



New Mexico Board of Pharmacy

Published to promote compliance of pharmacy and drug law

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Season's Greetings

PMP Awarded National Harold Rogers PDMP Grant

Recently, the New Mexico Board of Pharmacy was awarded the Bureau of Justice Assistance Fiscal Year 2014 Harold Rogers Prescription Drug Monitoring Program (PDMP) grant for use in enhancing the New Mexico Prescription Monitoring Program (PMP). This award will be used for a variety of enhancements and innovative initiatives, with the goal of making the PMP of greater value and better ease of use for prescribers and pharmacists.

One of the enhancements affecting pharmacists specifically is the expansion of so-called unsolicited reports. Currently, e-mail notices are sent out quarterly to prescribers with patients who have prescriptions written by more than five different prescribers and filled at more than five different pharmacies within a six-month period (considered the threshold value).

The enhancement will expand this to include pharmacist-in-charge (PIC) accounts that will be tied to the PIC at each retail pharmacy. In addition, when running a PMP report, if the patient matches the threshold value, an alert will be presented to the PMP user.

The PMP will also implement the inclusion of the NAR_xCHECK[®] report as an optional request report format within the PMP itself; New Mexico will be the first state to do this. NAR_xCHECK provides a propriety NAR_xCHECK Score as well as graphical representations of prescription history. The Board is hoping that this will help users' ability to quickly digest the sometimes dense PMP information on their patients.

Be sure to subscribe to the *New Mexico PMP Newsletter* at www.nmpmp.org/newsletter for updates on these and other enhancements to the PMP.

Upcoming Changes to PMP Data Submission

Recently, a complete rewrite of the rule affecting the PMP – NMAC 16.19.29 – was presented to the Board by the PMP director. A number of changes were proposed and approved, and the rule will next be noticed at the January 2015 Board meeting. These changes include the requirement of file submission in the American Society for Automation in Pharmacy (ASAP) 4.2 format (currently, the PMP accepts data only in the ASAP 4.1 format) as well as a change in the period within which a controlled substance (CS) prescription fill must be reported to the PMP. Currently this period is seven days. The change will require this information to be reported to the PMP within one business day.

Many states already require daily reporting, and there has been strong support for this in New Mexico. These changes are expected to become effective sometime in March 2015.

Reminder

Practitioners who have an approved system to transmit electronic prescriptions for controlled substances (EPCS), and pharmacies that have an approved system to accept EPCS, may transmit/receive prescriptions in all schedules. EPCS for medications listed in Schedule II are valid.

2015 Board Meeting Schedule

In 2015, five Board meetings are scheduled. The meeting dates are as follows:

- ◆ January 22-23, 2015
- ◆ April 16-17, 2015
- ◆ June 24-26, 2015 (June 24, starting at 1 PM; June 25, starting at 9 AM; and June 26, starting at 9 AM, if necessary)
- ◆ August 20-21, 2015, Ruidoso, NM, Board meeting
- ◆ October 15-16, 2015

Except as listed above, meetings will be on Thursday and Friday. Board meetings begin each day at 9 AM, and are subject to change. Please visit the Board web page to find the agenda for each Board meeting. Agendas must be posted at least 72 hours prior to the meeting. Please mark your calendar.

Law Update 2015

In 2015, Board inspectors will present two law updates each month at the Board office. These monthly law updates are scheduled on a Friday in each month. Law updates are two hours long. One is scheduled in the morning from 9 AM until 11 AM. The other is scheduled in the afternoon from 2 PM until 4 PM. There is no charge to attend; however, the Board does ask that you register. To register, please contact the Board office. You may also send an e-mail to Jessica.Chavez-Lanc@state.nm.us. By receiving registrations, the Board can ensure that the room does not get too crowded. The schedule is as follows:

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|----------------------|--------------------|
| ◆ January 16, 2015 | ◆ February 6, 2015 |
| ◆ March 6, 2015 | ◆ April 10, 2015 |
| ◆ May 1, 2015 | ◆ June 5, 2015 |
| ◆ July 10, 2015 | ◆ August 7, 2015 |
| ◆ September 11, 2015 | ◆ October 2, 2015 |
| ◆ November 6, 2015 | ◆ December 4, 2015 |

In addition to these Albuquerque, NM, area law updates, Board inspectors will present nine law updates in different areas of New Mexico. These law updates will generally be held on a Tuesday from 7 PM until 9 PM. The exception is the Santa Fe, NM, law update held on Tuesday, July 21, 2015. The time for this law update will be 1 PM until 3 PM. It is especially important that you register in advance for these

