January 2014

Oklahoma State Board of Pharmacy News

Published to promote compliance of pharmacy and drug law

4545 N Lincoln Blvd, Suite 112 • Oklahoma City, OK 73105-3413

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Disciplinary Actions

For more information you may view hearing minutes at *www.pharmacy.ok.gov.*

14.01. October 24, 2013 Board Hearing

Byron Banks, Technician #10394 – Case No. 1210: Found guilty of four violations including possession of a controlled dangerous substance (CDS) without a valid prescription and abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Garrett Best, Technician #12037 – Case No. 1211: Found guilty of three violations including abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Alicia A. Byard, Technician #17416 – Case No. 1212: Admitted guilt on four violations including possession of a CDS without a valid prescription and abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Darren Cobble, Technician #10663 – Case No. 1213: Found guilty of five violations including theft; possession of a CDS without a valid prescription; and abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Dana Cothern, Technician #14799 – Case No. 1214: Found guilty of three violations including theft. **Revoked.**

Heather Duff, Technician #3800 – Case No. 1215: Found guilty of four violations including possession of a CDS without a valid prescription and abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Rebecca Eidson, Technician #10066 – Case No. 1216: Found guilty of seven violations including theft; possession of a CDS without a valid prescription; abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite; and filing a report or record that the registrant knows to be false. **Revoked.**

Micaiah Naboth Rea, Technician #16177 – Case No. 1217: Found guilty of three violations including theft. **Revoked.**

Cheyanne Reece, Technician #3781 – Case No. 1218: Found guilty of four violations including possession of a CDS without a valid prescription and abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

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Changes to Fentanyl Pain Patch Warnings Required by FDA

To reduce the risk of accidental exposure, Food and Drug Administration (FDA) has announced new requirements that change the appearance of fentanyl pain patch warnings to make them more visible. The change also requires new language in the warning that emphasizes the risk of death from accidental exposure, particularly in children. The announcement coincided with a Consumer Update that stressed the potential danger of improperly discarded fentanyl patches to children and pets. FDA reminded consumers of the agency's previous advice for securely storing unused patches and disposing of used fentanyl patches by folding the sticky sides together and then flushing them down the toilet. The agency also advises patients to cover in-use patches with an adhesive film to keep them from coming loose, and to regularly check patches to ensure they are securely in place. FDA offers additional information for health care providers on the "Fentanyl Transdermal System (marketed as Duragesic) Information" page, available at *www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm114961.htm*. Consumer information about safe drug disposal methods is also available on the AWAR$_X$E® Web site at *www.AWARERX.ORG*.

New: Free ISMP Medication Safety Alert! Newsletter for LTC Facilities

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 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.*

In July, ISMP began publishing *Long-Term Care Advise-ERR,* a new *ISMP Medication Safety Alert!* newsletter for nurses and administrators in long-term care (LTC) facilities. ISMP receives error reports that have occurred in LTC facilities. The newsletter is provided free to LTC facilities in the United States thanks in part to corporate sponsorship from Lilly and for a nominal subscription fee for pharmacies that service LTC facilities and others. Please visit ISMP's Web site at *www.ismp.org/Newsletters/longtermcare* for more information, and let your LTC facilities know about this free offer.

Here are a few excerpts from a recent issue.

Immediate Vs Extended Release Error

A physician called a LTC facility to change a resident's oxycodone order from an extended-release formulation to an immediate release formulation at the same dose and frequency. The nurse receiving the verbal order transcribed it as "Discontinue OxyContin 10 mg BID, Start OxyContin 10 mg IR BID," with "IR" meant to represent immediate release. Although Oxy**Contin**® is a brand of oxy**codone,** it is only available as an extended-release tablet. The pharmacy had previously been dispensing Oxy**Contin** for the resident, so the nurse thought she could communicate the prescriber's order by discontinuing the current Oxy**Contin** order and then ordering Oxy**Contin** as an immediate-release product. The pharmacy continued dispensing Oxy**Contin.** The differences between these products and formulations were brought to the attention of nursing staff via an in-service. To minimize the risk of confusion, do not attach modifiers such as "IR" for immediate-release or "RS" for regular strength unless it is part of the official drug name.

