffective products that may be stolen, counterfeit, contaminated, or improperly stored and transported. FDA advises that the receipt of suspicious or unsolicited offers from unknown suppliers should be questioned, and extra caution should be taken when considering such offers.

FDA notes that the "Verify Wholesale Drug Distributor Licenses" FDA Web page, available at *www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm281446.htm,* may be used to verify that a wholesale drug distributor is licensed in the state(s) where it is conducting business.

The FDA warning letters were sent following two incidences of counterfeit injectable cancer drugs found in US medical practices, one in February 2012, involving counterfeit Avastin® 400 mg/16 mL, and another in April 2012, involving a counterfeit version of Roche's Altuzan® 400 mg/16 ml (bevacizumab).

More information and a list of the medical practices that were sent warning letters are available on the FDA Web site at *www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm299920.htm.*

Rethink the Vial

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. *ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also an FDA MedWatch partner. Call 1-800/FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at* www.ismp.org. *ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.*

Recently, ISMP has been receiving many reports from consumers who report the pharmacy "shorted them" on a variety of opioid prescriptions. They report that when they call the pharmacy to complain about the missing number of tablets or capsules the pharmacy staff insists the proper quantity was dispensed. ISMP also receives reports from pharmacists reporting this same situation. The concern is that pharmacy personnel may be diverting the medication, the patient may be seeking more medication than what was prescribed, or some of the medication may be taken by someone else in the patient's home.

In the US, we dispense almost all oral solid drugs as loose tablets or capsules in a plastic vial that is labeled for the patient. This manner of dispensing makes diversion of a few tablets or capsules relatively easy. However, in many other countries, unit-dose and unit-of-use packaging is widely used.

It seems to reason that if unit-of-use, manufacturer-sealed containers or individual unit-dose packages of medications were used in the US for these drugs, diversion and/or speculation of diversion could be reduced. Manufacturers could produce unit-dose or unit-of-use packages, in numbered strips for ease of inventory and dispensing. Patients could be asked to sign for and agree to the amount dispensed at the point-of-sale. The numbered packaging would also help patients at home know if they had taken their medication or possibly alert them to diversion within their home. Of course, prescribers would need to prescribe quantities available in patient compliance packs or in multiples of that packaging, and insurance companies would have to pay for this specialized packaging.

Unit-of-use packs would provide other safety benefits. For example, patients would be able to verify the drug name on the label for each dose, which would add a redundancy in checking the pharmacy label to what was actually dispensed. Also, the manufacturer could print and attach the patient information sheet and/or medication guide to the package the patient receives, eliminating extra work in the pharmacy to print and supply these mandated education sheets to the patient.

It is evident that further steps must be taken to reduce and minimize abuse of prescription drugs. It is critical that education be provided to patients, caregivers, and health care providers to increase awareness about the dangers of prescription drug abuse and about ways to appropriately prescribe, dispense, store, and dispose of prescription medications. Development and deployment of consumer-friendly and environmentally responsible prescription drug disposal programs may also help to limit diversion (as well as reduce the risk of accidental ingestion) of drugs by family members and friends. FDA must continue its efforts to require new concepts for risk evaluation and mitigation strategies and provider education for opioid drugs. For more information on understanding prescription drug abuse, and to request *Parents' Guide to Understanding Prescription Drug Abuse* brochures for distribution to your patients, visit *www.SafeguardMyMeds.org.*

Counterfeit Vicodin ES Sold Via Rogue Internet Drug Outlet, Abbott Reports

In March 2012, Abbott warned consumers and health care providers about counterfeit Vicodin® ES purchased via the Internet. Abbott reports that the counterfeit product drug and package do not match that of Abbott's FDA-approved Vicodin ES (hydrocodone bitartrate and acetaminophen). Descriptions and images of the counterfeit product and authentic Vicodin ES are shown in a consumer alert posted on the Abbott Web site at *www.abbott.com/vicodin-consumer-alert.htm.* Abbott advises that anyone who has the counterfeit ver-

sion should stop taking the product. Further, consumers who suspect a product to be counterfeit or have questions about the legitimacy of Vicodin ES are encouraged to make a report to FDA Office of Criminal Investigations (OCI) by calling 800/551-3989 or by completing the online form on the OCI Web site at *www.accessdata.fda.gov/scripts/email/oc/oci/contact.cfm.*

