

April 2013

News



# Oklahoma State Board of Pharmacy

*Published to promote compliance of pharmacy and drug law*

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

## ***New Board Compliance Officer***



**Melissa Reichert, PharmD, DPh,** of Pocola, OK, began employment with the Oklahoma State Board of Pharmacy as a compliance officer on January 23, 2013. Melissa graduated Rho Chi with special distinction from the University of Oklahoma College of Pharmacy in 2007. Melissa was previously employed as a community pharmacist for

an independent pharmacy in Fort Smith, AR. Melissa's territory includes southeastern Oklahoma. She receives e-mail at [mreichert@pharmacy.ok.gov](mailto:mreichert@pharmacy.ok.gov).

## ***New Board Office Building***

Construction of the new Board office building continues on schedule and on budget. The new building is located at 2920 N Lincoln Blvd, just a few blocks north of the State Capitol, and should be completed by early June. The new building will be completely paid for when the Board moves in. Funding for the construction of the building was generated entirely from over two decades of frugal financial management and savings by the Board. The building was designed by Krittenbrink Architecture with ultra-high efficiency geothermal-based heating, ventilation, and air conditioning; insulated glass; high R-value foam wall and roof insulation; and high efficiency lighting to make it one of the most energy efficient buildings on the State Capitol campus. The Board has rented space since 1907, when the Board was created by the Oklahoma Constitution by combining the Indian and Oklahoma Territorial Boards of Pharmacy, and the new building will be a permanent home. The Board offices will occupy the west wing of the building while the east wing of the building will be leased to two other small state agencies. All three agencies will share the main entry, which opens to a central common area housing the boardroom, restrooms, and utility rooms, giving exceptional value to the building by multi-tasking rooms for cost-efficient utilization of space. The new larger boardroom will allow the Board to expand its use as a continuing education (CE)

venue. For example, the Board plans to require all college of pharmacy students intending to license in Oklahoma to attend one Board meeting during their senior year so that they may become more familiar with their professional Board's duties in the protection of the health, safety, and welfare of the citizens of the state. An open house is planned for June.

## ***From the Inspector's Desk***

### ♦ **13.09. Faxed Prescriptions and Tamper-Resistant Paper:**

If you receive a faxed prescription from the physician's office written on tamper-resistant paper and it states **VOID** all across the prescription, it is okay to use that prescription as the original prescription. You do not need to call the physician and verify the prescription. The tamper-resistant paper is intended to prevent the patient from photocopying the prescription.

♦ **13.10. CII-V Invoices:** All CII-V invoices must be dated when received (21 CFR 1304.21(d)). Simply dating the Drug Enforcement Administration Form 222 is not sufficient, nor is the pre-printed date on the invoices. It must be manually written. Each separate invoice must be dated individually, but not each page. The Board also recommends that the person checking in the order initial or sign the invoice. Do not forget to maintain a three-file system for the invoices (CII, CIII-V, and non-controlled). Pseudoephedrine (PSE) invoices may be kept separately or may be filed with CIII-CV invoices. Transfers to/from other pharmacies (even intra-company) must be documented with invoices complete with date received.

### ♦ **13.11. PMP Reporting for Hospital Emergency Rooms:**

The Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) Prescription Monitoring Program (PMP) requires that all controlled dangerous substance (CDS) medications dispensed by a hospital emergency room for a patient to take with him or her when he or she leaves must be reported to the PMP in the same manner as all other dispensed CDS prescriptions. There are no exceptions. It is the responsibility of the hospital and the hospital pharmacy or drug room pharmacist-in-charge (PIC) by virtue

*Continued on page 4*



## FDA Issues New Guidelines for Sleep Aids Containing Zolpidem

Food and Drug Administration (FDA) has issued new dosing recommendations for sleep aids containing zolpidem. The new recommendations are based upon new data that shows that when taken at night, blood levels of zolpidem remain high enough in the morning to impair activities that require alertness, such as driving. The new guidelines halve the dosage for women because the new data showed that their bodies take longer to eliminate the drug.

