December 2015

New Mexico Board of Pharmacy News

Published to promote compliance of pharmacy and drug law

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Season's Greetings

Board Members

During the October 22-23, 2015 New Mexico Board of Pharmacy meeting, new officers of the Board were elected. The following is a current list of Board members.

- Richard B. Mazzoni, RPh – Northeast District, Chairperson
- Amy Buesing, RPh – Hospital Representative, Vice Chairperson
- LuGina Mendez-Harper, RPh – Northwest District, Secretary
- Joe Anderson, RPh – Central District
- Danny Cross, RPh – Southeast District
- Buffie Saavedra – Public Member
- Cathleen Wingert – Public Member
- Chris Woodul, RPh – Southwest District
- Vacant – Public Member

Anise Yarbrough, public member, has left the Board. She moved to Colorado. Anise contributed greatly to the Board. The comments and opinions from Anise were greatly appreciated. The Board would like to thank her for all she has done and wishes her happiness and success in all her future endeavors. Thank you, Anise.

If you would like to contact a Board member, please contact the Board office and your question will be forwarded to the appropriate Board member.

New Regulations

During the August 20-21, 2015 Board meeting, the following regulation changes were made.

- Changes were made in Regulation 16.19.4 NMAC – Pharmacist, Regulation 16.19.10 NMAC – Limited Drug Clinics, and Regulation 16.19.12 NMAC – Fees. The changes were made to finalize the Class D clinic regulations. Regulations were finalized to allow schools to obtain albuterol metered-dose inhaler and epinephrine auto-injector for use on school students in emergency situations. This was mandated by the legislature. The consultant pharmacist for these facilities will be required to review the self-assessment form on a yearly basis. The consultant pharmacist will not be required to visit the facility. All forms necessary, including the policy and procedure manual, are posted on the Board website under "Forms and Applications."
- The fees regulation was modified to correct certain fees charged.
- Regulation 16.19.6.29 NMAC was added to the pharmacy regulation. This regulation will allow for remote pharmacy technician data entry sites. This will allow a pharmacy technician to work from home. To qualify, the pharmacy technician must have at least one year of experience working at the pharmacy.
- Regulation 16.19.20 NMAC – Controlled Substances, was revised. As done periodically, the controlled substances (CS) list was modified to show changes made in the Code of Federal Regulations. Also, working with the New Mexico Poison & Drug Information Center, many designer CS were added.
- Regulation 16.19.30 NMAC, the regulation for nonsterile compounding, was modified to clarify the expiration date necessary for placing on the label of compounded products.

During the October 22-23, 2015 Board meeting, the following changes were made.

- A new regulation, 16.19.37 NMAC, was added. This addition will allow for the registration and regulation of outsourcing facilities. An outsourcing facility may compound non-patient-specific sterile products. These non-patient-specific sterile products may then be sold to licensees for administration to their patients. This regulation was developed after Congress passed the Drug Quality and Security Act (DQSA). The DQSA was made in response to the meningitis outbreak caused by unsanitary conditions at the New England Compounding Center Pharmacy.
- Regulation 16.19.11 NMAC is the regulation for custodial care facilities. The regulation was modified to allow for a lesser level of custodial care facility that employs a nurse to possess CS in an emergency kit. A nurse must be present at the facility 24 hours a day, 365 days a year.

New Employee

The Board would like to introduce you to its new administrative assistant, Yvette Tenorio. Yvette has been with state government for over 20 years. Yvette transfers to the Board from the New Mexico Department of Health. Yvette had last worked with the Developmental Disabilities Supports Division with the Department of Health. If you meet Yvette, please welcome her. She is the first person contacted when you dial the Board. Her telephone number is 505/222-9830, and her email is yvette.tenorio2@state.nm.us.

Disciplinary Actions

Rosa Elva Gurule – License PT00003091. Respondent was a pharmacy technician. Respondent stated to people that she was a compounding pharmacist. Respondent met with patients, charged for consultations, and opened an account with a lab. Respondent performed work that can only be performed by a registered pharmacist. Respondent surrendered her pharmacy technician registration and may not reapply for 10 years. Must pay $5,000 fine and investigation fee.

