



New Mexico Board of Pharmacy

Published to promote compliance of pharmacy and drug law

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Season's Greetings!

2014 Board Meeting Schedule

Five two-day New Mexico Board of Pharmacy meetings are scheduled for 2014. Four of the five meetings will be held at the Board office. When held at the Board office, the meetings are scheduled for Thursday and Friday. One meeting is to be held in Ruidoso, NM. This meeting will be held on Monday and Tuesday. The Board encourages attendance by licensees and the public. Remember, licensees may obtain credit of one contact hour per year, in the subject area of pharmacy law, by attending one full day of a regularly scheduled Board meeting or by serving on a Board-approved committee. If you wish to obtain credit for attending a Board meeting, please notify Board staff prior to the meeting. The agenda for each Board meeting is posted on the Board Web site. The following meetings are scheduled:

- ◆ January 16-17, 2014
- ◆ April 17-18, 2014
- ◆ June 19-20, 2014
- ◆ August 25-26, 2014, Ruidoso Board Meeting
- ◆ October 16-17, 2014

State Drug Inspector

There is an opening for the position of state drug inspector (RLD #3952). If you are interested, please apply online with the New Mexico State Personnel Office. Questions regarding the position should be directed to Mary James, human resources manager, Human Resources Bureau, Regulation and Licensing Department, at 505/476-4501, 505/476-4511 (fax), or Mary.James2@state.nm.us.

2014 Law Update Schedule

In 2014, there will be one free law update offered at the Board office each month. These updates will be offered on Fridays from 2 to 4 PM. Remember that these updates are not Accreditation Council for Pharmacy Education (ACPE) approved. If you need an ACPE number, please attend the law update provided by either the New Mexico Pharmacists Association (NMPhA) or the New Mexico Society of Health-System Pharmacists (NMSHP). To attend a law update at the Board office, please contact Jessica Chavez-Lance at Jessica.Chavez-Lanc@state.nm.us or 505/222-9838. Seating is limited to the first 60 attendees. The following law updates are currently scheduled:

- ◆ January 24, 2014
- ◆ February 7, 2014
- ◆ March 21, 2014
- ◆ April 4, 2014
- ◆ May 9, 2014
- ◆ June 6, 2014
- ◆ July 18, 2014
- ◆ August 1, 2014
- ◆ September 5, 2014
- ◆ October 3, 2014
- ◆ November 21, 2014
- ◆ December 19, 2014

If you would like to attend a law update as offered by an association, please contact them directly. The following law updates are scheduled:

- ◆ January 25, 2014, 1 to 3 PM, NMPhA 2014 Mid-Winter Meeting
- ◆ June 21, 2014, 2 to 4 PM, NMPhA Annual Conference
- ◆ October 5, 2014, 3 to 5 PM, NMSHP 2014 Balloon Fiesta Symposium

The Board state drug inspectors are required by regulation to host a law update in each of the districts at least once each year. Each of the following updates is scheduled for a Tuesday evening from 7 to 9 PM. Similar to the updates held at the Board office, these updates do not offer ACPE credit. To attend a law update please contact Jessica Chavez-Lance for scheduling. This way, your certificate can be pre-printed. The following law updates are scheduled:

- ◆ February 4, 2014, Memorial Medical Center, Las Cruces, NM
- ◆ February 25, 2014, Eastern New Mexico University-Roswell, Occupational Technology Center, Roswell, NM
- ◆ March 11, 2014, Presbyterian Espanola Hospital, Espanola, NM
- ◆ March 25, 2014, Gila Regional Medical Center, Silver City, NM
- ◆ April 29, 2014, Rehoboth McKinley Christian Hospital, Gallup, NM
- ◆ May 13, 2014, Miners' Colfax Medical Center Long Term Care Facility, Raton, NM
- ◆ May 20, 2014, San Juan College, Farmington, NM
- ◆ September 23, 2014, Gerald Champion Regional Medical Center, Alamogordo, NM

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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

ISMP
INSTITUTE FOR SAFE MEDICATION PRACTICES

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 technology¹ 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 2006² 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.

¹Cochran 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.

²Ukens C. "New study sheds light on medication errors." *Drug Topics*. 2002;146(21):33.

³Skrepnek GH, Armstrong EP, Malone DC, Abarca J, et al. "Workload and availability of technology in metropolitan community pharmacies." *J Amer Pharm Assoc*. 2006; 46(2):154-160.

⁴American 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."



Pharmacists & Technicians:
Don't Miss Out on Valuable CPE Credit.
Set Up Your NABP e-Profile and
Register for CPE Monitor Today!

Continuing pharmacy education (CPE) providers who are accredited by the Accreditation Council for Pharmacy Education (ACPE) have integrated CPE Monitor® into their systems and are requiring pharmacists and pharmacy technicians to provide a National Association of Boards of Pharmacy® (NABP®) e-Profile ID number and date of birth (MMDD) in order to process ACPE-accredited CPE credit.

Visit www.MyCPEmonitor.net to set up your NABP e-Profile and register for CPE Monitor and avoid possible delays in your CPE reporting.