Errors Occur During Transitions of Care

A pharmacist reported the following hazardous situation that can occur during a hospital to LTC transfer. Residents are often admitted to a LTC facility with a list of medications printed from the hospital pharmacy computer. On these printouts, doses are expressed along with the number of tablets. For example, the printout may list hydrochlorothiazide 50 mg/2 tablets daily for an order in which the total dose was 50 mg because the hospital only stocks the 25 mg tablets. During hospitalization the patient required two tablets for each dose; however, the LTC nurse may misinterpret the order to mean two 50 mg tablets, making the total dose 100 mg, or two times more than prescribed. This issue arises every time the resident's total dose in the hospital requires more than one tablet or capsule. Discharge medication summaries and transfer orders should only list the total dose in mg or mcg and other directions for use (ie, frequency, route, drug name) to avoid misinterpretation.

2013 USP Chapter <797> Compliance Survey Shows Compliance Trends Unchanged From 2012

The 2013 United States Pharmacopoeia (USP) Chapter <797> Compliance Survey, the third annual report released since 2011, shows that the overall compliance rate of 77.2% remains nearly unchanged from the 2012 rate. Budgetary restrictions and physical plant limitations were among the top challenges to compliance by survey respondents. The report also details the

survey's findings on what types of facilities are participating in compounding, and compliance in specific domain areas such as environmental sampling and gloved fingertip sampling. Of the survey's 1,045 participants, 97% of the survey's respondents said that USP Chapter <797> "has had a positive influence on patient safety." The report notes National Association of Boards of Pharmacy® (NABP®) efforts to assist state boards of pharmacy in evaluating pharmacy compliance with USP Chapter <797> requirements for sterile compounding in their states. The report also noted that those who participated in the 2011 survey had a higher compliance score than those who did not. The survey's authors encouraged pharmacy owners with multiple areas of noncompliance to target one or two areas to improve. They also encouraged organizations that participated in the survey to make use of the free Action Plan – generated upon completion of the survey – and other free resources to "reshape" their sterile compounding practices. The full report on the survey's results is available in the October 2013 issue of *Pharmacy Purchasing & Products Magazine* and on the magazine's Web site at *www.pppmag.com/article/1403*.

FDA Recommends Schedule II Classification for Hydrocodone Combination Products

FDA planned to submit a formal recommendation to reclassify hydrocodone combination products as Schedule II controlled substances to the Department of Health and Human Services by early December 2013. FDA expects the National Institute on Drug Abuse to concur with the recommendation, indicates a statement on the FDA Web site. FDA also indicates that while "the value of and access to these drugs has been a consistent source of public debate," the agency has "been challenged with determining how to balance the need to ensure continued access to those patients who rely on continuous pain relief while addressing the ongoing concerns about abuse and misuse." Drug Enforcement Administration makes the final decision about the appropriate scheduling of these drugs. In January 2013, FDA's Drug Safety and Risk Management Advisory Committee made a recommendation that hydrocodone combination products be classified as Schedule II drugs following a 19-to-10 vote that concluded a two-day meeting during which members discussed the potential for abuse and misuse of the medications and the potential impact of rescheduling the drug products. FDA's statement on the recommendation is available at *www.fda.gov/Drugs/DrugSafety/ucm372089.htm*.

New FDA Drug Info Rounds Training Videos Available

FDA Drug Info Rounds, a series of online videos, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better medication decisions. In the latest two Drug Info Rounds videos, pharmacists discuss the review and approval of new drug names and the review of marketing and advertising materials for new drugs. The videos can be viewed at *www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm368620.htm* and *www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm371785.htm,* respectively. Drug Info Rounds is developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research, Office of Communications, and Division of Drug Information.

CPPA Developing Specialty Pharmacy Accreditation Program

The Center for Pharmacy Practice Accreditation® (CPPA) has announced the development of a new accreditation program for specialty pharmacy practices. CPPA Executive Director Lynnae Mahaney, MBA, RPh, FASHP, VHA-CM, indicates that "CPPA will be able to develop the new specialty pharmacy standards quickly and efficiently with the existing standards development methodology, infrastructure, and network of specialty pharmacy expertise."