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FDA Issues Warning About Name Confusion for Brintellix and Brilinta

Due to similar brand names, there have been incidents where the antidepressant Brintellix® (vortioxetine) and the anti-blood clotting medication Brilinta® (ticagrelor) have been confused, resulting in prescribing and dispensing errors, warns Food and Drug Administration (FDA). The agency notes that no reports indicate that a patient has ingested the wrong medication; however, reports of prescribing and dispensing errors continue. FDA recommends that health care providers include the generic name of the medication in addition to the brand name, as well as the indication for use when prescribing these medications. Patients are advised to check their prescriptions to ensure that the correct medication was dispensed. More information is available in an FDA safety alert at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm456569.htm.*

Seven Persistent Safety Gaffes in Community/Ambulatory Settings That Need to Be Resolved!

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. *Email: ismpinfo@ismp.org.*

This is part two of a three-part series on seven persistent safety gaffes of 2014.

3) Vaccine Errors: Repetitive Errors Reported in the Last Decade

How often do DTaP (diphtheria and tetanus toxoids, and acellular pertussis) and Tdap (tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis) vaccine mix-ups need to occur before regulatory action is taken to prevent confusion? Whatever the number, we can say that health care providers have probably met that threshold! Yet, vaccine errors like this continue to occur at an alarming rate (based on those reported to ISMP alone). Vaccine mix-ups occur often because of age-dependent formulations of the same vaccine, similar vaccine abbreviations, similar vaccine containers and labels, and storage near each other. Confusion between the diluent and vaccine has led to administration of the diluent alone or use of the wrong diluent. With an unfortunate rise in parents choosing not to vaccinate their children or themselves, health care providers cannot continue to make errors when vaccinating those who choose to be immunized; the impact on both individual and community immunity may be far-reaching.

4) Wrong Patient Errors: Not Opening the Bag at the Point of Sale

Community pharmacies are vulnerable to dispensing correctly filled prescriptions to the wrong patient at the point of sale, a risk that is well substantiated in the literature. This error is not influenced by the attributes of a specific medication; thus, dispensing any prescription medication to the wrong patient at the point of sale carries a similar level of risk. Based on an ISMP study, the error happens frequently at an estimated rate of 1.22 per 1,000 prescriptions. Among approximately 56,000 community pharmacies in the United States, this error rate suggests that 332,755 prescriptions will be dispensed to the wrong patient each month, or about six every month per pharmacy. One of the most effective ways to prevent this error is to open the bag of filled prescriptions at the point of sale to verify that the medications are for the correct patient. According to the ISMP study, this simple step reduces the risk of error by 56%, yet few pharmacies follow this practice.

5) Disrespectful Behavior: A History of Tolerance in Health Care

Bullying, incivility, and other forms of disrespectful behavior are still rampant in health care and allowed to exist. Health care providers tolerate the behavior, remain silent, or make excuses in an attempt to minimize the profound devastation that disrespectful behavior causes. An ISMP survey conducted in 2003 clearly demonstrated the scope of disrespectful behavior among many levels of interdisciplinary staff, and an ISMP survey conducted a decade later demonstrates little progress. Disrespect diminishes a person's ability to think clearly, make sound judgments, speak up regarding questions, or avoid at-risk behaviors. Disrespectful behaviors also underlie a resistance to collaborate with others, follow procedures that promote safe practices, or implement new safety practices. While a culture of disrespect is harmful on many levels, its effect on patient safety makes it a matter of national urgency.

FDA Advises Caution Against Codeine for Treating Colds in Young Patients

FDA is evaluating the safety of using medicines containing codeine to treat patients under 18 years old for coughs and colds because of the possibility of severe side effects. Codeine, an opioid, may cause slowed or difficult breathing in children, especially for those who already suffer from breathing problems, the agency notes. FDA recommends that health care providers use caution when prescribing or recommending codeine for patients under 18 years old, and that parents and caregivers be alert for signs of shallow or noisy breathing, confusion, or unusual sleepiness. FDA is also considering a European Medicines Agency recommendation made in April to not give children under 12 codeine for coughs and colds, and to not use codeine for patients 12 to 18 years old who have asthma or other chronic breathing problems. More information is provided in an FDA safety alert available at *www.fda.govSafety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm453379.htm.*

Daytrana Patch May Cause Permanent Skin Color Changes, FDA Warns

In June 2015, FDA warned health care providers and consumers that Daytrana®, a methylphenidate transdermal system prescribed for treating attention deficit hyperactivity disorder, may cause permanent loss of skin color in the affected area. FDA has added a new warning to the drug label to describe this skin condition, known as chemical leukoderma. Chemical leukoderma is a skin condition that causes the skin to lose color as a result of repeated exposure to specific chemical compounds, according to an FDA safety alert. The condition is not physically harmful, but it is disfiguring.