PSM LEADER's Guide Offers Tips for Protecting Patients from Counterfeits

The Partnership for Safe Medicines (PSM) released a guide to assist health care providers in protecting patients from counterfeit drugs and recognizing the signs that may indicate use of counterfeits. Three versions of the *LEADER's Guide* – including one for nurses, one for doctors, and another specific to pharmacists – are available for download from the PSM Web site at *www.safemedicines.org/resources-for-healthcare-professionals.html*. Each guide provides tips specific to these health care provider roles and includes guidance for safe sourcing of medications, evaluating suspect medications, educating patients about counterfeit drugs and the risks of ordering drugs online, and reporting suspected counterfeit drugs.

FDA Urges Providers to Help Prevent Children's Accidental Exposure to Fentanyl Patches

FDA issued a safety alert reminding patients, caregivers, and health care providers to appropriately store, use, and dispose of fentanyl patches to prevent children's accidental exposure to the medication, which is potentially life-threatening. FDA recently evaluated a series of 26 cases of pediatric accidental exposures to fentanyl patches reported over the past 15 years, and determined that 10 of the cases resulted in death, and 12 in hospitalization. In addition, 16 of the 26 cases occurred in children two years old or younger.

FDA warns that young children may be at risk for accidental exposure when fentanyl patches are discarded in trash receptacles, or when children find lost or improperly stored patches. Young children can be harmed when they place the patches in their mouths or stick the patches to their skin. In addition, young children are at risk of exposure when being held by someone wearing a partially detached patch that can then transfer to the child. Exposure of young children to a fentanyl patch can lead to serious adverse events and even death, due to the amount of fentanyl present in the patches. FDA stresses that harm can even occur with used patches because they may still contain a considerable amount of fentanyl.

To prevent accidental exposure, FDA advises that patients securely store needed fentanyl patches out of children's reach and sight. When applying a patch, FDA also recommends that patients consider covering the fentanyl patch with an adhesive film to make sure the patch does not come off. Finally, FDA recommends checking throughout the day to make sure that the patch is still in place.

Further, FDA advises that used or unneeded patches are properly disposed. FDA recommends that the adhesive side of the patch should be folded together and then the patch should be flushed down the toilet. FDA notes that the agency "recognizes that there are environmental concerns about flushing medicines down the toilet. However, FDA believes that the risk associated with accidental exposure to this strong narcotic medicine outweighs any potential risk associated with disposal by flushing. When the patches are no longer needed, disposing by flushing completely eliminates the risk of harm to people in the home."

FDA urges health care providers to educate patients and their caregivers about the appropriate use and disposal of fentanyl patches. FDA's consumer Web page provides detailed information for patients and caregivers and is available at *www.fda.gov/ForConsumers/ConsumerUpdates/ucm300803.htm.* Providers, patients, and caregivers are also encouraged to review the fentanyl patch product label for instructions. The FDA safety alert is available at *www.fda.gov/Drugs/DrugSafety/ucm300747.htm.* Additional consumer information about safe medication use and storage, and the importance of proper disposal of unneeded medications, is available on the AWAR$_X$E® Web site at *www.awarerx.org/informedSiteMap.php.*

Providers Asked to Advise Patients of Acetaminophen Safe Use Steps

With a world of conditions and hundreds of medicines, the Acetaminophen Awareness Coalition asks pharmacists and other health care providers to educate patients and caregivers about the proper use of medications containing acetaminophen. As the most common drug ingredient in America, acetaminophen can be found in over 600 medicines, including many prescription and over-the-counter medicines. The coalition notes that when used as directed, acetaminophen is safe and effective. The coalition asks providers to advise patients that there is a daily dosage limit for acetaminophen and that taking more than directed is an overdose and can lead to liver damage.