FDA urges drug manufacturers and health care providers to follow the new dosing instructions, which apply to brand name and generic drugs containing zolpidem:

- ◆ Ambien<sup>®</sup>, Edluar<sup>™</sup>, and Zolpimist<sup>®</sup>: 5 mg for women, 5 mg or 10 mg for men
- ◆ Ambien CR<sup>®</sup>: 6.25 mg for women, 6.25 mg or 12.5 mg for men

Additionally, manufacturers of these drugs have been instructed to follow the new guidelines and print new patient information drug labels containing the new recommendations.

The recommended doses of Intermezzo<sup>®</sup>, a lower dose zolpidem product approved for middle-of-the-night awakenings, are not changing. At the time of Intermezzo's approval in November 2011, the label already recommended a lower dosage for women than for men. Additional details are available in an FDA Drug Safety Communication, available at [www.fda.gov/Drugs/DrugSafety/ucm334033.htm](http://www.fda.gov/Drugs/DrugSafety/ucm334033.htm).

## What is the National Medication Error Rate? What Standards Are Available for Benchmarking?

 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!<sup>®</sup> Community/Ambulatory Care Edition by visiting [www.ismp.org](http://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](http://www.ismp.org). ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: [ismpinfo@ismp.org](mailto:ismpinfo@ismp.org).

A national or other regional medication error rate does not exist. It is not possible to establish a national medication error rate or set a benchmark for medication error rates. Each pharmacy organization is different. The rates that are tracked are a measure of the number of **reports** at a given organization, not the actual number of **events** or the quality of the care given. Most systems for measuring medication errors rely on voluntary reporting of errors and near-miss events. Studies have shown that even in good systems, voluntary reporting only captures the "tip of the iceberg." For this reason, counting **reported** errors yields limited information about how safe a pharmacy actually is. It is very possible that a pharmacy organization with a good

reporting system, and thus what appears to be a high error "rate," may have a safer system.

The National Coordinating Council for Medication Error Reporting and Prevention published a statement refuting the use of medication error rates. The statement, which is posted on the council's Web site ([www.nccmerp.org](http://www.nccmerp.org)), states the "Use of medication error rates to compare health care organizations is of no value." The council has taken this position for the following reasons:

- ◆ Differences in **culture** among health care organizations can lead to significant differences in the level of reporting of medication errors.
- ◆ Differences in the **definition** of a medication error among health care organizations can lead to significant differences in the reporting and classification of medication errors.
- ◆ Differences in the **patient populations** served by various health care organizations can lead to significant differences in the number and severity of medication errors occurring among organizations.
- ◆ Differences in the **type(s) of reporting and detection systems** for medication errors among health care organizations can lead to significant differences in the number of medication errors recorded.

According to the statement, the council believes that there are no acceptable incidence rates for medication errors. The goal of every health care organization should be to continually improve systems to prevent harm to patients due to medication errors. Pharmacies should monitor actual and potential medication errors that occur within their organization, and investigate the root cause of errors with the goal of identifying ways to improve the medication-use system to prevent future errors and potential patient harm. The value of medication error reporting and other data gathering strategies is to provide the information that allows an organization to identify weaknesses in its medication-use system and to apply lessons learned to improve the system. The sheer number of error reports is less important than the quality of the information collected in the reports, the organization's analysis of the information, and its actions to improve the system to prevent harm to patients.

It is more important to create the open environment that encourages the reporting of errors and near errors than to develop less meaningful comparative error rates.