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DEA Reschedules Hydrocodone Combination Products as Schedule II

Drug Enforcement Administration (DEA) has published its final rule rescheduling hydrocodone combination products from Schedule III to Schedule II in the *Federal Register*. The change imposes Schedule II regulatory controls and sanctions on anyone handling hydrocodone combination products, effective October 6, 2014. DEA first published the proposed rules in March 2014 in response to a Food and Drug Administration (FDA) recommendation. DEA received almost 600 public comments regarding the proposed rules after they were published, with a small majority of the commenters supporting the change, DEA notes in a press release, which is available at www.justice.gov/dea/divisions/hq/2014/hq082114.shtml.

The announcement is available on the *Federal Register* website at <https://federalregister.gov/articles/2014/08/22/2014-19922/schedules-of-controlled-substances-rescheduling-of-hydrocodone-combination-products-from-schedule>.

The mL-Only Standard for Liquid Dosing Gathers Steam

 This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization 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 provides legal protection and confidentiality for submitted patient safety data and error reports. Help others by reporting actual and potential medication errors to the ISMP National Medication Errors Reporting Program Report online at www.ismp.org. E-mail: ismpinfo@ismp.org.

ISMP first reported on the confusion of teaspoonfuls and milliliters (mL) in its newsletter in 2000, and in 2009, issued a call for practitioners to move to sole use of the metric system for measuring over-the-counter and prescription oral liquid doses, but mix-ups have continued to result in the serious injury of children and adults. Use of the metric system alone when prescribing, dispensing, and administering medications would prevent mix-ups because there would only be one method used to communicate and measure doses.

The health care industry is beginning to acknowledge the risk of confusion when using non-metric measurements, especially with oral liquid medications. The National Council for Prescription Drug Programs (NCPDP) just released a white

paper entitled *NCPDP Recommendations and Guidance for Standardizing the Dosing Designations on Prescription Container Labels of Oral Liquid Medications*, which is available at www.ismp.org/sc?id=337. The white paper supports mL as the standard unit of liquid measure used on prescription container labels for oral liquid medications. It also calls for dosing devices with numeric graduations, and for units that correspond to the container labeling to be easily and universally available, such as including a device each time oral liquid prescription medications are dispensed. NCPDP also reiterates that dose amounts should always use leading zeroes before the decimal point for amounts less than one, and should not use trailing zeroes after a decimal point on labels for oral liquid medications.

The white paper comes as welcome news and is well-aligned with the *ISMP 2014-15 Targeted Medication Safety Best Practices for Hospitals*, Best Practice 5, which calls for organizations to use oral liquid dosing devices (oral syringes/cups/droppers) that only display the metric scale. The white paper also comes at a time when the Centers for Disease Control and Prevention, ISMP, the Consumer Healthcare Products Association, the United States FDA, the US Metric Association, and the American Academy of Pediatrics have initiatives in place that will help guide health care organizations to commit to metric measurements.

ISMP recommends the following actions to help prevent errors:

- ◆ Use only metric units, not teaspoon or other non-metric measurements, for all patient instructions, including those listed in prescribing and pharmacy computer systems. This should cover directions incorporated into computer system mnemonics, speed codes, or any defaults used to generate prescriptions and prescription labels.
- ◆ Take steps to ensure patients have an appropriate device to measure oral liquid volumes in milliliters.
- ◆ Coach patients on how to use and clean measuring devices; use the “teach back” approach and ask patients or caregivers to demonstrate their understanding.

DEA Classifies Tramadol a Controlled Substance

Under a final rule published in the *Federal Register*, the pain reliever tramadol is now classified as a Schedule IV controlled substance. As of August 18, 2014, DEA requires manufacturers to print the “C-IV” designation on all labels that contain 2-[(dimethylamino)methyl]-1-(3-methoxyphenyl)cyclohexanol (tramadol), including its salts, isomers, and salts of isomers. The agency notes that every “DEA registrant who possesses any quantity of tramadol on the effective date of this final rule must take an inventory of all stocks of tramadol on hand as of August 18, 2014, pursuant to 21 U.S.C. 827 and 958, and in accordance with 21 CFR 1304.03, 1304.04, and 1304.11 (a) and (d).” In addition, all “prescriptions for tramadol



or products containing tramadol must comply with 21 U.S.C. 829, and be issued in accordance with 21 CFR part 1306 and subpart C of 21 CFR part 1311 as of August 18, 2014.”