The coalition calls on health care providers to participate in the Know Your Dose campaign, by reminding all patients and caregivers to (1) always read and follow the labels on their medicines; (2) know if a medicine contains acetaminophen; and (3) never take or administer two medicines that contain acetaminophen at the same time. Additional medication safety tips for consumers and more information about the Know Your Dose campaign are available on the "OTC Medication Use" page of the AWAR$_X$E Web site at *www.awarerx.org/OTCMedUse.php.* The AWAR$_X$E consumer protection program and the National Association of Boards of Pharmacy® (NABP®) are part of the Acetaminophen Awareness Coalition.

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of their partners came in for treatment in 2010, with this percentage being even lower for partners of patients diagnosed with gonorrhea. These infections are easy to treat, yet more than half of partners to patients with confirmed infections go untreated.

Expedited Partner Therapy (EPT) is "the practice of treating the sex partners of persons with sexually transmitted diseases (STD) without an intervening medical evaluation or professional prevention counseling" (Centers for Disease Control and Prevention (CDC), 2006) and has been proven to increase treatment rates and decrease re-infection rates. Since 2005, the CDC has recommended the use of EPT as an option for treating partners of patients diagnosed with chlamydia or gonorrhea. EPT is particularly effective for these two infections because each can be treated with a single oral dose of appropriate antibiotic (azithromycin or cefixime, respectively) with minimal risk of side effects or allergic reactions.

In April 2012, the Arkansas State Medical Board granted a specific waiver to the Arkansas Code State Medical Board Regulation 2(8) to allow physicians to prescribe EPT for a person with whom the physician has not established a proper physician/patient relationship. The Prescriptive Authority Committee of the Arkansas State Board of Nursing has also indicated support for the waiver. Ideally the prescriber electing to utilize EPT will write the prescription in the name of the partner to be treated. However, in cases where the name of the sexual partner is unknown, the Arkansas State Board of Pharmacy approves the following prescription labeling:

1. Label the treated patient's prescription by the patient's own name.
2. Label the untreated partner's prescription by the treated patient's name immediately followed by the word "Partner." For example, for the treated patient – "Joe Smith," then for the untreated patient – "Joe Smith's Partner."*
3. Assign a separate and unique identifying number to each prescription and clearly identify this number on each corresponding prescription label.

* Only prescriptions bearing the actual name of the patient can legitimately be billed to third-party payers. Therefore, prescriptions labeled as per No. 2 above would be cash pay only.

Golden Certificates Presented

The Arkansas State Board of Pharmacy presented Golden Certificates to honor the following pharmacists during the Arkansas Pharmacists Association Annual Meeting on June 23, 2012.

Frederick Robert Baggett	Don Kenneth Hall
Charles Foster Baker	Harold Delton Lewis
Amos Wayne Baker	John Roscoe Massey
Robert Edward Beard	James Darrell McMellon
Jack Lyndal Burson	John Richard Page
Norman Francis Canterbury	Rodney Dale Prince
Bernie Patterson Cook, Jr	John Burt Ragland
James Gerard Crone	James Rutledge Rankin
William Stayton Dorsey	Ruel Norwood Rothwell
Louie Frank Dudley	William Frank Slaughter
Herman Larry Dunn	Stephen Rex Smith
Gary Dean Grammer	Charles Edward Wimberly

These pharmacists were all recognized for 50 years of service as licensed pharmacists in Arkansas. This honor also includes the bonus consideration that Golden Certificate holders are able to renew their licenses each biennium for free. Congratulations and thank you for your service.

Special Notice About the Arkansas State Board of Pharmacy Newsletter

The Arkansas State Board of Pharmacy has designated this *Newsletter* as an official method to notify pharmacists licensed by the Board about information and legal developments. Please read this *Newsletter* and keep it for future reference because this *Newsletter* will be used in hearings as proof of notification of the *Newsletter's* contents. Please contact the Board office at 501/682-0190 or asbp@arkansas.gov if you have questions about any of the articles in this *Newsletter.*

Arkansas Pharmacy Support Group Help Line
870/636-0923

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