October 2013

News

Arizona State Board of Pharmacy

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Influential Pharmacist Passes

Albert Stanley Sirota

Stan Sirota passed away on August 25, 2013, at his home with his beloved wife by his side. He was born on August 31, 1931, in Kankakee, IL. He married his high school sweetheart Jean Giguere on December 23, 1950. Stan joined the United States Navy that same year and attended training at the Great Lakes Naval Hospital in Illinois. His military service included serving on several ships in the Far East, combat corpsman in the US Marine Corps, and on the staff of the Yokosuka Naval Hospital in Japan. Upon honorable discharge from the US Navy, Stan attended the College of Pharmacy at the University of Illinois. He graduated in 1959, and subsequently owned and operated two drug stores in the Chicago, IL, suburbs. In August 1970, Stan, Jean, and their five sons moved to Scottsdale, AZ, where Stan owned and operated several pharmacies in Scottsdale and Phoenix, AZ.

Perhaps most noteworthy as it relates to the Arizona State Board of Pharmacy is the fact that Stan had a passion for helping people with chemical dependency issues and served for six years on the board of directors at the New Arizona Family Residential Drug Treatment Program. He was also actively involved in several other local residential and outpatient chemical dependency programs. For several years Stan also anonymously aided members of his own profession. He assisted impaired pharmacists by finding treatment programs for them, expediting the admission process, and working with them so that they were able to obtain much needed treatment. As a result of Stan's dedication, many of these pharmacists were allowed to retain their pharmacist licenses contingent upon completion of their rehabilitation programs. After serving his fellow colleagues anonymously for nine years, his activities evolved into the "PAPA" program, which is the acronym for Pharmacists Assisting Pharmacists of Arizona. Llyn Lloyd, Mike Henry, and Ed Saba worked with Stan to design and implement the program, which still exists and serves pharmacists and pharmacy technicians today.

Stan received numerous awards, honors, and accolades during his career. Perhaps the most emblematic of his distinguished career is the Bowl of Hygeia Award for public service. This award is the most prestigious award given to practicing pharmacists by their peers. Seldom does a single pharmacist have such an enormous impact on the lives and careers of his or her pharmacist colleagues as did Stan Sirota.

News Regarding Hydrocodone/Acetaminophen Products

The following content includes communications from and medication information published by AbbVie, a major manufacturer of these products, and is reprinted at AbbVie's request.

This communication is to inform you of two key changes to AbbVie's Vicodin® (hydrocodone bitartrate and acetaminophen tablets, USP) formulations and potential dispensing errors that may warrant your attention. Before explaining these changes, there are a couple of points to communicate regarding Vicodin products. As you may know, Vicodin **5 mg/300 mg,** Vicodin ES® **7.5 mg/300 mg,** and Vicodin HP® **10 mg/300 mg** tablets are indicated for the relief of moderate to moderately severe pain. It is also important to note a **safety consideration** related to hepatotoxicity: acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most cases of liver injury are associated with doses that exceed 4,000 mg/day.[1]

On January 13, 2011, US Food and Drug Administration (FDA) asked drug manufacturers to limit the strength of acetaminophen in prescription drug products, including combination acetaminophen and opioid products, to no more than 325 mg per tablet, capsule, or other dosage unit. FDA has stated that limiting the amount of acetaminophen per dosage unit in prescription products may reduce the risk of severe liver injury from acetaminophen overdosing.[2] (Please visit the FDA Web site for more information on acetaminophen dosing: *www.fda.gov/Drugs/DrugSafety/ucm239821.htm.*)

As a result of this mandate, in May 2012, Abbott (now AbbVie) discontinued the manufacturing and distribution of its original formulations of Vicodin (Vicodin **5 mg/500 mg,** Vicodin ES **7.5 mg/750 mg,** and Vicodin HP **10 mg/660 mg),** which contained higher strengths of acetaminophen. **In October 2012, Abbott introduced into the market a reformulated Vicodin that is a generic and contains 300 mg of acetaminophen per tablet together with varying strengths of hydrocodone.**

AbbVie's Vicodin reformulations have each been introduced as generic products. This means that patients will pay a generic co-pay for AbbVie's Vicodin products and the retailer/pharmacy will be reimbursed for a Tier 1 generic, even though the products retain the "Vicodin" trade name that was previously associated with the original branded Vicodin formulations.

