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Oklahoma State Board of Pharmacy News

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Board Welcomes New Members

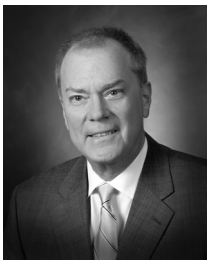
Justin Wilson, DPh, of Norman, OK, was appointed for a five-year term that began July 1, 2013, and ends June 30, 2018. Justin replaced Oklahoma State Board of Pharmacy member Gordon Richards.

Justin is the co-owner of Valu-Med Pharmacy in Midwest City, OK; BestYet Pharmacy in Harrah, OK; and Valu-Med Pharmacy in Fort Gibson, OK. In addition, he is an assistant clinical professor with the University of Oklahoma (OU) College of Pharmacy. He is a member and past president of the Oklahoma Pharmacists Association (OPhA) and a member of the National Community Pharmacists Association (NCPA). Justin earned his doctor of pharmacy degree in 2002, from OU.

Kyle Whitehead, DPh, of Enid, OK, has been appointed for a five-year term beginning July 1, 2014, and ending June 30, 2019. Kyle replaces Board member John Lassiter.

Kyle is the owner of Evans Pharmacy and Evans Express Pharmacy, both in Enid. He is a member of OPhA and an Enid Public Schools board member. In 2010, Kyle was awarded the Distinguished Young Pharmacist Award by OPhA. He is also a member of the NCPA, the Enid Chamber of Commerce, and the Enid Rotary Club, and serves on the Board of Directors for the Hospice Circle of Love and the Retired and Senior Volunteer Program. Kyle earned his bachelor of science degree in pharmacy in 1997, from OU.

Oklahoma Pharmacist Named NASPA President



The National Alliance of State Pharmacy Associations (NASPA) has named Phillip Woodward, DPh, of Yukon, OK, as president.

Dr Woodward has served as the executive director of OPhA for 14 years. He also serves as an adjunct professor of pharmacy practice with both the OU College of Pharmacy and Southwestern Oklahoma State University (SWOSU) College of Pharmacy. Dr Woodward was previously employed for six years as director of clinical services for Pharmacy Providers of Oklahoma. He received his bachelor of science degree in pharmacy from SWOSU and completed his doctor of pharmacy degree in 2003, from OU.

From the Inspector's Desk

- **14.15. Pharmacies Providing Filled Prescriptions to Patients in Other States:** Oklahoma licensed pharmacies that mail or ship filled prescriptions to patients in other states must review the licensing requirements of the state into which they are sending medications in order to assure compliance with that state's laws. Nearly all states require that out-of-state pharmacies shipping products into their state be licensed by the state into which they are shipping. Many states also require that the pharmacist-in-charge (PIC) be licensed to practice pharmacy in that state. In addition, state laws should be reviewed on a regular basis to determine if there have been changes in licensing requirements. Many states are implementing more stringent regulations and rules regarding prescriptions shipped across state lines.
- **14.16. Take-Back Boxes for Medication Destruction:** The Oklahoma Bureau of Narcotics (OBN) has

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New Educational Video for Pharmacists Addresses Prescription Drug Abuse

The National Association of Boards of Pharmacy® (NABP®) and the Anti-Diversion Industry Working Group (ADIWG), a consortium of pharmaceutical manufacturers and distributors of controlled substances (CS), have released an educational video for pharmacists to help them identify the warning signs of prescription drug abuse and diversion when dispensing CS prescriptions. The video, entitled "Red Flags," encourages pharmacists to help combat this national problem by exercising their professional judgment to ensure that the prescriptions they dispense were written for a legitimate medical purpose, and to act upon any unusual behavior they observe.

Drug Enforcement Administration and various state pharmacy boards have described "red flags" as circumstances surrounding the presentation of a CS prescription that should raise reasonable suspicion about the validity of that prescription. The video highlights a number of these potential warning signs, some of which are not easy to spot, by weaving personal narratives with interactions between pharmacists and customers.