FDA advises patients and caregivers to watch for new areas of lighter skin, especially under the drug patch, and to immediately report any changes to their health care providers. Patients should not stop using the Daytrana patch without consulting a health care provider. FDA also recommends that providers for patients who experience these skin color changes consider alternative treatments. More details are included in the FDA safety alert available at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm452595.htm.*

FDA Expands NSAID Warning Labels Regarding Risks of Heart Attack, Stroke

The labels of certain non-steroidal anti-inflammatory drugs (NSAIDs) will soon contain more detailed information about the risk that the drugs may contribute to heart attack and stroke, reports FDA. Such warnings have been on prescription and over-the-counter NSAIDs since 2005, but the new requirements take into account new data showing that the risk of heart attack and stroke occurs even during the first few weeks of taking an NSAID. People who have cardiovascular and other heart problems are at even greater risk of adverse effects. An FDA alert available at *www.fda.gov/ForConsumers/ConsumerUpdates/ucm453610.htm* provides more details.

Baxter International, Inc, Recalls Three Lots of IV Solutions Due to Particulate Matter

In July 2015, Baxter International, Inc, voluntarily recalled two lots of intravenous (IV) solutions distributed to hospitals and other health offices because of the presence of particulate matter identified as an insect. The problem was identified before patient administration and no adverse health effects have been reported. The recall affects 0.9% sodium chloride injection, USP 50 mL and 100 mL, lot numbers P319921 and P327635, which were distributed to US customers between October 7, 2014, and July 14, 2015. Additional information is available in an FDA press release at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm455421.htm.*

Baxter also voluntarily recalled one lot of IV solution to the hospital/user level because of the potential for leaking containers, particulate matter, and missing port protectors. This recall affects 0.9% sodium chloride injection, USP (AUTO-C) with lot number C964601 (National Drug Code 0338-0049-03; expiration date: April 30, 2016). This recalled lot was distributed to customers and distributors nationwide between January 22, 2015, and February 12, 2015. Leaking containers, particulate matter, and missing port protectors could result in contamination of the solution and, if not detected, could lead to a bloodstream infection or other serious adverse health consequences, explains FDA. The agency notes further that "injecting a product containing particulate matter, in the absence of in-line filtration, may result in blockage of blood vessels, which can result in stroke, heart attack or damage to other organs such as the kidney or liver. There is also the possibility of allergic reactions, local irritation and inflammation in tissues and organs." More information about this recall is available in an FDA safety alert at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm456793.htm.*

FDA Warns Against Unapproved Prescription Ear Drops

FDA has ordered the manufacturers of certain prescription ear drops to stop making and distributing the products because they are not FDA-approved. The product labels do not disclose that they lack FDA approval, and health care providers may not be aware of the unapproved status, notes FDA. The agency took action against unapproved prescription otic drug products containing these ingredients:

- benzocaine;
- benzocaine and antipyrine;
- benzocaine, antipyrine, and zinc acetate;
- benzocaine, chloroxylenol, and hydrocortisone;
- chloroxylenol and pramoxine; and
- chloroxylenol, pramoxine, and hydrocortisone.

These drugs are frequently given to relieve ear swelling and pain in young children, and FDA took this action to protect patients from the risks of taking unapproved drugs with no proven safety or effectiveness information. Further, such drugs may be contaminated or manufactured incorrectly, notes the agency. More information is provided in an FDA news release available at *www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm453348.htm.*

Acino Products in New Jersey Ordered to Stop Selling Rectacort-HC and GRx HiCort 25

Under the direction of FDA, a federal judge for the District of New Jersey has ordered Acino Products, LLC, of Hamilton, NJ, to stop selling and destroy certain unapproved and misbranded prescription drugs in its possession.

According to FDA, Acino has marketed unapproved hydrocortisone acetate 25 mg suppositories, under the brand names Rectacort-HC and GRx HiCort 25, for treatment of medical conditions including inflamed hemorrhoids, chronic ulcerative colitis, and other inflammatory conditions. The drugs have not been FDA-approved and also fail to carry adequate directions for use on their labels. Acino continued to market and sell the products despite several warnings from FDA investigators. The FDA news release is available at *www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm453466.htm.*

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Brianna Harrand – License RP00007296. Respondent voluntarily surrendered her pharmacist registration. Must pay fine and investigation costs of $275. During the October 22-23, 2015 Board meeting, respondent's pharmacist registration was reinstated. Must pay $100 for Board costs. Must take and pass Multistate Pharmacy Jurisprudence Examination®. Must enter five-year contract with Monitored Treatment Program. On probation for five years.