The announcement is available on the *Federal Register* website at www.federalregister.gov/articles/2014/07/02/2014-15548/schedules-of-controlled-substances-placement-of-tramadol-into-schedule-iv.

FDA Lowers Recommended Starting Dose for Lunesta Due to Risk of Morning Impairment

FDA has lowered the recommended starting dose of the sleep drug Lunesta® (eszopiclone) from 2 mg to 1 mg. Patients who are currently taking 2 mg and 3 mg doses of eszopiclone should contact their health care provider to ask for instructions on how to continue to take their medication safely at a dose that is best for them, FDA advises. The dose change came after findings from a study of 91 healthy adults found that the medication was associated with impairment to driving skills, memory, and coordination for as long as 11 hours after the drug is taken, FDA notes.

More information is available in an FDA news release at www.fda.gov/newsevents/newsroom/pressannouncements/ucm397453.htm.

Lidocaine Should Not Be Used to Treat Teething Pain in Children, FDA Warns

FDA is recommending that prescription oral viscous lidocaine 2% solution should not be used to treat infants and children with teething pain, and is now requiring a new boxed warning to be added to the drug label to highlight this information. Oral viscous lidocaine solution is not approved to treat teething pain, and use in infants and young children can cause serious harm, including death, indicates FDA in a June 2014 Safety Announcement. FDA advises health care providers not to prescribe or recommend this product for teething pain. FDA is also requiring the “Warnings” and “Dosage and Administration” sections of the drug label to describe the risk of severe adverse events and to include additional instructions for dosing when the drug is prescribed for approved uses.

In 2014, FDA reviewed 22 case reports of serious adverse reactions, including deaths, in infants and young children who were either given lidocaine for treatment of mouth pain, or who accidentally ingested the medication.

More information is available in the safety announcement on FDA’s website at www.fda.gov/Drugs/DrugSafety/ucm402240.htm.

FDA Reiterates Warning Against Using NuVision Pharmacy Products

Health care providers should not use or distribute compounded drugs marketed as sterile produced by Downing Labs, LLC, of Dallas, TX, also known as NuVision Pharmacy,

warns FDA. Inspection results issued on July 16, 2014, indicate that FDA observed unsanitary conditions resulting in a lack of sterility assurance of sterile drug products produced by the company, which may put patients at risk, FDA notes in the safety announcement. “The inspection revealed sterility failures in 19 lots of drug products intended to be sterile, endotoxin failures in three lots of drug products, and inadequate or no investigation of these failures,” states FDA in the announcement.

In 2013, the agency issued several similar warnings following NuVision’s refusal to recall all sterile products. In April 2013, NuVision recalled methylcobalamin injection and lyophilized injection products, citing concerns about sterility in the wake of adverse event reports. Health care providers and consumers may report adverse events or quality problems associated with NuVision products to FDA’s MedWatch Safety Information and Adverse Event Reporting Program.

Additional information is available in the safety announcement, available on FDA’s website at www.fda.gov/Drugs/DrugSafety/ucm405940.htm.

JCPP Releases New Patient-Care Document to Promote Consistency

The Joint Commission of Pharmacy Practitioners (JCPP) has released a resource document aimed at promoting consistency in the pharmacists’ process of patient care service delivery. “Pharmacists’ Patient Care Process” was developed by examining key source documents on pharmaceutical care and medication therapy management. The document describes the process in five parts: collect, assess, plan, implement, and follow-up.

JCPP brings together the chief executive officers and elected officers of national pharmacy associations, including the National Association of Boards of Pharmacy®, to create a forum for discussion and opportunity for collaborative work on issues and priorities of pharmacy practice.

The document can be downloaded online at www.pharmacist.com/sites/default/files/JCPP_Pharmacists_Patient_Care_Process.pdf.