The video is available in the Pharmacists section of the AWAR$_X$E® Prescription Drug Safety website at *www.AWARERX.ORG/pharmacists*.

Root Causes: A Roadmap to Action

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 Error Reporting Program Report online at* www.ismp.org. *E-mail: ismpinfo@ismp.org.*

Errors are almost never caused by the failure of a **single** element in the system. More often, there are **multiple** underlying system failures that lead to an error, many of which can be identified when the involved health care providers take the time to uncover them.

Consider the following error: A doctor sent a hand-written order for car**bam**azepine 400 mg twice daily for an adult patient with a history of seizures.

The pharmacist entered the medication into the profile of a four-year-old child with the same last name as the adult patient for whom the medication had been prescribed.

The pharmacist failed to notice that the patient was a child, as age was not in a prominent location on the order entry screen. The nurse failed to recognize that the dose was too high and administered 400 mg of car**bam**azepine to the child. She also never thought to question why the pharmacy would send oral tablets for a four-year-old child, considering that the drug is available in chewable tablets and as a liquid suspension.

The nurse **assumed** that the child was receiving the medication because he had a history of seizures. However, the nurse did not check the patient's medical record. In fact, the child did **not** have a history of seizures.

The parents had a very limited understanding of English, so they were unable to intervene to correct the erroneous seizure history.

The error was finally detected after the child became lethargic and developed nausea and vomiting. At the time of discovery, the child's car**bam**azepine level was 18 mcg/mL; levels greater than 12 in pediatric patients are supratherapeutic.[i]

It may be discouraging to see how many things go wrong when a medication error reaches a patient. However, a thorough root cause analysis (RCA) can uncover the latent failures and produce an action plan to avoid future errors.

ISMP, through a generous grant from the National Association of Boards of Pharmacy Foundation™, has developed the *Root Cause Analysis Workbook for Community/Ambulatory Pharmacy.* The workbook is designed to assist community pharmacy personnel in completing RCA for a sentinel event that may have occurred in their pharmacy. The RCA workbook uses a specific set of steps and associated tools to identify the primary causes of the **sentinel event.**

The goal of the RCA is to create an action plan framework, including risk-reduction strategies, communication and implementation strategies, and measurement of effectiveness.

RCA for **sentinel events** is required in the Center for Pharmacy Practice Accreditation's standards developed by NABP, American Pharmacists Association, and American Society of Health-System Pharmacists Association, as well as by several boards of pharmacy in conjunction with their continuous quality improvement regulations.

This ISMP RCA workbook is suitable for use in community pharmacy, mail-order pharmacy, or other ambulatory pharmacy practice settings that need to investigate a **sentinel event.** For more information and to access the **free** workbook, visit *www.ismp.org/tools/rca/.*

[i] *http://pediatrics.aappublications.org/content/113/2/406.abstract*

FDA Withdraws Approval of Some High Dose Acetaminophen Products

Food and Drug Administration (FDA) is withdrawing approval of 108 abbreviated new drug applications (ANDAs) for prescription combination drug products containing more than 325 mg of acetaminophen per dosage unit. For the 108 ANDAs, the manufacturers asked to withdraw their applications, as announced in the March 27, 2014 *Federal Register* notice. A second *Federal Register* notice addresses the applications of six manufacturers who have discontinued marketing their products, but who have not withdrawn their applications. The notice also announces FDA's intention to begin the process of withdrawing approval of those applications.

In light of these announcements, and to protect patients from inadvertent acetaminophen overdose, NABP advises that pharmacies no longer dispense combination drugs containing more than 325 mg of acetaminophen per dosage unit. NABP also advises that pharmacists consult with prescribers to discuss alternative products with lower acetaminophen doses.

FDA asked manufacturers to voluntarily withdraw these products from the market to reduce the risk of severe liver injury from inadvertent acetaminophen overdose. In January 2014, FDA recommended that providers consider prescribing acetaminophen products containing 325 mg or less per dose. The original announcement may be found in the Drug Safety and Availability section of FDA's website at *www.fda.gov/Drugs/DrugSafety*.