Nicholas Hidalgo – License PT00010168. Respondent voluntarily surrendered his pharmacist technician registration. Must pay $200 for investigative costs.

Chris J. Trujillo – License RP00007033. Respondent voluntarily surrendered his pharmacist registration. Must pay fine and investigation costs of $275.

Commcare Pharmacy – FTL, LLC – License PH00003245. Respondent admitted to being delinquent in reporting CS prescription information to the New Mexico Prescription Monitoring Program. Respondent must report in a timely manner as required. Respondent's pharmacy registration is on probationary status for a period of six months. Respondent shall pay $100 fine.

Significant Adverse Drug Events

1. A 67-year-old female received another patient's prescription for buspirone 15 mg. The patient took the medication for 10 days before noticing it that was the wrong medication, and experienced nausea and stomach irritation. Pharmacist recommends double-checking name, address, and date of birth to confirm the correct prescription is delivered to the correct patient.
2. A 33-year-old female was prescribed Percocet® 5/325 mg, but was dispensed bupropion XL 150 mg. Patient took the medication and then contacted prescriber's office to identify that the tablets were not Percocet. Patient reported experiencing insomnia as a result. Pharmacist recommends double-checking that medication matches the label.
3. A 28-year-old female was prescribed verapamil ER 180 mg, but was dispensed verapamil ER 120 mg. Patient took medication and reported "a slight spike" in blood pressure. Pharmacist recommends double-checking the National Drug Code (NDC) and strength when using multiple bottles to fill a prescription.
4. A 71-year-old female was prescribed fentanyl 25 mg/hr patches, but was dispensed 75 mg/hr patches. Patient called pharmacy when she noticed that the medication was a higher dose than normal. The patient reported no injury. Pharmacist reported the pharmacy being very busy, and when staff entered the prescription, it read "Fentanyl Patch 72 hour 25 mcg/hr Transdermal," but the "72" was read as "75 mg" when entering the prescription, which lead to the incorrect strength being dispensed. Pharmacist recommends hiring additional staff to assist with increased workload. This would allow for the double check of the filling process by both the technician and pharmacist.
5. A 59-year-old female was prescribed BENICAR HCT® 20/12.5 mg, but was dispensed benazepril and HCTZ 20/12.5 mg. Pharmacist reported initiating a refill and noticing the incorrect drug was dispensed for the previous fill. Pharmacist counseled patient on the two different medications and their side effects, and notified the doctor of the incident. The patient reported a dry cough. Pharmacist attributes the initial misfill to the implementation of the pharmacy's new system. No recommendations for improvement were provided.
6. A 40-year-old male was prescribed omeprazole 20 mg and metoprolol ER 100 mg, but was dispensed metoprolol ER 200 mg and metoprolol ER 100 mg. Patient reported being drowsy and that he was difficult to wake. Pharmacist reports the handwriting was difficult to read and the pharmacy was busy. Pharmacist recommends double-checking data entry by technicians, calling to verify prescriptions if they are difficult to read, checking the drug utilization review (DUR) history, and asking about questionable doses.
7. A 43-year-old female was prescribed lisinopril/HCTZ 20/12.5 mg, but was dispensed lisinopril/HCTZ 10/12.5 mg. Patient reported no symptoms. Patient noticed the tablets were a different color than the normal dose, reported it to the pharmacy, and the pharmacist noticed the misfill. Pharmacist recommends double-checking the NDC to the label and slowing down during the final check.
8. A 52-year-old female was prescribed OxyContin® 30 mg, but was dispensed oxycodone IR 30 mg. Patient reported no symptoms. During data entry, the wrong product was selected and the pharmacist failed to notice it at final check. Pharmacist recommends not multitasking when reviewing data entry.
9. A 75-year-old Spanish-speaking female was prescribed levothyroxine 125 mcg, but was dispensed another patient's prescription. Patient reported feeling on fire the next day and was referred for blood work. The last names were very similar and the cashier sold the prescription to the wrong patient. Pharmacist recommends asking date of birth when patients are picking up their medications.
10. A 78-year-old male was prescribed hydroxyzine HCL 25 mg, but received hydrochlorothiazide 25 mg. Patient reported hypotension. The error occurred at data entry and was verified incorrectly. Pharmacist recommends completing one task at a time, getting a second opinion about handwriting issues before entering the prescription, and performing a double check on all look-alike, sound-alike medications.
11. A 63-year-old male was prescribed fentanyl 25 mg/hr patches, but was dispensed 75 mg/hr patches. Patient reported "palpitations and nausea after applying first patch." He then applied a second patch after 72 hours and went to the doctor's office. The doctor noticed the patch was the wrong strength. The prescription was typed "Fentanyl Patch 72 hour 25 mcg/hr Transdermal," but the "72" was read as "75 mg" when entering the prescription, which lead to the incorrect strength being dispensed. Pharmacist recommends double-checking data entry, and carefully reading prescriptions when entering.
12. A 78-year-old female was prescribed metformin ER 500 mg, but was dispensed ibuprofen 600 mg. Patient's daughter reported her mother experienced gastrointestinal distress. A return to stock vial was used to fill the medication instead of the stock bottle. The return to stock vial was in the wrong location, and the filling technician failed to notice it was the wrong medication. The pharmacy utilizes a robot for filling these medications, so there is no matching the NDCs when filling. Pharmacist recommends opening the vial to show the medication to the patient when he or she is picking up medications.
13. A 48-year-old female was prescribed WP Thyroid® 130 mg (2 gr), but was dispensed WP Thyroid 260 mg (4 gr). Patient reported excessive anxiety and rapid heartbeat. Prescription read "2 grains daily in the am w/o food," but was entered as two tablets daily. Pharmacist recommends carefully reading prescriptions during data entry and carefully reviewing the prescriptions.
14. A 50-year-old female was prescribed dilaudid 4 mg, but was dispensed hydromorphone 4 mg and methylphenidate. Patient reported experiencing insomnia. The error occurred at filling when two different stock bottles were used to fill the medication. The stock bottles look very similar and were not noticed by the filling technician. Pharmacist recommends double-checking the NDCs when using two stock bottles.
15. A 75-year-old male was prescribed clonazepam 0.125 mg, but was dispensed clonazepam 0.125 mg and clonazepam 2 mg. Patient reported feeling "sleepy all the time and could not walk steadily." Patient went to the emergency room on two different days, having an MRI and CAT scan completed. Patient also visited a neurologist. The error occurred at filling when two different stock bottles were used to fill the prescription. Pharmacist recommends separating the stock bottles on the shelf so they are not directly next to each other, coaching the filling technician on double-checking the label and the NDC, and carefully matching the tablet to the NDC during the final check.