Additionally, AbbVie's reformulated Vicodin has different National Drug Code (NDC) numbers that are not interchangeable with the NDCs of the original Vicodin formulations. The NDCs for the original Vicodin formulations have been delisted, as those products were discontinued approximately one year ago. Prescribers sometimes write prescriptions for the hydrocodone/acetaminophen combination as "Vicodin," "Vicodin ES," or "Vicodin HP" and do not include specifics for product strength.[3] It has come to our attention that some of these prescriptions are being filled with product that contains acetaminophen content other than 300 mg, the strength contained in the reformulated Vicodin. These pharmacists are also

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Enteric-Coated Aspirin Recalled for Potential Acetaminophen Mix-Up

In June 2013, Advance Pharmaceutical Inc initiated a voluntary recall of Rugby Laboratories label enteric-coated aspirin tablets, 81 mg (Lot 13A026; expiration date: January 2015) due to a complaint that a bottle labeled with this product name actually contained acetaminophen 500 mg tablets. This over-the-counter (OTC) product is packaged in bottles of 120 tablets with National Drug Code 0536-3086-41 and Universal Product Code 3 0536-3086-41 9. The affected lot was distributed nationwide by Rugby Laboratories to wholesalers and retailers. The manufacturer warns that inadvertently taking acetaminophen, 500 mg, instead of enteric coated aspirin, 81 mg, according to the directions on the label, can lead to an acetaminophen overdose and potential severe liver damage. The manufacturer indicates that consumers who take the dosage as indicated on the defective product labeling may be ingesting up to 24,000 mg of acetaminophen, which is about six times the maximum recommended daily dose of acetaminophen (4,000 mg).

Consumers who have bottles from the affected lot should stop using the product and return it to the pharmacy or store where it was purchased and should contact a health care provider if they are experiencing any problems that may be related to using the product. Food and Drug Administration (FDA) notes that any adverse reactions related to the use of the product should be reported to FDA's MedWatch Program. More information about this recall is available on the FDA Web site at *www.fda.gov/Safety/Recalls/ucm357909*.

Barcoding Technology for Community Pharmacy

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.*

Barcoding technology is well-established in industries outside of the health care sector and is now being used within health care to enhance efficiency and safety, and in pharmaceutical wholesale operations to improve supply chain inventory and efficiency. Numerous studies prove the effectiveness and cost benefits of using barcoding technology during the drug dispensing process. About 75% of wrong drug or wrong dose errors are captured and corrected using barcode technology[1] and there is sufficient evidence that barcode scanning is becoming the standard of practice in pharmacies.

Although barcoding technology is mature with abundant evidence regarding its effectiveness, a 2006[2] study showed that only half (53.5%) of United States community pharmacies utilize a barcode scanner for verification/identification of medications. The study also revealed significantly lower adoption in independent pharmacies (11.5%) compared to chain pharmacies (62.6%).

According to a survey conducted by ISMP in 2009, the most frequently reported reasons for implementing barcode scanning for product verification included a desire to improve the accuracy and safety of the dispensing process, the ease with which the technology fits with pharmacy workflow, improvement of staff efficiency and inventory control, and a belief that the technology was necessary to stay in business. The most common reasons for **not** implementing barcode scanning for product verification, other than cost, included uncertainty regarding the "right" vendor product, satisfaction with the current system (without barcode product verification), and perceptions that the technology would reduce staff efficiency.

ISMP has developed a tool, Assessing Barcode Verification System Readiness in Community Pharmacies, to help address the reasons why barcode scanning has not been implemented and to facilitate the adoption of this technology in an estimated 27,327 community pharmacies that do not currently utilize it for product verification.

Given the resource commitment to purchase barcoding systems and the potential for technology to have a profound effect upon the work environment, this tool will help community pharmacy managers and owners better understand the issues related to barcode product verification systems. It will also help managers assess the pharmacy's readiness for the technology, prepare for the selection of a system, and implement the technology effectively.

Barcode scanning to verify prescription products prior to dispensing improves the safety and quality of pharmacy care provided to patients and increases efficiency during the provision of pharmacy services. Although technology should not be seen as a panacea, it can be a useful tool when used appropriately and combined with other patient safety strategies.[3] Does your pharmacy use barcode technology for product verification? If not, please access this free tool, at *www.ismp.org/AHRQ/Default.asp?link=sa.*

[1]*Cochran GL, Jones KJ, Brockman J, Skinner A, et al. "Errors prevented by and associated with barcode medication systems." Joint Comm J Qual Pt Safety. 2007;33(5):293-301.*

Ukens C. "New study sheds light on medication errors." Drug Topics. 2002;146(21):33.