CPE Credit Offered for FDA Course on Misleading Prescription Drug Promotion

To raise awareness about the risks associated with false or misleading prescription medication marketing, FDA, in partnership with Medscape, is offering an online, one-hour continuing education course through its Bad Ad Program. Pharmacists may receive continuing pharmacy education (CPE) credit by taking this course. Learning objectives, faculty information, and other information is available on the course’s website at www.sigmatech.com/BadAd. There is no registration fee for the course. Upon completion, pharmacists will receive one Accreditation Council for Pharmacy Education-accredited CPE hour (0.1 continuing education unit).

law updates. This way, the Board can ensure that it has a large enough room. In addition, the Board is able to pre-print your certificate. The schedule is as follows:

- ♦ February 10, 2015, Memorial Medical Center of Las Cruces – Las Cruces, NM
- ♦ February 24, 2015, Eastern New Mexico University-Roswell, Lawrence C. Harris Occupational Technology Center – Roswell, NM
- ♦ March 10, 2015, Clavis-Carver Public Library, North Annex – Clovis, NM
- ♦ May 19, 2015, San Juan College – Farmington, NM
- ♦ July 21, 2015, 1-3 PM, Toney Anaya Building – Santa Fe
- ♦ September 1, 2015, Holy Cross Hospital – Taos, NM
- ♦ October 27, 2015, Alta Vista Regional Hospital – Las Vegas, NM
- ♦ November 17, 2015, Lea Regional Medical Center – Hobbs, NM
- ♦ December 15, 2015, MountainView Regional Medical Center – Las Cruces

The Board is not certified by the Accreditation Council for Pharmacy Education (ACPE). If ACPE credit is necessary, a law update is presented at the New Mexico Pharmacists Association (NMPHA) 2015 Mid-Winter Meeting, the NMPHA Annual Convention, and at the New Mexico Society of Health-System Pharmacists Balloon Fiesta Symposium. Contact the association of your choice to register. There is a fee to attend these events.

CE Reminder

Reminder: Beginning January 1, 2015, pharmacists are required to obtain the two required patient safety continued education (CE) credits in the area of opioid safety. This required CE can be live or home study. The ACPE number for patient safety will end with “05.”

Destruction of Drugs

Regulation NMAC 16.19.6.15 allows pharmacies to collect and dispose of dispensed pharmaceuticals. The dispensed pharmaceuticals allowed did not include CS. Beginning in October 2014, Drug Enforcement Administration approved the final rule for the Secure and Responsible Drug Disposal Act of 2010. The act outlines methods for pharmacies to collect unused or unwanted pharmaceutical CS from the public for the purpose of disposal. The act also allows for the collection of unused or unwanted pharmaceutical CS from long-term care facilities for the purpose of destruction on behalf of residents or former residents of the facility. To do this, you must comply with both federal and state requirements. To review this new rule, visit www.dea.gov/divisions/hq/2014/hq090814.shtml.

Significant Adverse Drug Events

1. A parent picked up prescriptions for her six-year-old son. The boy was given 36 mg of methylphenidate. After a dose had been given, the parent discovered that the prescription belonged to a different patient. Other than hyperactivity, there were no other side effects or symptoms reported. Pharmacist recommends that both container and bag should be cross-checked prior to dispensing to patient.
2. A 62-year-old female was prescribed NovoLIN® N, but was dispensed NovoLIN R. Red eyes and trouble controlling blood sugar were side effects reported by the patient. It was determined that the wrong National Drug Code (NDC) number was used when filling the prescription. Pharmacist recommends double-checking that prescriptions are correct before dispensing them.
3. A 61-year-old female was prescribed ropinirole 0.5 mg, but was dispensed risperidone 0.5 mg. The patient's restless leg syndrome symptoms increased due to incorrect therapy. No other side effects or symptoms were reported. Pharmacist recommends that technicians double-check their work and that pharmacists be more alert during the final check.
4. A 53-year-old male was prescribed morphine sulfate 100 mg/mL. 100 mg/mL was the concentration dispensed, but the label read 20 mg/mL. As a result, compensation was made for the indicated strength change and the patient was given more medication than

prescribed. An increase in sedation and somnolence was reported. Pharmacist recommends double-checking work during verification.

