

October 2013

News



Oklahoma State Board of Pharmacy

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13.30. Band-Aids – Just a Cover-Up!

By Angela Wall

Drug abuse cannot simply be fixed with a Band-Aid®. As a society, it seems to be easier to ignore a problem and let someone else handle it instead of realizing if **everyone** did their part, it would make a big issue smaller. According to the Centers for Disease Control and Prevention, prescription drug abuse has become an epidemic and Oklahoma is the number one state in the nation with this problem. So what has been done?

Innovative and intelligent people at the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBND) have created a way to help deter the use of prescription drugs for illegal purposes. The system created is called the Prescription Monitoring Program (PMP).

In 1990, Oklahoma became the first state in the United States to implement a computerized PMP. OBND has continued improving the system to make it more effective and efficient for its registrants. Although many states have since created their own version of the PMP, Oklahoma is still the only state that has the “real-time” reporting benefit – information of a controlled dangerous substance (CDS) being reported within five minutes of being dispensed. So how can the system be used?

By **all** dispensers accurately reporting information into the system, health care professionals (HCPs) that are authorized to use the system can receive patient-specific reports along with their own prescribing reports – this includes pharmacy dispensing reports. These reports can help determine those with a legitimate use for prescription drugs and guard against those using them illegally.

By using the “Patient Report,” pharmacists can receive dispensed CDS data on each of their pharmacy customers. The pharmacists can use the report to check for any prescription fraud, including “doctor shopping” and/or forgery. The information can also be discussed with the customer to verify accuracy, but may not be given to the customer at any time.

By using the “Pharmacy Report,” all dispensing activity under the pharmacy’s National Council for Prescription Drug Programs provider ID number can be compiled for a

specified period of time. This report can be checked for any unusual dispensing activity and fraud. Remember, employee fraud can also occur.

If **all** OBND registrants register for the PMP, use it regularly, and dispensers enter information accurately, then prescription drug abuse will be reduced in Oklahoma. It does not matter how much or how little is prescribed or dispensed; a drug seeker will try to get whatever he or she can from whomever he or she can. No HCP wants to be taken advantage of, so using the PMP will not only help guard against diversion, but it will ultimately safeguard the HCP, his or her name, and his or her reputation.

In the end, many patients need to understand that pain is their body’s way of saying something is wrong, and pills cannot fix everything. HCPs need to **all** realize it is time to rip off the Band-Aid and expose prescription drug abuse for what it really is – a big problem.

Those who have questions about PMP registration may contact the help desk at 877/627-2674. If any groups (large or small) need PMP training, please contact Angela Wall at 800/522-8031, ext 162.

13.31. Greg Adams Named 2013 Outstanding Alumnus of SWOSU College of Pharmacy

Clinton, OK, pharmacist Greg Adams has been named the 2013 Outstanding Alumnus of the Southwestern Oklahoma State University (SWOSU) College of Pharmacy in Weatherford, OK.

The Outstanding Alumnus award is presented each year to an individual demonstrating exceptional support of the SWOSU College of Pharmacy and outstanding personal achievements in the profession.

Greg is a 1994 graduate of SWOSU, earning both a bachelor of science in chemistry and a bachelor of science in pharmacy. He has been the owner of Salisbury Pharmacy in Clinton since 1995.

According to SWOSU College of Pharmacy Dean Dennis Thompson, Greg has been a tremendous supporter of the

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Enteric-Coated Aspirin Recalled for Potential Acetaminophen Mix-Up

In June 2013, Advance Pharmaceutical Inc initiated a voluntary recall of Rugby Laboratories label enteric-coated aspirin tablets, 81 mg (Lot 13A026; expiration date: January 2015) due to a complaint that a bottle labeled with this product name actually contained acetaminophen 500 mg tablets. This over-the-counter (OTC) product is packaged in bottles of 120 tablets with National Drug Code 0536-3086-41 and Universal Product Code 3 0536-3086-41 9. The affected lot was distributed nationwide by Rugby Laboratories to wholesalers and retailers. The manufacturer warns that inadvertently taking acetaminophen, 500 mg, instead of enteric coated aspirin, 81 mg, according to the directions on the label, can lead to an acetaminophen overdose and potential severe liver damage. The manufacturer indicates that consumers who take the dosage as indicated on the defective product labeling may be ingesting up to 24,000 mg of acetaminophen, which is about six times the maximum recommended daily dose of acetaminophen (4,000 mg).

Consumers who have bottles from the affected lot should stop using the product and return it to the pharmacy or store where it was purchased and should contact a health care provider if they are experiencing any problems that may be related to using the product. Food and Drug Administration (FDA) notes that any adverse reactions related to the use of the product should be reported to FDA's MedWatch Program. More information about this recall is available on the FDA Web site at www.fda.gov/Safety/Recalls/ucm357909.

Barcoding Technology for Community Pharmacy

 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!® 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.