NCPDP Recommends Standardized Metric Measurements on Oral Liquid Medication Labels

The National Council for Prescription Drug Programs (NCPDP) has issued new recommendations and guidance for standardizing the dosing designation used on prescription container labels of oral liquid medications dispensed by community pharmacies in order to reduce dosing errors. NCPDP notes that such errors have been "a source of concern for many years," and that dosing errors involving young children are of particular concern because they may be more susceptible to harm from measurement errors and overdoses. The paper outlines the following recommendations for the dosing designation on prescription container labels for oral liquid medications:

- The millimeter (mL) should be used as a standard unit of measurement.
- Dose amounts should always use leading zeros before decimal points for amounts less than one and should not use trailing zeros after a decimal point.
- Dosing devices with numeric graduations and units corresponding to the container label should be made easily and universally available. For example, a device should be included with each dispensed medication.

The white paper was developed following a meeting with stakeholders representing 27 participants, including NABP. In addition to its general recommendations, the white paper also issued calls to action for relevant stakeholders, including government agencies, standards organizations, pharmacists and pharmacy technicians, pharmacy leadership, and health care associations. The white paper, *NCPDP Recommendations and Guidance for Standardizing the Dosing Designations on Prescription Container Labels of Oral Liquid Medications,* is available for download from the NCPDP website at *http://ncpdp.org/Education/Whitepaper*.

USP Proposes New General Chapter Addressing Compounding of Hazardous Drugs

In an effort to protect health care providers and personnel who handle hazardous drugs, United States Pharmacopeial Convention (USP) has proposed new General Chapter <800> Hazardous Drugs–Handling in Healthcare Settings. The new proposed chapter addresses standards that apply to all personnel who compound hazardous drug preparations and all places where hazardous drugs are prepared, stored, transported, and administered. The new chapter also covers standards for receiving, storing, compounding, dispensing, administering, and disposing of nonsterile and sterile products and preparations. The proposed chapter applies to all personnel who are involved in handling hazardous drugs, including health care providers and staff, occupational health and safety specialists, and human resources. General Chapter <800> was published in the May/June issue of *Pharmacopeial Forum,* and may currently be viewed on the USP website at *www.usp.org/usp-nf*. Comments will be accepted until July 31, 2014.

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provided take-back boxes, which are located around the state and may be used by consumers to dispose of medications for destruction. To locate the nearest take-back box, visit *https://portal.obn.ok.gov/takeback/default.aspx* and enter your zip code. The nearest available locations will be listed. These take-back boxes are **not** for pharmacies to destroy medications. All registrants must account for their controlled substances and must use their wholesaler or a reverse distributor who will give them a receipt for medications destroyed.

Disciplinary Actions

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

14.17. April 16, 2014 Board Hearing

Impaired Pharmacist #12272 – Case No. 836: Respondent shall complete the Pharmacist Assessment for Remediation Evaluation℠ (PARE℠). If respondent passes the PARE, her pharmacist's license #12272 will be reinstated and placed on probation for one year. Respondent must abide by her contract with Oklahoma Pharmacists Helping Pharmacists (OPHP).

Stacie M. Miller, DPh, #13125 – Case No. 1266: Admitted to guilt on seven counts and neither admits nor denies guilt on 6,530 counts including attempting diagnosis or treatment that might infringe upon the legally constituted right or obligation of any practitioner of the healing arts; failing to oppose any secret arrangement between pharmacist and physician whereby fees are divided; making or filing a report or record that she knew or should have known to be false; submitting fraudulent billing or reports to a third party payor of prescription drugs; filling or refilling a prescription without authorization; allowing an intervening person to alter a prescription order; allowing someone other than an authorized practitioner or his or her designated agent to transmit prescription drug orders; entering into an agreement with a practitioner that requires that prescription orders be transmitted from the practitioner to only the pharmacy; failing to maintain reports; failing to supervise employees; failing to comply with United States Pharmacopeia Compounding Standards; failing to ensure the validity of all prescriptions; failing to document training of a currently permitted technician; billing or charging for quantities greater than delivered; misfilling a prescription; substitution without authorization; filling a prescription without a license; entering into an arrangement whereby prescription orders are received or delivered at a place other than the pharmacy in which they are compounded and dispensed; filling a written prescription that has not been manually signed by the practitioner; and failing to handwrite the initials of the pharmacist on a controlled dangerous substance (CDS) prescription. **License is suspended for six years until April 16, 2020, and $10,000 fine. After one year, suspension is stayed and respondent's license is placed on probation for five years. Respondent may not work as a PIC in a pharmacy until after April 16, 2020.**