5. A 75-year-old female was prescribed progesterone 3% cream, but was dispensed testosterone 3% cream. The patient noticed hot flashes, aggressiveness, mood changes, acne, breast tenderness, dark facial hairs, weight gain, and pelvic cramping. After approximately three months of using the product, the patient brought it back to the pharmacy, where it was discovered to be testosterone. The pharmacist recommends adding color coding to compounds and labels. It is also recommended that PRN pharmacists be prohibited from performing quality assurance on compounds.
6. A four-month-old female was prescribed furosemide 4 mg, but was dispensed furosemide 25 mg. The incorrect dose had been administered for 13 days, during which the baby experienced diarrhea and weight loss. Pharmacist recommends that all calculations are checked by a pharmacist and that all math is shown either on the hard copy or on a separate sheet of paper scanned into the patient's profile.
7. A 53-year-old male was prescribed Humalog® Mix 75/25 KwikPen™, but was dispensed Humalog KwikPen. The medication was never injected. Pharmacist recommends verifying before dispensing.
8. A 62-year-old female was dispensed oxycontin 40 mg with the incorrect prescribing physician on the label. The physician's office was notified and it immediately contacted the pharmacy. Pharmacist recommends that this be checked by the pharmacy technician and pharmacist before dispensing.
9. A two-year-old male was prescribed clonidine 0.1 mg/mL, quantity 0.3 mL, but was dispensed 1 mg/mL, quantity 0.3 mL. The nurse calling in the prescription had incorrectly verbalized the concentration. The child became lethargic and was hospitalized. No long-term side effects or symptoms were noted. Pharmacist recommends that when a prescription order seems incorrect or may cause harm to a patient, the order should be verified with the doctor before dispensing.
10. A 23-year-old female was prescribed metoprolol tartrate 50 mg, but was dispensed metoprolol succinate 50 mg. No side effects or symptoms were reported. Pharmacist recommends double-checking and not interrupting the pharmacy technician during input.
11. A 56-year-old-female was prescribed tramadol 50 mg, but was dispensed trazodone 50 mg. Patient reported feeling drunk and lethargic, and had swollen eyes and blurry vision. Pharmacist recommends checking for the correct NDC and following procedures.
12. A 71-year-old female was prescribed ropinirole 4 mg, but was dispensed risperidone 4 mg. After taking the medication, the patient was lethargic and reported having a difficult time getting out of bed for three days. Pharmacist recommends that the final quality assurance check of scanning the bottle never be bypassed.
13. A 70-year-old female was prescribed duloxetine 60 mg, but was dispensed Dexilant™ 60 mg. The patient took one capsule and noticed no side effects or symptoms. The two medications are stored in the pharmacy side-by-side. Pharmacist recommends checking the stock bottle against the label.

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.

Regulation Changes

During the October 15, 2014 meeting, the following rules were changed:

- ♦ Regulation NMAC 16.19.10.11 was revised to allow schools to maintain and administer emergency dangerous drugs. Schools shall obtain a Class D clinic drug permit. Under this permit, albuterol inhaler and epinephrine auto-injector are approved.
- ♦ Regulation NMAC 16.19.11.8 B(6)(a)(iv) no longer pertains solely to Hepatitis B vaccine. Nursing home stock will also include vaccines as recommended by the Centers for Disease

Control and Prevention's Advisory Committee on Immunization Practices, and as appropriate for the facility population served. Amendments are effective as of October 24, 2014.

Disciplinary Actions

Kelly Dillon, RPh – License RP-6789. During the October 17, 2014 Board meeting, respondent requested to be dismissed from the remainder of his five-year probation. Respondent, by a stipulated agreement, was placed on probation on August 29, 2011. Respondent's request for early release was denied. Respondent's probation period will expire August 29, 2016 (in 22 months).

Fitz Glasgow, RPh – License RP-7612. Stipulated agreement with the Board. Respondent pled no contest to the allegation described in a Board investigative report that respondent engaged in unprofessional conduct by distributing prescription drugs to two of his coworkers who did not have a prescription for the drugs. Respondent distributed one tablet of Fioricet®, one tablet of ibuprofen, and one tablet of Relpax®. Respondent was given a letter of reprimand. Must pay investigative costs in the amount of \$800.

James Gonzales, RPh – License RP-7378. Respondent voluntarily surrendered his registration as a pharmacist. Respondent admitted to impairment and filling forged CS prescriptions. Must pay cost of investigation of \$2,000. Must successfully complete a five-year contract with the New Mexico Monitored Treatment Program (MTP).

Jennifer N. Kobyljanec-Rodgers, RPh – License RP-6539. Respondent voluntarily surrendered her pharmacist registration on May 30, 2014. The Board accepted this surrender at its June 18, 2014 meeting. During the October 17, 2014 Board meeting, respondent requested her pharmacist registration be reinstated. The Board granted the request. Respondent is subject to mandatory conditions, including compliance with MTP contract; probation for five years; and payment of remaining investigative costs still owed to the Board within five months.

Janet Lovato, PT – License PT-8486. The Board accepted the voluntary surrender of respondent's pharmacy technician registration. Must pay \$100 in investigative costs.