## ISMP Launches Program to Track Vaccine Errors

ISMP has launched a National Vaccine Error Reporting Program (VERP) that allows health care providers to confidentially report vaccine administration errors and near misses. Health care providers from all practice settings, including pharmacies and physicians' offices, are encouraged to report all mistakes related to vaccines, regardless of whether any harm resulted from the incident. The program will help ISMP "better quantify the sources of errors and advocate for vaccine name, labeling, device, information, and other needed product changes to ensure patient safety," stated Michael Cohen, ISMP president. The ISMP VERP was designed with the assistance of the California Department of Public Health and with input from experts in the field, indicates ISMP. Reports sent to the ISMP VERP will be shared with FDA and forwarded to the vaccine manufacturer when applicable. ISMP also plans to work with the Centers for Disease Control and Prevention on information received to address vaccine-related safety. VERP can be accessed at <http://verp.ismp.org/>.



## Providers Should Ensure Only Diluted Forms of Acetic Acid Are Used, ISMP Warns

ISMP has issued a National Alert Network (NAN) notice advising that health care organizations should take immediate steps to ensure that only diluted acetic acid solutions are used in patient care. ISMP advises that the use and purchase of glacial acetic acid, the most concentrated form of acetic acid available, should be eliminated. Several cases of severe burns, scarring, and other permanent damage to skin or mucous membranes due to the inadvertent application of glacial acetic acid have been reported to the National Medication Errors Reporting Program operated by ISMP. ISMP provides the following steps for preventing further such events:

- ◆ Remove glacial acetic acid, which has no use in its current form in clinical medicine, from the pharmacy and replace with vinegar (5% solution) or commercially available diluted acetic acid 0.25% (for irrigation) or 2% (for otic use).
- ◆ Restrict purchasing so that pharmacy staff is purchasing acetic acid for all procedural areas.
- ◆ Restrict choices for purchasing so that glacial acetic acid is not selected by mistake.
- ◆ Ensure the correct strength is ordered.
- ◆ Educate staff about the differences between glacial acetic acid and diluted forms of acetic acid.
- ◆ Order 5% as “vinegar,” which reduces the potential for confusion with glacial acetic acid.
- ◆ Verify the product by requiring an independent double-check of acetic acid solutions before dispensing or applying the product.

Information on the cases reported and common reasons for the cases are included in the NAN alert, which is available on the ISMP Web site at [www.ismp.org/NAN/files/20130121.pdf](http://www.ismp.org/NAN/files/20130121.pdf).

## New FDA Training Video

FDA Drug Info Rounds, a series of online training 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 Drug Info Rounds video, pharmacists discuss how FDA Drug Safety Communications let health care providers, patients, and consumers know about newly observed potential risks of FDA-approved drugs. Drug Info Rounds videos are developed with contributions from pharmacists in FDA’s Center for Drug Evaluation and Research, Office of Communications, and Division of Drug Information and are available on the FDA Web site at [www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm](http://www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm).

## Progress Made in Implementing Recommendations Intended to Prevent Acetaminophen Overdose

Compelling progress has been made by stakeholders seeking to address the public health issue of acetaminophen overdose, indicates a white paper published by the National Council for Prescription Drug Programs (NCPDP). In 2011, NCPDP made recommendations that the health care industry take actions to support the safe use of acetaminophen, including recommending that pharmacies produce prescription labels with the complete spelling of acetaminophen and eliminating use of abbreviations such as “acet” or “APAP.” Previous to that, in July 2010, the National Association of Boards of Pharmacy® (NABP®) recommended that “state boards of pharmacy