*CPE Monitor is a national collaborative service from
NABP, ACPE, and ACPE providers that will allow licensees
to track their completed CPE credit electronically.*

- ◆ November 4, 2014, Carlsbad Medical Center, Carlsbad, NM
- ◆ December 16, 2014, MountainView Regional Medical Center, Las Cruces

Prescription Monitoring Program

The New Mexico Prescription Monitoring Program (PMP) is pleased to announce the debut of the New Mexico PMP Web site at <http://nmpmp.org>. This new Web site serves as a companion to the PMP Web portal and provides a wealth of information on how to use the PMP, news and information on upcoming functionalities, as well as resources for health care professionals and interested parties working to combat the prescription drug abuse and misuse epidemic.

Significant Adverse Drug Events

1. Fifty-four-year-old female was taking clonazepam 1 mg. An office assistant to a physician called the pharmacy to discontinue medication and change dose and directions. Pharmacist heard assistant say lorazepam 0.5 mg #25 with directions to take one-half tablet in the morning, one-half tablet at 1 PM, and two tablets at bedtime. Pharmacist was later contacted by assistant claiming to say to start clonazepam 0.5 mg with above directions, but pharmacist claimed that he heard lorazepam. Patient did not appear to have any adverse effects from the error. Pharmacist will require only original hard copies or faxes from the doctor in the future to prevent errors.
2. Patient had dropped off a prescription for amlodipine 5 mg but was entered wrong and filled for amiloride 5 mg. Patient took one dose at night and claimed she had been up all night peeing. She called her doctor the next day to report the side effects and the doctor contacted the pharmacist. Pharmacy corrected the mistake and the pharmacist claims that labels will be placed on shelves with names Norvasc® and Midamor® in red letters under generics to prevent further errors.
3. Fifty-three-year-old female was prescribed Lyrica® 75 mg, two capsules twice daily. Patient was dispensed Lyrica 200 mg, two capsules twice daily. Medication was typed for wrong dose by technician. Patient claimed to be drowsy but with no other side effects. Error was due to multitasking by personnel; will be fixed by completing one task before moving on to the next task.
4. Sixty-eight-year-old female was prescribed prednisone 5 mg through an electronic prescription system. Drug was not "available/in database" and therefore was filled for prednisone 50 mg. Patient took entire course and presented to doctor agitated and anxious with no other side effects noted. In order to prevent further errors like this, pharmacist will verify drug strength and name of prescription against hard copy for all prescriptions.
5. Patient was dispensed BuSpar® in place of Sensipar® due to a misinterpretation of the written copy. Prescription was a telephone/verbal order and when the technician entered it, read it to be BuSpar since they are sound-alike drugs. Patient only took one tablet when the spouse recognized the patient becoming dizzy and anxious. Patient notified the prescriber who in turn notified the pharmacy of the error. Pharmacist states that prescriptions need to be looked at extra hard to make sure right drug is being dispensed in the future.
6. Seventy-year-old female had a prescription for OxyContin® 30 mg, one tablet q12h and was dispensed OxyContin 60 mg, 1 tablet q12h. Patient took eight doses before noticing the change due to drowsiness with no other side effects. The error was entered incorrectly by technician and was not caught by pharmacist. Pharmacy plans to retrain technicians to double check input (especially Schedule II prescriptions) before sending to pharmacist and pharmacist needs to come up with a system to double check input prescription against the written prescription. Will also try to eliminate interruptions and distractions for the pharmacist checking computer input against the hard copy.
7. Sixty-three-year-old male patient was given his medications plus another patient's medication who has the same first and last name. Patient received zolpidem that was intended for the other patient. He proceeded to take the medication without realizing it was not his and reported drowsiness and having slurred speech. Pharmacy will start to verify address, date of birth, and phone number with patients before selling prescriptions to them.
8. Electronic prescription was sent to pharmacy for 53-year-old female for hydroxyzine 10 mg and was processed as hydroxyzine 10 mg. It was dispensed as hydralazine 100 mg. Pharmacist will start to quadruple check prescriptions for hydroxyzine/hydralazine to make sure correct medication is being entered and filled.
9. Electronic prescription was sent to pharmacy for 18-year-old female for hydroxyzine 25 mg and was entered and filled as hydrochlorothiazide 25 mg. Patient left pharmacy with medication. Pharmacist will pay more attention to the different ways that physicians' offices can send prescriptions for the same drugs.
10. A patient's prescription for Isopto® Tears 0.5% was incorrectly filled with Isopto Homatropine 5%. The two-year-old child experienced eye dilation, which improved over 24 hours. The error was attributed to having too many people filling prescriptions during a hectic time. No recommendations for improvement were given.
11. Sixty-one-year-old female had a prescription for Haldol® 0.5 mg and was given a prescription for haloperidol 5 mg. The prescription was incorrectly input into the computer and patient did take the medication. She complained of being lethargic with no other side effects. Pharmacy plans to read prescriptions more carefully in their entirety prior to comparing to the data input in the computer system. Also to verify that the information put into the computer system matches the hard copy.
12. Pharmacy received electronic prescription for venlafaxine 75 mg tablets for an 87-year-old patient. Prescription was input by technician as venlafaxine ER 75 mg capsules. Caregiver gave full capsule to patient, which made patient nauseated. Patient required prescription for promethazine due to the

event. Pharmacist will check prescriptions more closely and also connect directions with drug dispensed.