[2]*Skrepnek GH, Armstrong EP, Malone DC, Abarca J, et al. "Workload and availability of technology in metropolitan community pharmacies." J Amer Pham Assoc. 2006; 46(2):154-160.*

[3]*American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices. "Pathways for medication safety: assessing bedside bar-coding readiness." 2002. Accessed on October 15, 2010 at:* www.ismp.org/selfassessments/PathwaySection3.pdf.

ISMP Launches Medication Safety Alert! Newsletter Tailored for LTCFs

ISMP has launched a new *ISMP Medication Safety Alert!* publication, *Long-Term Care Advise-ERR,* as a means to provide medication error prevention information tailored to assist staff and providers in long-term care facilities (LTCFs).

With *ISMP Medication Safety Alert!* publications making a significant impact on preventing medication errors, ISMP is now providing this new resource tailored to LTCFs. ISMP notes that medication errors reported to ISMP Medication Errors Reporting Program include reports from LTCFs. More information and a link to subscribe to this new publication are available in the Newsletters section of the ISMP Web site at *www.ismp.org/newsletters/longtermcare.*

FDA Warns of Rare Skin Reactions in Patients Taking Acetaminophen

FDA has issued a consumer update that warns of rare but serious skin reactions that may occur in patients taking acetaminophen. These complications include three serious skin reactions: Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and acute generalized exanthematous pustulosis (AGEP). SJS and TEN can both be fatal, and usually require hospitalization. Patients suffering from AGEP commonly recover within a few weeks after they stop taking the medication that caused the reaction.

Symptoms of these conditions include skin rashes, blisters, and widespread damage to the surface of the skin. Patients taking acetaminophen or other compounds that contain acetaminophen should be advised to stop taking the medication if they experience such symptoms and should consult their health care providers or seek an emergency department immediately.

FDA emphasizes that this information should be viewed within the context of millions of patients who, over generations, have used and benefited from acetaminophen and stresses that severe allergic skin reactions are an extremely rare condition. Further, the agency notes that many medications can cause allergic reactions, and skin allergy warnings have already been added to the drug labels of other categories of OTC analgesics including ibuprofen and naproxen. "This new information is not intended to worry consumers or health care professionals, nor is it meant to encourage them to use other medications," said Sharon Hertz, MD, deputy director of FDA's Division of Anesthesia, Analgesia, and Addiction Products. "However, it is extremely important that people recognize and react quickly to the initial symptoms of these rare but serious side effects, which are potentially fatal." The full consumer update is available on the FDA Web site at *www.fda.gov/ForConsumers/ConsumerUpdates/ucm363010.htm.*

Reminder to Purchase Drugs Only from Licensed Wholesalers, Including VAWD-Accredited Wholesale Distributors

To ensure that patients are receiving safe, FDA-approved medications, pharmacists and other health care providers should purchase prescription drugs either directly from the manufacturer or from wholesale drug distributors licensed in the US as advised by FDA. The agency provides a list of state agencies for assistance in verifying licensure at *www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm281446.htm*.

Another way that pharmacies can be assured of the legitimacy of a wholesale distributor is to look for the National Association of Boards of Pharmacy® (NABP®) Verified-Accredited Wholesale Distributors® (VAWD®) Seal. Those wholesale distributors that achieve VAWD accreditation are in compliance with state and federal laws and NABP's VAWD criteria. NABP has recently revised the VAWD criteria to allow virtual manufacturers and virtual wholesale distributors – a growing segment of the pharmaceutical wholesale industry – to qualify for VAWD, as well as to implement other changes aimed to help to ensure that the drug supply chain remains secure.

The revised VAWD criteria responds to changing business models and helps safeguard drugs in distribution at a time when there is an increased risk of counterfeit and substandard drugs entering the legitimate US drug supply chain. In particular, the criteria have been revised to provide stronger assurance that drugs diverted from pharmacies and unlawful sources are prevented from entering into the supply chain.

For a listing of VAWD-accredited facilities, please visit *www.nabp.net/programs/accreditation/vawd.*

Voluntary Recall of Unexpired Sterile Products After Reports of Adverse Events

FDA has announced a voluntary recall of all lots of unexpired sterile products produced by Specialty Compounding, LLC, in Cedar Park, TX. FDA received reports of 15 adverse events at two hospitals (Corpus Christi Medical Center Doctors Regional and Corpus Christi Medical Center Bay Area) potentially related to the use of these sterile products. Affected patients received an intravenous infusion of calcium gluconate supplied by the company.