CPPA is a partnership between the American Pharmacists Association, the American Society of Health-System Pharmacists, and NABP. CPPA develops and implements comprehensive programs of pharmacy practice site accreditation, including the promotion, development, and maintenance of principles, policies, and standards. CPPA offers the general public and users of pharmacy services a means of identifying those pharmacies that satisfy the accreditation criteria and are focused on advancing patient care, safety, and quality.

More information may be found in the press release, available at *www.pharmacypracticeaccredit.org/news/2013/10/cppa-to-develop-specialty-pharmacy-accreditation-program*.

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Michelle Robertson, Technician #18173 – Case No. 1219: Found guilty of four violations including theft and possession of a CDS without a valid prescription. **Revoked.**

Summer Washington, Technician #17338 – Case No. 1220: Found guilty of four violations including theft and possession of a CDS without a valid prescription. **Revoked.**

Timothy Weigand, Technician #16322 – Case No. 1221: Found guilty of five violations including theft; possession of a CDS without a valid prescription; and conducting business in a registrant's capacity without reasonable skill and safety. **Revoked.**

Trinity Apothecary, #99-6362 – Case No. 1222: Found guilty of five violations including failing to make application and receive an annual nonresident pharmacy license; failing to send Schedule II, III, and IV prescription records to the Oklahoma Control Reporting program; engaging in selling at retail, or offering for sale, dangerous drugs or accepting prescriptions for same without first procuring a license from the Oklahoma State Board of Pharmacy; and failing as a dispenser to transmit to a central repository designated by the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control certain information for each dispensation of Schedule II, III, IV, or V CDS. **Probation for three years until October 24, 2016. Total fine of $15,000.**

Walgreens Pharmacy #10957, #47-5233 – Case No. 1223: Neither admits nor denies guilt on five violations including failing to have a pharmacy manager who established and maintained effective controls against the diversion of prescription drugs; failing to have a pharmacy manager who supervises employees as they relate to the practice of pharmacy; failing to provide effective controls and procedures to guard against theft and diversion of CDS; and failing to establish and maintain effective controls against the diversion of prescription drugs. **Probation for one year until October 24, 2014. Total fine of $15,000.**

Jeremy Shawn Logan, DPh, #14595 – Case No. 1224: Neither admits nor denies guilt on two violations including failing, as pharmacy manager, to establish and maintain effective controls against the diversion of prescription drugs; and failing, as pharmacy manager, to supervise employees as they relate to the practice of pharmacy. **Letter of reprimand for one year until October 24, 2014. Total fine of $2,000. Shall attend a one-day (eight hour) law seminar in addition to the required 15 hours of continuing education (CE) during either calendar year 2013 or 2014. All 15 hours of required CE during calendar year 2014 shall be live.**

14.02. November 21, 2013 Board Hearing

Christopher Gibson, Technician #16592 – Case No. 1226: Found guilty of three violations including theft; possession of a CDS without a valid prescription; and unlawfully distributing, dispensing, transporting with intent to distribute or dispense, or possessing with intent to manufacture, distribute, or dispense a CDS. **Revoked.**

Kelley Vaverka, Technician #17320 – Case No. 1227: Found guilty of four violations including theft; possession of a CDS without a valid prescription; abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite; and attempting diagnosis or treatment that is the legally constituted right or obligation of any practitioner of the healing arts. **Revoked.**

Linda Lucille Caygle, Technician #4103 – Case No. 1228: Pled no contest on four violations including performing duties that may not be performed by supportive personnel. **Revoked.**

Destiny Jameson, Technician #16888 – Case No. 1229: Admitted guilt on two violations including abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Adrianne Jones, Technician #17245 – Case No. 1230: Found guilty of two violations including theft. **Revoked.**

Serena L. Dodson, Technician #2187 – Case No. 1231: Neither admits nor denies guilt on four violations including theft and possession of a CDS without a valid prescription. Revoked.