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16. A 71-year-old female was prescribed metolazone 5 mg, but was dispensed methimazole 5 mg. Patient reported going to the hospital with symptoms of chest pain. At follow-up, the primary care provider noticed the medication error and contacted the pharmacy. The wrong drug was entered, and when the pharmacist performed a DUR, nothing was identified because the patient uses two pharmacies. Pharmacist recommends double-checking prescription during data entry.
17. A 53-year-old male was prescribed Namenda® Titration Pak and Namenda XR® 28 mg, but was dispensed only Namenda XR 28 mg. Patient reported anxiety and sweating. Patient was supposed to start with the titration pak and then start the XR 28 mg once the pak was completed. The pharmacy did not have the titration pak in stock. The patient was informed at pickup to return to the pharmacy the next day to pickup the titration pak, but he never returned. Pharmacist recommends dispensing starter packs first and, once completed, dispensing the maintenance strength.
18. A 32-year-old female was prescribed HCTZ 25 mg, but was dispensed lisinopril 10 mg. Patient reported being hospitalized due to low blood pressure. The wrong medication was placed in the correctly labeled vial. Pharmacist recommends opening the vial and examining the tablets during the final check.
19. A 50-year-old female was prescribed medications, but was dispensed another patient's medication of Coumadin® 7.5 mg. Patient reported swollen legs and feet and went to the emergency room where the medication error was discovered. Patient's international normalized ratio was 16 and was corrected with Vitamin K and plasma. A prescription from the same doctor for two different patients was scanned in under one patient. The patient received the additional prescription. Pharmacist recommends double-checking name and date of birth at data entry for each prescription, and also slowing down and thoroughly checking medications that are high risk.