13. Fourteen-year-old diabetic male patient was written a prescription for Humalog® KwikPen™ in August 2012, and was filled for Humalog 50/50 Mix KwikPen due to patient having received the 50/50 mix in the past. Patient received the wrong medication for a full year until doctor noticed the error at the one-year follow-up appointment. Doctor reported erratic blood sugars and HgA1c of 12.7. Pharmacy will make sure prescriptions are clarified with prescriber, not just checked against profile, with caregiver, or with patient.

Disclaimer: The suggestions are made by the pharmacist submitting the Significant Adverse Drug Event Report. The New Mexico Board of Pharmacy may not necessarily agree with these suggestions.

Prescription Drug Overdose Deaths

According to the Trust for America's Health Web page, <http://tfah.org/reports/drugabuse2013/>, New Mexico is no longer number one in prescription drug overdose deaths. We have moved to number two. West Virginia is now number one.

New Mexico scored 10 out of 10 on the New Policy Report Card of Promising Strategies to Help Curb Prescription Drug Abuse. The Board knows that all the new regulations relating to controlled substances (CS) can be burdensome. But they seem to be working. The Board wishes to thank pharmacy personnel for taking on these extra responsibilities.

Disciplinary Actions

Atria Vista Del Rio – License CU-6350. Atria Vista Del Rio is a custodial care facility. Entered into a stipulated agreement with the Board. Agreed not to contest record keeping violations. Must pay investigative costs and fine of \$5,750. Must submit a written compliance plan to the Board, submit a root cause analysis, submit documentation of education/training to staff that handle medications, and submit documentation of electronic medication administration record accuracy.

Amanda Elam, PT – License PT-4185. Respondent voluntarily surrendered her registration as a pharmacy technician.

Ronald Inkrott, RPh – License RP-7132. Respondent entered into a settlement agreement and order with the Board. Respondent plead no contest to the allegations described in the Board investigative report in that respondent acquired and dispensed CS by fraud or deception. Specifically by dispensing CS to Christy Inkrott, the respondent's wife, by falsifying authorizations from a prescribing practitioner. Respondent failed to pay for medications dispensed to wife. Respondent's pharmacist registration is suspended for a period of 180 days. Respondent must pay a fine of \$5,000. Plus, respondent must pay cost of the investigation in the amount of \$2,025. Respondent must be evaluated by the New Mexico Monitored Treatment Program (MTP) and abide and complete any and all requirements imposed by MTP. Respondent agrees to never fill any prescriptions for himself or any family member. Respondent shall be on probation for a period of five years. Respondent must make full restitution to the insurance company for the 47 prescriptions that were filled pursuant to falsified and unauthorized prescriptions.

Harriet James, NP – License CS-00207595. Respondent failed to renew her Board-issued CS registration that expired on December 31, 2012. Respondent continued to authorize CS prescriptions after this date. Respondent voluntarily surrendered her CS registration. Respondent must pay investigative costs in the amount of \$500.

Dorothy Lewis, PT – License PT-4421. The Board served a notice of contemplated action on respondent alleging that the Board had sufficient evidence to take action to suspend or revoke respondent's pharmacy technician registration. Respondent was suspected of diverting and stealing dangerous drugs, including CS, from the pharmacy where she worked. Respondent admitted that she gave these stolen medications to her husband and son over a period of six months. Respondent did not request a hearing within the allowed time. Respondent's registration was revoked by default for a period of five years. Respondent must pay a fine of \$5,000. Respondent must pay investigative costs in the amount of \$200.

Joseph Alexander Morrow, PT – License PT-8260. Respondent voluntarily surrendered his registration as a pharmacy technician. Must pay a fine of \$100.

Mikki Pacheco, PT – License PT-7932. Respondent admitted she stole 500 tablets of oxycodone 30 mg from the pharmacy where she worked. Respondent voluntarily surrendered her pharmacy technician registration.

Boyd Shomour, PT – License PT-8291. Board received information that respondent might not be in compliance with the Parental Responsibility Act. Board requested respondent become current in his payment of his child support obligations. Respondent did not respond to request. Respondent was notified of his noncompliance. Respondent did not request a hearing within allowed time. Respondent's pharmacy technician registration was revoked by default.

Board Members

The Board has elected new officers for 2014. The following members make up the current Board:

- ◆ Danny Cross, RPh, Southeast District, Board Chairperson
- ◆ Amy Buesing, RPh, Hospital Representative, Board Vice Chairperson
- ◆ LuGina Mendez-Harper, RPh, Northwest District, Secretary
- ◆ Joe R. Anderson, RPh, Central District
- ◆ Allen Carrier, Public Member
- ◆ Richard Mazzoni, RPh, Northeast District
- ◆ Buffie Saavedra, Public Member
- ◆ Chris Woodul, RPh, Southwest District
- ◆ Anise Yarbrough, Public Member

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