prohibit the use of the abbreviation ‘APAP’ on prescription labels, and require that ‘acetaminophen’ be spelled out to assist in preventing the well-recognized danger of acetaminophen induced hepatotoxicity.” The recommendation was based on established policy and a letter, sent by FDA to state boards of pharmacy, regarding the pharmacist’s role in educating patients about acetaminophen induced hepatotoxicity caused by unintentional overdose. The recommendation was also consistent with the report of the NABP Task Force on Uniform Prescription Labeling Requirements, which made recommendations to encourage use of prescription labels that are organized in a patient-centered manner. NCPDP reports that pharmacy retailers “estimated to collectively represent more than half of the prescriptions dispensed in 2011, have either implemented or committed to a phased implementation” of the recommendation to use the complete spelling of acetaminophen on prescription labels. “This update to our white paper provides additional guidance for those industry stakeholders who have not yet implemented the new pharmacy labeling practices for acetaminophen-containing medicines,” states Lee Ann Stember, president, NCPDP. The updated white paper is accompanied by a bulletin (PDF), available at [www.ncdpd.org/pdf/wp/NCPDPAcetaminophenInfoBulletin\\_PharmacyStakeholders.pdf](http://www.ncdpd.org/pdf/wp/NCPDPAcetaminophenInfoBulletin_PharmacyStakeholders.pdf), developed for pharmacists that summarizes some of NCPDP’s key recommendations regarding acetaminophen. In addition, the white paper, available for download at [www.ncdpd.org/ind\\_WP.aspx](http://www.ncdpd.org/ind_WP.aspx), includes a list of resources for pharmacists to use in educating staff and pharmacy staff to use in educating patients (see Appendix D of the white paper). More information is available in an NCPDP news release available at [www.ncdpd.org/press/013113\\_NCPDP\\_Acetaminophen%20WP\\_FINAL.pdf](http://www.ncdpd.org/press/013113_NCPDP_Acetaminophen%20WP_FINAL.pdf).

## Pharmacists Rated High for Honesty and Ethical Standards in Gallup’s 2012 Poll

Pharmacists ranked as the second most trusted profession in the 2012 Gallup Poll that asked consumers to rate 22 professions according to their honesty and ethical standards. Pharmacists were ranked as very high or high in this category by 75% of those surveyed, with nurses ranking first at 85%, and medical doctors third at 70%. Additional information on the results of the 2012 poll is available on the Gallup Web site at [www.gallup.com/poll/159035/congress-retains-low-honesty-rating.aspx](http://www.gallup.com/poll/159035/congress-retains-low-honesty-rating.aspx).



**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 an NABP e-Profile ID number and date of birth (MMDD) in order to process ACPE-accredited CPE credit.

Visit [www.MyCPEmonitor.net](http://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.*

Continued from page 1

of their OBNDD and Board of Pharmacy licenses to ensure that the hospital is reporting emergency room dispensing to the PMP. Hospital administrators and PICs must verify that the PMP data is being submitted properly. Failure to submit PMP data appropriately may result in disciplinary action against the hospital pharmacy or drug room license and the PIC. Please contact Kelly Couch at OBNDD at 405/521-2885 for further information.

- ◆ **13.12. Patient Complaints:** Many patient complaints to the Board can be resolved at the store level by the pharmacist if the technician does not try to “take control” of a situation he or she is not allowed to be in charge of. Please remind your staff that technicians are not permitted to counsel or answer questions about prescriptions. Any concerns about possible errors should be immediately referred to the pharmacist.
- ◆ **13.13. Acceptable Forms of Identification (ID):** Acceptable forms of IDs for CDS prescriptions and PSE sales must be one of the four following: (1) military ID, (2) passport, (3) driver’s license, or (4) state-issued ID. A state-issued ID is defined as one that is issued by any state, territory, or possession of the United States, the District of Columbia, or foreign nation. A concealed gun permit does not qualify as a state-issued ID. Most tribal IDs are not acceptable because they do not meet all the criteria required by law. However, OBNDD has determined that the Cherokee Nation citizenship ID with photo has met those criteria and is an acceptable form of ID. Any questions regarding tribal IDs should be directed to the OBNDD at 405/521-2885.
- ◆ **13.14. Failure to Document Technician Training:** The most common violation during a pharmacy inspection is failure to document technician training. Each pharmacy must have technician training documentation for **each** technician regardless of his or her previous education, previous employment, or length of employment. The Board does not dictate what that training entails, as each pharmacy’s needs are different. Documentation of the training must be readily available for review. The compliance officers do not want to take up your valuable time logging into the computer or going to the Human Resources Department to review records.
- ◆ **13.15. Updating Physician Information in Computer:** The Board has received complaints about refill requests being faxed to the wrong number due to physician’s information not being updated or having several different addresses in the computer. This causes delays in refill requests and is also a violation of patient confidentiality. When inputting prescription information and a physician has several addresses in the computer database, it is important to select the correct address, that is, the physician’s location as shown on the prescription. Technicians should be educated in the importance of this step in inputting information. And the pharmacists who verify the prescription information must check the physician address information to ensure that it matches the location on the prescription.
- ◆ **13.16. Compounding Animal Drugs:** Compounding animal drugs from bulk drug substances (active pharmaceutical ingredients) violates the Federal Food, Drug, and Cosmetic