Patients who were administered the injectable drug products are at risk of life-threatening infections. The recall applies to all unexpired sterile compounded medications dispensed by the company, including all strengths and dosage forms. Recalled products were distributed directly to hospitals and physicians' offices in Texas, and to patients located nationwide (with the exception of North Carolina). No calcium gluconate was shipped outside the state of Texas. Health care providers and patients should stop using all recalled products and return them to Specialty Compounding.

Veterinarians Not Eligible for NPIs, CMS Clarifies

Centers for Medicare and Medicaid Services (CMS) has become aware of cases in which veterinarians are told, incorrectly, that they must provide a National Provider Identifier (NPI) number for prescriptions they have written to be dispensed. The agency has issued a clarification, stressing that veterinarians do not meet the regulatory definition of "health care provider," and thus may not obtain NPI numbers. The clarification also states that "Any entity that insists veterinarians obtain an NPI [is] attempting to require veterinarians to obtain NPIs fraudulently." CMS also notes that "if a veterinarian fulfills the definition of 'health care provider' in a profession other than furnishing veterinary services," such as if they are also a nurse practitioner, "the veterinarian would be eligible for an NPI but would select a Nurse Practitioner code (not a Veterinarian code) from the Healthcare Provider Taxonomy Code Set when applying for an NPI."

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reporting that they are making this substitution without consultation with the prescribing physician.[3]

According to FDA, drug products are considered pharmaceutical equivalents if they are identical with regard to active ingredients, dosage form and route of administration, and strength or concentration.[4]

In both "Orange Book" states and *Professional Judgment* states, pharmacists are required to call the prescriber before dispensing any product that is not a pharmaceutical equivalent to the product prescribed.

When pharmacists receive a prescription for Vicodin, Vicodin ES, or Vicodin HP and the strength is not included, the pharmacist should dispense a product containing 300 mg of acetaminophen or call the prescribing physician to clarify. In addition to AbbVie's Vicodin, there are at least two other distributors with FDA-approved products that contain hydrocodone and 300 mg acetaminophen. Dispensing a hydrocodone/acetaminophen product that contains an acetaminophen strength associated with the original Vicodin will result in patients receiving an additional amount of acetaminophen that may not have been intended by the prescriber. According to FDA, acetaminophen can cause serious liver damage if more than directed is used.[2]

Rx written[1]	If you dispense (instead of a substitutable 300 mg acetaminophen tablet): hydrocodone/ acetaminophen	Excess acetaminophen per tablet	Excess acetaminophen per day as per maximum daily dose
Vicodin or Vicodin 5	5 mg/500 mg[5]	200 mg	1,600 mg
Vicodin ES or Vicodin 7.5	7.5 mg/750 mg[6]	450 mg	2,700 mg
Vicodin HP or Vicodin 10	10 mg/660 mg[7]	360 mg	2,160 mg

AbbVie is committed to patient safety and to providing appropriate access to its products. We continue making efforts to ensure that pharmacists are aware of the changes to the Vicodin product line, and we appreciate any assistance you can provide in educating pharmacists in order to address any potential dispensing errors that may be occurring. AbbVie thanks you for your support, and asks that you please consider disseminating this information to inspectors and pharmacists as you deem appropriate.

The following information is reprinted from the relevant patient mediation information.

Indication[1,5-7]

Vicodin **5 mg/300 mg,** Vicodin ES **7.5 mg/300 mg,** Vicodin HP **10 mg/300 mg,** Vicodin **5 mg/500 mg,** Vicodin ES **7.5 mg/750 mg,** and Vicodin HP **10 mg/660 mg** (hydrocodone bitartrate and acetaminophen tablets, USP) tablets are indicated for the relief of moderate to moderately severe pain.

Important Safety Information[1, 5-7]

Boxed Warning

Hepatotoxicity: Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with the use of acetaminophen at doses that exceed 4,000 milligrams per day, and often involve more than one acetaminophen-containing product.

Contraindications

Vicodin, Vicodin ES, and Vicodin HP tablets are contraindicated in patients previously exhibiting hypersensitivity to hydrocodone or acetaminophen, and also in patients known to be hypersensitive to other opioids, as they may exhibit cross-sensitivity to hydrocodone.