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.

2016 Board Law Update Schedule

You may receive one hour per year of continuing education (CE) in the area of pharmacy law by attending one full day of a regularly scheduled Board meeting or serving on a Board-approved committee. You will need to do this each year, because a total of two hours in pharmacy law is required.

Two hours of pharmacy law is required of every active licensed pharmacist each biennial renewal period. If you are a pharmacist who resides and/or practices within New Mexico, you can attend a live law update put on by the Board to meet this requirement.

For 2016, one law update will be scheduled in the Albuquerque, NM area each month. The update will be held at the Board office. The Board office has moved to 5500 San Antonio Dr NE, Suite C. Each of these law updates will be held on a Friday from 2 to 4 PM. Please note that there will no longer be a morning and afternoon session; it will only be one session in the afternoon. The following law updates are currently scheduled: January 8, February 12, March 11, April 1, May 6, June 3, July 8, August 5, September 9, October 7, November 18, and December 16, 2016.

The Board will conduct 10 law updates for areas outside of Albuquerque. These updates are held in different areas of New Mexico, and will all be on a Tuesday night from 7 to 9 PM. The following updates are currently scheduled.

- **February 9, 2016**
  Memorial Medical Center of Las Cruces
  Conference Rooms A & B West Annex
  2450 S Telshor Blvd, Las Cruces, NM 88011
- **February 23, 2016**
  Eastern New Mexico University-Roswell, Lawrence C. Harris Occupational Technology Center
  20 W Mathis, Roswell, NM 88203
- **March 22, 2016**
  Presbyterian Española Hospital
  1010 Spruce St, Española, NM 87532
- **April 5, 2016**
  Gila Regional Medical Center
  1313 East 32nd St, Silver City, NM 88061
- **April 26, 2016**
  Rehoboth McKinley Christian Health Care Services
  1901 Redrock Dr, Gallup, NM 87301
- **May 10, 2016**
  Miners' Colfax Medical Center Long Term Care Facility
  900 S 6th St, Raton, NM 87740
- **May 24, 2016**
  San Juan College
  4601 College Blvd, Farmington, NM 87401
- **September 27, 2016**
  Gerald Champion Regional Medical Center
  2669 Scenic Dr, Alamogordo, NM 88310
- **November 15, 2016**
  Carlsbad Medical Center
  2430 W Pierce St, Carlsbad, NM 88220
- **December 13, 2016**
  MountainView Regional Medical Center
  4311 E Lohman Ave
  Las Cruces, NM 88011

To ensure you receive a certificate and required credit for your live pharmacy law as offered by the Board, please call the Board at 505/222-9830 to register, or you can register by emailing yvette .tenorio2@state.nm.us. By registering, you can be ensured a spot in case the room fills. Also, the Board can notify you, if necessary, in case an update needs to be moved to a different location or an unforeseen event takes place. Law updates as offered by the Board are not Accreditation Council for Pharmacy Education (ACPE)-accredited.

In addition, the Board will offer a pharmacy law update for the New Mexico Pharmacists Association (NMPhA) during the NMPhA Annual Convention and the 2016 Mid-Winter Meeting. During the New Mexico Society of Health-System Pharmacists Balloon Fiesta Symposium, a law update will be held. Both of these associations offer ACPE-accredited CE. Please contact the respective association for information and to register.

2016 Regular Meeting Schedule

The following Board meetings are scheduled for 2016:

- Monday and Tuesday, January 25-26, 2016
- Thursday and Friday, April 21-22, 2016
- Thursday and Friday, June 23-24, 2016
- Thursday and Friday, August 25-26, 2016 – Ruidoso, NM, meeting
- Thursday and Friday, October 20-21, 2016

All meetings begin at 9 AM. Information regarding Board meetings is posted at least 72 hours prior to the start of a meeting. For information, you may look on the Board website under the "Members and Meetings" tab, which is where the agenda is posted. Links are provided for information pertaining to the meeting. If you do not have access to the Internet, contact the Board and it will mail you the requested information. All meetings, except for the Ruidoso meeting, will be held at the Board office. Please verify meeting dates, times, and locations, as they can be changed.

The *New Mexico Board of Pharmacy News* is published by the New Mexico Board of Pharmacy and the National Association of Boards of Pharmacy Foundation™ (NABPF™) 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 NABPF or the Board unless expressly so stated.

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