Act (FD&C Act). The FD&C Act does not distinguish compounding from manufacturing or other processing of drugs for use in animals, so animal drugs produced by compounding fall within the FD&C Act’s approval, adulteration, and misbranding requirements. The only exception is for drugs compounded from finished, approved human or animal drug products, which Food and Drug Administration (FDA) considers a legal extralabel use under the Animal Medicinal Drug Use Clarification Act of 1994, so long as the compounding of those drugs meets the extralabel use requirements in the FD&C Act and FDA regulations in 21 CFR Part 530. Extralabel use does not include compounding starting with bulk drug substances.

### **Disciplinary Actions**

For more information, you may view hearing minutes at [www.pharmacy.ok.gov](http://www.pharmacy.ok.gov).

#### **13.17. January 16, 2013 Board Hearing**

**Impaired Pharmacist #14362 – Case No. 1126:** Respondent appeared to request that the suspension of her license be placed on probation. **License was placed on indefinite probation.**

**Shaun Davis, Technician #16785 – Case No. 1140:** Found guilty of failing to disclose an arrest, charge, plea of *nolo contendere*, or conviction, or deferred sentence for any misdemeanor or felony offense and furnishing false or fraudulent material in an application made to the Board. **Revoked.**

**Celeste Hendrickson, Technician #11527 – Case No. 1141:** Admitted to possession of a CDS without a valid prescription and abusing alcohol or drugs, using an illegal CDS substance, and/or testing positive for such substance or its metabolite. **Revoked.** (Agreed Order)

**Impaired Pharmacist #14486 – Case No. 1144:** Admitted to violating her contract for a voluntary rehabilitation program for the impaired (eg, Oklahoma Pharmacists Helping Pharmacists (OPHP) contract). **Ten years probation until January 16, 2023. Ten-year OPHP contract. Must attend an eight-hour law seminar in addition to the required 15 hours of CE in 2013 and 2014. Must complete 15 hours of live CE each year of probation.** (Agreed Order)

**Jamaal Walker, Technician #9521 – Case No. 1145:** Admitted to theft and abusing alcohol or drugs, using an illegal CDS substance, and/or testing positive for such substance or its metabolite. **Revoked.** (Agreed Order)

**James Myers, Technician #12483 – Case No. 1146:** Admitted to theft; possession of a CDS without a valid prescription; and abusing alcohol or drugs, using an illegal CDS substance, and/or testing positive for such substance or its metabolite. **Revoked.** (Agreed Order)

**Nicole Mullicane, Technician #13513 – Case No. 1147:** Admitted to theft and possession of a CDS without a valid prescription. **Revoked.** (Agreed Order)

**Laura Matlock, Technician #6402 – Case No. 1148:** Admitted to obtaining or attempting to obtain a CDS by fraud and concealment of a material fact. **Revoked.** (Agreed Order)

Continued on page 5

*Continued from page 4*

**Cherri Stark, Technician #14754 – Case No. 1150:** Admitted to theft and possession of a CDS without a valid prescription. **Revoked.** (Agreed Order)