Warnings

Controlled Substance (CS): Vicodin, Vicodin ES, and Vicodin HP contain hydrocodone, which is an opioid agonist and a Schedule III CS with an abuse liability.

Abuse and Dependence: Vicodin, Vicodin ES, and Vicodin HP can be abused in a manner similar to other opioid agonists, legal or illicit. Psychological dependence, physical dependence, and tolerance may develop upon repeated administration of narcotics; therefore, these products should be prescribed and administered with caution.

Hypersensitivity/Anaphylaxis: There have been post-marketing reports of hypersensitivity and anaphylaxis associated with use of acetaminophen.

Respiratory Depression: At high doses or in sensitive patients, hydrocodone may produce dose-related respiratory depression.

Head Injury and Increased Intracranial Pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury or other intracranial pressure.

Acute Abdominal Conditions: The administration of narcotics may obscure the diagnosis or clinical course of patients with acute abdominal conditions.

Precautions

As with any narcotic, special caution should be used when prescribing hydrocodone to elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy, or urethral stricture. Caution should also be exercised with patients who are likely to take other acetaminophen-containing medications, antihistamines, antipsychotics, anti-anxiety agents, other narcotic analgesics, or other central nervous system depressants (including alcohol) concomitantly. When combined therapy is contemplated, the dose of one or both agents should be reduced. Hydrocodone, like all narcotics, may impair mental and/or physical abilities required for the performance of potentially hazardous tasks, such as driving a car or operating machinery.

The use of monoamine oxidase inhibitors or tricyclic antidepressants with hydrocodone preparations may increase the effect of either the antidepressant or hydrocodone.

Vicodin, Vicodin ES, and Vicodin HP tablets should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Babies born to mothers who have been taking opioids regularly prior to delivery will be physically dependent. Administration to the mother during labor or shortly before delivery may result in some degree of respiratory depression in the newborn.

Adverse Reactions

The most frequently reported adverse reactions include lightheadedness, dizziness, sedation, nausea, and vomiting. Prolonged administration may produce constipation.

Dosage and Administration

- **Vicodin 5 mg/300 mg:** The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total daily dosage should **not exceed eight tablets.**
- **Vicodin ES 7.5 mg/300 mg:** The usual adult dosage is one tablet every four to six hours as needed for pain. The total daily dosage should **not exceed six tablets.**
- **Vicodin HP 10 mg/300 mg:** The usual adult dosage is one tablet every four to six hours as needed for pain. The total daily dosage should **not exceed six tablets.**

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Dosage and Administration

- **Vicodin 5 mg/500 mg:** The usual adult dosage is one or two tablets every four to six hours as needed for pain. The total daily dosage should **not exceed eight tablets.**
- **Vicodin ES 7.5 mg/750 mg:** The usual adult dosage is one tablet every four to six hours as needed for pain. The total daily dosage should **not exceed five tablets.**
- **Vicodin HP 10 mg/660 mg:** The usual adult dosage is one tablet every four to six hours as needed for pain. The total daily dosage should **not exceed six tablets.**

References: *1. VICODIN, VICODIN ES, VICODIN HP 5, 7.5, 10 mg (hydrocodone)/300 mg (acetaminophen) [package insert]. 2. US Department of Health and Human Services. FDA drug safety communication. FDA Web site.* www.fda.gov/Drugs/DrugSafety/ucm239821.htm. *Accessed June 13, 2013. 3. Data on file, AbbVie Inc. 4. US FDA, Center for Drug Evaluation and Research. Approved Drug Products with Therapeutic Equivalence Evaluations. 33rd ed.* www.fda.gov/downloads/Drugs/DevelopmentApprovalProcess/UCM071436.pdf. *Accessed January 14, 2013. 5. VICODIN 5 mg (hydrocodone)/500 mg (acetaminophen) [package insert]. 6. VICODIN ES 7.5 mg (hydrocodone)/750 mg (acetaminophen) [package insert]. 7. VICODIN HP 10 mg (hydrocodone)/660 mg (acetaminophen) [package insert].*

Editor's Note: The above article has been lightly edited for American Medical Association and *Arizona State Board of Pharmacy Newsletter* style only; the content has not been altered. Portions of this communication are available at *www.vicodin.com.*

License and Permit Renewal Time Again

Renewal of permits and licenses that expire on October 30, 2013, started on September 4, 2013. Please contact the Board office by telephone or e-mail if you have questions or do not receive your renewal information. You can also visit this hyperlink to renew: *https://az.gov/app/pharmacy/index.xhtml.*

Disciplines – Licensees

Pharmacists

Allen, Casey (S014694) – Probation terminated. Effective June 27, 2013.