Adam Charles Stewart, DPh, #14724 – Case No. 1267: Admitted to guilt on two counts including failing to adequately supervise a pharmacy technician and failing to verify all critical processes to ensure that procedures will consistently result in the expected qualities in the finished preparation. The remainder of the counts were dismissed. **One year probation until April 16, 2015, and $5,000 fine.**

Marshon Lewis, Technician #18321 – Case No. 1269: Admitted to guilt on four counts including theft while working as a registrant; abusing alcohol or drugs, using an illegal CDS, and/or testing positive for such substance or its metabolite; and possession of a CDS without a valid prescription. **Revoked.**

Andrea Lewis, Technician #18457 – Case No. 1270: Found guilty on four counts 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.**

Melissa Mercado Belvin, Technician #17427 – Case No. 1271: Admitted to guilt on four counts including theft while working as a registrant and possession of a CDS without a valid prescription. **Revoked.**

Maria Del Ruby Becerra, Technician #18757 – Case No. 1272: Admitted to guilt on three counts including theft while working as a registrant. **Revoked.**

Impaired Pharmacist #15361 – Case No. 1273: Admitted to guilt on 12 counts including possession of a CDS and dangerous drugs without a valid prescription; unlawful distribution of a CDS; attempting diagnosis or treatment that might infringe upon the legally constituted right or obligation of any practitioner of the healing arts; making or filing a report or record that he knew or should have known to be false; practicing pharmacy without reasonable skill and safety; theft while practicing pharmacy; failure to establish and maintain effective controls against the diversion of prescription drugs; and failing, as pharmacy manager, to be responsible for all aspects of the operation related to the practice of pharmacy. **Ten years probation until April 16, 2024, and $5,000 fine.**

Aetna Rx Home Delivery, LLC, #99-705 – Case No. 1274: Admitted to guilt on 986 counts and neither admits nor denies guilt on five counts including failing as a dispenser to transmit to a central repository designated by the Oklahoma Bureau of Narcotics and Dangerous Drugs Control; failing to report certain required information to a central repository maintained by the OBN; and filing a report or record that the registrant knows to be false. **$9,860 fine.**

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Newman Medical Center Pharmacy, Inc, #75-5174 – Case No. 1276: Admitted to guilt on eight counts including filling or refilling a prescription without authorization; filing a report or record that the registrant knows to be false; providing fraudulent billing or reports to a third party payor of prescription drugs; selling dangerous drugs to a person or entity not eligible to receive such drugs; and misfilling a prescription. **One year probation until April 16, 2015, and $4,000 fine.**

John D. Herber, DPh, #12191 – Case No. 1277: Admitted to guilt on nine counts including attempting diagnosis or treatment that might infringe upon the legally constituted right or obligation of any practitioner of the healing arts; making or filing a report or record that he knew or should have known to be false; submitting fraudulent billing or reports to a third party payor of prescription drugs; misfilling a prescription; failing to fullfill the required responsibilities of a pharmacist or pharmacy manager; and selling dangerous drugs to a person or entity not eligible to receive such drugs. **$4,000 fine.**

Calendar Notes

The Board will meet on **August 6, 2014,** and **October 1, 2014.** The Board will be closed **Friday, July 4,** for Independence Day and **Monday, September 1,** for Labor Day. Future Board dates will be available at *www.pharmacy.ok.gov* and will be noted in the October *Newsletter.*

Change of Address or Employment?

Please be diligent in keeping your information up to date and if possible, remind your co-workers 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.

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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™ (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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