Kortni Fox-Hendrix, Technician #16560 – Case No. 1232: Admitted guilt on three violations including theft and possession of a CDS without a valid prescription. **Revoked.**

Cherokee Hills Pharmacy, Inc, #36-5140 – Case No. 1252: Admitted guilt on 940 violations including providing fraudulent billing or reports to a third-party payer; filling or refilling a prescription without authorization; failing to maintain and have readily retrievable for five years an original prescription; failing to maintain and have readily retrievable all prescription purchases and inventory records for a period of at least two years; and failing to maintain the area(s) used for the compounding of drugs in a good state of repair. **Total fine of $100,000.**

Richard Dandridge, DPh, #12894 – Case No. 1253: Admitted to guilt on 947 violations including providing fraudulent billing or reports to a third-party payer; knowingly billing or charging for quantities greater than delivered, or for a brand when a generic or a compounded product is dispensed; filling or refilling a prescription without authorization; failing to maintain and have readily retrievable for five years an original prescription; failing to maintain and have readily retrievable all prescription purchases and inventory records for a period of at least two years; failing to ensure that all compounders who compound sterile pharmaceuticals meet all requirements for training, testing, and education; failing as pharmacist-in-charge (PIC) to have available written policies and procedures for all steps in the compounding of preparations; failing to ensure that staff is adequately trained and evaluated; failing, as PIC, to make sure that appropriate procedures for compounding high-risk sterile products are met; failing to maintain the area(s) used for the compounding of drugs in a good state of repair; failing to maintain drug compounding controls; and failing to include the required information on the outpatient prescription label. **Respondent is suspended for five years and the suspension is immediately stayed and placed on probation for five years until November 21, 2018. Total fine of $100,000. Shall attend a one-day (eight hour) law seminar in addition to the required 15 hours of CE during the calendar years of 2014 and 2015. All 15 hours of required CE during the five years of probation shall be live.**

Calvin Vanzandt, DPh, #7694 – Case No. 1254: Admitted to guilt on 11 violations including knowingly billing or charging for quantities greater than delivered, or for a brand when a generic or a compounded product is dispensed; filling or refilling a prescription without authorization; failing to maintain and have readily retrievable for five years an original prescription; failing to be proficient in compounding and failing to be familiar with all details of United States Pharmacopeia compounding standards; compounding a drug product that is commercially available in the marketplace; failing to maintain drug compounding controls; failing to set correct beyond-use dates; and failing to include the required information on the outpatient prescription label. **Respondent is suspended for five years and the suspension is immediately stayed and respondent's license is placed on senior inactive status. Total fine of $5,500.**

From the Inspector's Desk

♦ **14.03. Gray Market Vendors:** Of 125 hospital pharmacy directors in Texas, more than 85% reported that they have been contacted by "gray market" vendors offering to sell drugs in short supply, as indicated by preliminary results of

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an ongoing study presented at Interchange 2013, a conference held by the Partnership for Safe Medicines. The study also found that almost 25% of pharmacy directors surveyed reported being asked to sell drugs they had in their inventories. Oklahoma hospital and retail pharmacies are prohibited from selling medications to wholesalers. (Pharmacies may return drugs to the wholesaler they were purchased from.) Oklahoma pharmacies that wish to purchase drugs from gray market vendors should check the Board Web site to determine if the vendor is licensed by the Board. Compliance officers often find pharmacies that have purchased drugs from companies that are not licensed, including Canadian and other non-United States-based companies that did **not** have a Food and Drug Administration license to ship drugs into the US.