Erickson, Janice (No No. Issued) – Application for licensure denied. Effective June 27, 2013.

Intern

Miller, Anthony (I010349) – Revoked. Effective June 27, 2013.

Pharmacy

Advantage Medical Pharmacy – MS (Y005681) – Application for licensure denied. Effective June 27, 2013.

Disciplines Affecting Prescribing and Modifications – Other Health Care Boards

Arizona Medical Board (MDs)

Gettel, Roy R. (MD 11015) – Non-Disciplinary – *Consent Agreement for Practice Limitation* – Physician's practice is limited in that he shall not practice medicine in the state of Arizona and is prohibited from prescribing any form of treatment including prescription medications until physician applies to the Board and receives permission to do so. Effective June 21, 2013.

Holden, Paul Kenneth (MD 43170) – Non-Disciplinary – *Interim Consent Agreement for Practice Limitation* – Physician's practice is limited in that he shall not practice medicine in the state of Arizona and is prohibited from prescribing any form of treatment including prescription medications until physician applies to the Board and receives permission to do so. Effective July 23, 2013.

McGroarty, John J. (MD 6345) – *Consent Agreement for Practice Restriction* – Respondent shall not practice medicine and is prohibited from prescribing any form of treatment, including prescription medications, in Arizona. Respondent shall not seek to renew his Arizona medical license and shall not reapply for an Arizona medical license for a period of five years from the effective date of this order. Effective June 10, 2013.

McKinney, Michael (MD 24574) – Inactivation of License With Cause. Effective August 13, 2013.

Schold, Alan C. (MD 29169) – Letter of Reprimand and Consent Agreement for Practice Restriction and Probation – Respondent is placed on probation for two years with set terms and conditions. Among the terms and conditions, for a period of two years, respondent is prohibited from prescribing any CS, and may only dispense or utilize CS on patients undergoing surgical/diagnostic procedures. Effective June 10, 2013.

Sirkin, Sara R. (MD 13969) – *Consent Agreement for Practice Restriction* – Respondent's practice is restricted with set terms and conditions. Among the terms and conditions, respondent shall not practice medicine in the state of Arizona and is prohibited from prescribing any form of treatment including prescription medications until the Board has determined respondent is safe to practice medicine. Effective June 10, 2013.

Arizona State Board of Dental Examiners (DDSs, DMDs)

Bashara, Timothy J. (DMD D5688) – Amended Stipulation Agreement – Dr Bashara is no longer required to provide meeting logs. Dr Bashara's prescribing privileges are no longer restricted and he is eligible to apply for a license through Drug Enforcement Administration (DEA). Effective August 5, 2013.

Bernath, David J. (DDS D06565) – License is fully restored. Effective June 27, 2013.

Hatch, Alexander C. (DDS D7073) – Amended Stipulation Agreement – Dr Hatch's license to practice dentistry is placed on probation for five years with set terms and conditions. Among the terms and conditions, Dr Hatch's prescribing privileges for Schedule II and III CS are restricted. At the end of two years under the restriction, Dr Hatch may request the Board to lift the restriction. Effective August 28, 2013.

Kloss, David (DDS D5650) – Amended Stipulation Agreement – Dr Kloss is no longer required to provide meeting logs. Dr Kloss's prescribing privileges are no longer restricted and he is eligible to apply for a license through DEA. Effective August 5, 2013.

Wismann, Enrique G. (DMD D6905) – Amended Stipulation Agreement – Dr Wismann is no longer required to provide meeting logs. Dr Wismann's prescribing privileges are no longer restricted and he is eligible to apply for a license through DEA. Effective June 11, 2013.

Arizona Regulatory Board of Physician Assistants (PAs)

Teague, Linda (PA 1883) – *Interim Consent Agreement for Practice Restriction* – Physician assistant's practice is restricted in that she shall not perform health care tasks in the state of Arizona and is prohibited from prescribing any form of treatment including prescription medications until physician assistant applies to the Board and receives permission to do so. Effective August 20, 2013.

The *Arizona State Board of Pharmacy News* is published by the Arizona State Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, to promote compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of the Foundation or the Board unless expressly so stated.

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