Judy Manzanares, PT – License PT-9267. The Board accepted the voluntary surrender of respondent's pharmacy technician registration. Must pay \$100 in investigative costs.

Melanie Martinez, PT – License PT-4289. Respondent voluntarily surrendered her registration as a pharmacy technician. Must pay investigative costs in the amount of \$200.

New Life Assisted Living Facilities – Licenses CU-10593 and CU-10677. Stipulated agreement with the Board. Respondent did not admit to any violations, but in the interest of resolving the matter agreed not to contest the allegations described in a Board investigative report. Must pay a fine of \$500 for each facility, totaling a \$1,000 fine. Plus must pay \$250 in investigative costs. Consultant pharmacist must inspect each facility on a monthly basis, rather than quarterly, for a period of one year.

Ashley Primrose, PT – License PT-8194. On November 26, 2012, the Board was informed of unexplained loss at a pharmacy. Respondent was interviewed by a state drug inspector and scheduled to be evaluated by the Board's Impaired Health Care Provider Examining Committee (Examining Committee). Respondent met with the Examining Committee on February 15, 2013, and was ordered to be evaluated by MTP. Respondent did not meet with MTP. On April 5, 2013, another pharmacy alerted the Board of an unexplained loss of CS. Pharmacy was concerned that respondent was involved in this loss of CS. On May 14, 2013, respondent was handed an order of summary suspension and a Notice of Contemplated Action. Respondent did not request a hearing within the required time. Respondent's registration as a pharmacy technician was revoked by default for a period of 10 years. In order to renew, respondent must address charges from May 14, 2013. Respondent must pay costs of investigation of \$650.

Rio Rancho Nursing and Rehab Center – License CU-9957. Stipulated agreement with the Board. Respondent admits that it

engaged in the business of operating a custodial care facility on an expired license from the period of approximately March 2011 until November 2012. Respondent must pay \$1,000, plus investigative costs of \$300.

Melissa Rodriguez-Benavidez, PT – License PT-7144. Respondent voluntarily surrendered her registration as a pharmacy technician. Respondent may never reapply with the Board. Must pay a fine and investigative costs totaling \$2,375.

Joseph M. Simmons, Jr, RPh – License RP-5869. Stipulated agreement with the Board. Respondent pled no contest to the allegation that a prescription for ciprofloxacin was incorrectly filled and dispensed to a customer. Respondent did not label the bottle of medication dispensed. Respondent did not bill insurance for the medication. Respondent did not provide professional consultation with the customer regarding medication. Respondent must pay a fine of \$1,000 and investigative costs of \$575. Respondent must complete CE on error reduction. Respondent is on probation for one year.

Specialty Compounding Pharmacy, LLC – Licenses PH-3131 and CS-214887. Respondent entered into a stipulated agreement with the Board. Respondent voluntarily surrendered both the New Mexico pharmacy registration and the New Mexico CS registration. Respondent plead no contest to the allegations that CS prescriptions were sent to residents of New Mexico between March 1, 2013 and September 4, 2013, after its CS registration expired on February 28, 2013.

Coverage for Prescription Eye Drop Refills Problem

Patients, mostly older adults, suffering from glaucoma and other degenerative eye diseases are required to use daily eye medication. These prescription eye medications are essential for the preservation of sight. Often prescription eye drops run out well before their intended expiration.

Background

Insurance plans typically allow and pay for a one-month or a three-month supply of medication. This is not a problem with a pill, but eye drops are completely different. Payers calculate the number of drops in a bottle and then estimate when the bottle will run out and the prescription can be refilled. In practice, however, many patients will run out early and leave their disease untreated for many days.

Eye drops run out early for three reasons: (1) the lack of standard titration in eye droppers; (2) the amount of medication in a bottle is not enough to cover the time period for which it is prescribed; and (3) the large wastage of drops when applied poorly by visually impaired patients. In the latter case, it is easy to understand how a patient with poor vision may not always place just one drop correctly and needs to use two or many more drops to successfully get one in the eye. These factors cause the prescribed bottle to run out before it can be refilled. Without access to prescription drops on a continuous basis, patients risk further loss of sight, accompanied by enormous anxiety while waiting for a refill prescription to become available.

Review of the Bill

In the 2012 Legislative Session, Senator George Munoz and Representative Terry McMillan, MD, carried Senate Bill 81 (www.nmlegis.gov/sessions/12%20Regular/final/SB0081.pdf) for the New Mexico Medical Society that passed both chambers and was signed by Governor Susana Martinez on March 3, 2012.