- **14.04. Technician and Intern Identification:** All technicians and interns working in retail or hospital pharmacies must have name tags that identify them as a technician or intern. An intern may work in a pharmacy only as an intern, and only when there is a 1:1 ratio of preceptor-intern. Interns may work only in Board-licensed training sites. Interns should check the pharmacy license to ensure that it is approved as a training site, and check the pharmacist's license to ensure he or she is a preceptor.
- **14.05. Technicians May Not Counsel:** Technicians are not allowed to counsel patients at any time. The pharmacy, PIC, and the pharmacist on duty are all responsible for ensuring that technicians only complete tasks within the rules and regulations for technicians.
- **14.06. OBN Waiver Requirement for Misdemeanor Drug Conviction or Felony Conviction:** The requirement for a waiver from the Oklahoma Bureau of Narcotics (OBN) for a person who has a misdemeanor drug conviction or a felony conviction of any kind applies to **all** personnel working in a situation where they have access to controlled substances. This includes clerks, technicians, interns, and pharmacists. Background checks of pharmacy personnel, including interns, should be a vital part of all pharmacies' drug diversion prevention plan. Pharmacies and PICs are responsible for reviewing the background of personnel to determine if an OBN or Drug Enforcement Administration waiver is needed prior to employment.
- **14.07. Recycling Name Brand Prescription Drug Bottles:** There have been reports nationwide where pharmacy employees have been contacted and requested to "save" empty name-brand prescription drug bottles for a plastic recycling company. But rather than recycling the plastic bottles, the bottle is refilled with counterfeit medication and resealed to look like an original unopened bottle. The counterfeit is then resold outside the normal distribution channel, such as when a pharmacy receives a fax from an unknown wholesaler or other company offering a drug that is in short supply or at a substantial price reduction. No doubt there are legitimate plastic recycling companies that do recycle prescription drug bottles. However, the Board strongly recommends that if you do send plastic bottles for recycling, please obliterate the bar code and lot number information on the bottle. In addition, always use "due diligence" to ensure that any drugs you purchase come from legitimate companies that are licensed by the Board to ship into Oklahoma.
- **14.08. Hydrocodone Refill Update:** Visit *www.pharmacy.ok.gov* to view the full document.
  - ◊ A pharmacy may partially fill a hydrocodone prescription only if it is unable to supply the full quantity. The remaining portion must be filled within 72 hours, and no further quantity may be supplied after that time without a new prescription.
  - ◊ Pharmacies may partially fill hydrocodone prescriptions for terminally ill patients and/or patients in a long-term care facility for up to 60 days. See OAC 475:30-1-7 for more detailed information about documentation.
  - ◊ A hydrocodone prescription may be transferred from one pharmacy to another only if it has never been filled at the original pharmacy (ie, on hold). Examples of this may be when a prescriber has sent the prescription to the wrong pharmacy or a pharmacy does not have the medication in stock.
  - ◊ If a patient has a prescription for a certain quantity of hydrocodone and his or her insurance will only pay for part of that prescription, he or she may pay cash for the remainder but it must occur within the same transaction and the pharmacist should document this on the back of the prescription.
  - ◊ The Oklahoma Bureau of Narcotics and Dangerous Drugs has interpreted OAC 475:30-1-11 to mean that a prescriber may not write multiple prescriptions on the same date with instructions to fill some of those prescriptions at a later date. This applies to Schedule II prescriptions as well as all other CDS prescriptions, including hydrocodone.
  - ◊ There is no legal limitation on the days supply for any CDS prescription.

Calendar Notes

The Board will meet on **January 15, February 19,** and **April 16, 2014.** The Board will be closed Monday, **January 20,** for Martin Luther King, Jr, Day and Monday, **February 17,** for Presidents' Day. Future Board dates will be available at *www.pharmacy.ok.gov* and will be noted in the April *Newsletter.*

Change of Address or Employment?

Please be diligent in keeping your information up to date and if possible, remind your coworkers and employees. This continues to be an ongoing problem and failure to notify the Board is a violation of Oklahoma pharmacy law. All pharmacists, technicians, and interns must notify the Board in writing within 10 days of a change of address or employment. Online updates through the license renewal page are also accepted as official notification.

Special Notice About the Newsletter

The *Oklahoma State Board of Pharmacy Newsletter* is an official method of notification to pharmacies, pharmacists, pharmacy interns, and pharmacy technicians registered by the Board. Please read them carefully. The Board encourages you to keep them for future reference.

Oklahoma Pharmacists Helping Pharmacists

If you or a pharmacist you care about is suffering from chemical dependency, there is a solution. Oklahoma Pharmacists Helping Pharmacists (OPHP) is readily available for help. Pharmacists in Oklahoma, Texas, and Louisiana may call the OPHP help-line at 1-800/260-7574, ext 5773. All calls are confidential.

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John A. Foust, DPh - State News Editor

Carmen A. Catizone, MS, RPh, DPh - National News Editor & Executive Editor

Deborah Zak - Communications Manager