**Michael Payne, Technician #16629 – Case No. 1151:** Admitted to abusing alcohol or drugs, using an illegal CDS substance, and/or testing positive for such substance or its metabolite. **Revoked.** (Agreed Order)

**Impaired Pharmacist #12317 – Case No. 1153:** Admitted to failing to participate in a rehabilitation program for the impaired as required by the Board; and use or abuse of an illegal CDS substance or a positive drug screen for such illegal CDS substance or its metabolite. **Indefinite suspension. Must maintain and comply with his OPHP contract. Must attend an eight-hour law seminar in addition to the required 15 hours of CE in 2013 and 2014.** (Agreed Order)

**Oklahoma Respiratory Care, #7-D-1323 and Oklahoma Respiratory Care, #7-D-420 – Case No. 1157:** Admitted to misfilling a prescription or drug order which departs from the standards or care ordinarily exercised by a registrant; filing a report or record that the registrant knows to be false, intentionally or negligently failing to file a report or record required by federal, state, or local laws or rules; failing to employ personnel who have sufficient education, training, and/or experience to perform assigned functions and comply with federal, state, and local licensing requirements; failing to conform to the *Compressed Medical Gases Guidelines* published by the Department of Health and Human Services, FDA; failing to establish, maintain, and adhere to written policies and procedures; and engaging in medical gas distributing of drugs while failing to maintain or provide a complete and accurate record, when required. **Prohibited from transfilling for one year. \$19,600 fine on #7-D-1323. \$1,000 fine on #7-D-420. With documentation, up to half of total fines may be applied toward training of staff.** (Agreed Order)

### **13.18. March 7, 2013 Board Hearing**

**Brandi McKnight, Technician #16429 – Case No. 1149:** Found guilty of theft. **Revoked.**

**Ginger Kupsick, Technician #15431 – Case No. 1152:** Found guilty of theft and possession of a CDS without a valid prescription. **Revoked.**

**Natalie Houck, DPh, #13387 – Case No. 1154:** Admitted to failing as PIC to submit a report outlining issues encountered and decisions made during drug room visits. Fined for failing as PIC to make and document a minimum of 52 routine in-house visits per year to the hospital drug room as required by the health department. **Five years probation until January 16, 2018. \$9,000 fine. Must attend an eight-hour law seminar in addition to the required 15 hours of CE in 2013 and 2014. Must complete 15 hours of live CE each year of probation.** (Agreed Order)

**Target Store T-2061, #1-5040 – Case No. 1155:** Admitted to failing to prevent a non-pharmacist access to the pharmacy resulting in loss of CDS. **\$3,000 fine.** (Agreed Order)

**Oklahoma Respiratory Care, #7-D-1323 and Oklahoma Respiratory Care, #7-D-420 – Case No. 1157:** Appeared to request that they be allowed to resume transfilling of medical gases. **Suspension of transfilling removed and placed on probation.**

**Sarah Debron, Technician #14643 – Case No. 1158:** Admitted to possession of a CDS without a valid prescription and furnishing fictitious, false, misleading, or fraudulent material in an application to the Board. **Revoked.** (Agreed Order)

**Greta Merdanian, Technician #11073 – Case No. 1159:** Admitted to theft and possession of a CDS without a valid prescription. **Revoked.** (Agreed Order)

### **Calendar Notes**

The Board will meet on **April 11 and May 15.** The Board will be closed Monday, **May 27,** for Memorial Day. Future Board dates will be available at [www.pharmacy.ok.gov](http://www.pharmacy.ok.gov) and will be noted in the *July 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. 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.

“This publication is issued by the Oklahoma State Board of Pharmacy as authorized by Title 59 O.S. 353.7. Copies have not been printed but are available through the agency website.”

Page 5 – April 2013

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

John A. Foust, DPh - State News Editor

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

Deborah Zak - Communications Manager