Barcoding technology is well-established in industries outside of the health care sector and is now being used within health care to enhance efficiency and safety, and in pharmaceutical wholesale operations to improve supply chain inventory and efficiency. Numerous studies prove the effectiveness and cost benefits of using barcoding technology during the drug dispensing process. About 75% of wrong drug or wrong dose errors are captured and corrected using barcode technology¹ and there is sufficient evidence that barcode scanning is becoming the standard of practice in pharmacies.

Although barcoding technology is mature with abundant evidence regarding its effectiveness, a 2006² study showed that only half (53.5%) of United States community pharmacies utilize a barcode scanner for verification/identification of medications. The study also

revealed significantly lower adoption in independent pharmacies (11.5%) compared to chain pharmacies (62.6%).

According to a survey conducted by ISMP in 2009, the most frequently reported reasons for implementing barcode scanning for product verification included a desire to improve the accuracy and safety of the dispensing process, the ease with which the technology fits with pharmacy workflow, improvement of staff efficiency and inventory control, and a belief that the technology was necessary to stay in business. The most common reasons for **not** implementing barcode scanning for product verification, other than cost, included uncertainty regarding the "right" vendor product, satisfaction with the current system (without barcode product verification), and perceptions that the technology would reduce staff efficiency.

ISMP has developed a tool, Assessing Barcode Verification System Readiness in Community Pharmacies, to help address the reasons why barcode scanning has not been implemented and to facilitate the adoption of this technology in an estimated 27,327 community pharmacies that do not currently utilize it for product verification.

Given the resource commitment to purchase barcoding systems and the potential for technology to have a profound effect upon the work environment, this tool will help community pharmacy managers and owners better understand the issues related to barcode product verification systems. It will also help managers assess the pharmacy's readiness for the technology, prepare for the selection of a system, and implement the technology effectively.

Barcode scanning to verify prescription products prior to dispensing improves the safety and quality of pharmacy care provided to patients and increases efficiency during the provision of pharmacy services. Although technology should not be seen as a panacea, it can be a useful tool when used appropriately and combined with other patient safety strategies.³ Does your pharmacy use barcode technology for product verification? If not, please access this free tool, at www.ismp.org/AHRQ/Default.asp?link=sa.

¹Cochran GL, Jones KJ, Brockman J, Skinner A, et al. "Errors prevented by and associated with barcode medication systems." *Joint Comm J Qual Pt Safety*. 2007;33(5):293-301.

²Ukens C. "New study sheds light on medication errors." *Drug Topics*. 2002;146(21):33.

³Skrepnek GH, Armstrong EP, Malone DC, Abarca J, et al. "Workload and availability of technology in metropolitan community pharmacies." *J Amer Pharm Assoc*. 2006; 46(2):154-160.

⁴American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices. "Pathways for medication safety: assessing bedside bar-coding readiness." 2002. Accessed on October 15, 2010 at: www.ismp.org/selfassessments/PathwaySection3.pdf.

ISMP Launches Medication Safety Alert! Newsletter Tailored for LTCFs

ISMP has launched a new *ISMP Medication Safety Alert!* publication, *Long-Term Care Advise-ERR*, as a means to provide medication error prevention information tailored to assist staff and providers in long-term care facilities (LTCFs).

With *ISMP Medication Safety Alert!* publications making a significant impact on preventing medication errors, ISMP is now providing this new resource tailored to LTCFs. ISMP notes that medication errors reported to ISMP Medication Errors Reporting Program include reports from LTCFs. More information and a link to subscribe to this new publication are available in the Newsletters section of the ISMP Web site at www.ismp.org/newsletters/longtermcare.



FDA Warns of Rare Skin Reactions in Patients Taking Acetaminophen

FDA has issued a consumer update that warns of rare but serious skin reactions that may occur in patients taking acetaminophen. These complications include three serious skin reactions: Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and acute generalized exanthematous pustulosis (AGEP). SJS and TEN can both be fatal, and usually require hospitalization. Patients suffering from AGEP commonly recover within a few weeks after they stop taking the medication that caused the reaction.

Symptoms of these conditions include skin rashes, blisters, and widespread damage to the surface of the skin. Patients taking acetaminophen or other compounds that contain acetaminophen should be advised to stop taking the medication if they experience such symptoms and should consult their health care providers or seek an emergency department immediately.

FDA emphasizes that this information should be viewed within the context of millions of patients who, over generations, have used and benefited from acetaminophen and stresses that severe allergic skin reactions are an extremely rare condition. Further, the agency notes that many medications can cause allergic reactions, and skin allergy warnings have already been added to the drug labels of other categories of OTC analgesics including ibuprofen and naproxen. "This new information is not intended to worry consumers or health care professionals, nor is it meant to encourage them to use other medications," said Sharon Hertz, MD, deputy director of FDA's Division of Anesthesia, Analgesia, and Addiction Products. "However, it is extremely important that people recognize and react quickly to the initial symptoms of these rare but serious side effects, which are potentially fatal." The full consumer update is available on the FDA Web site at www.fda.gov/ForConsumers/ConsumerUpdates/ucm363010.htm.

Reminder to Purchase Drugs Only from Licensed Wholesalers, Including VAWD-Accredited Wholesale Distributors

To ensure that patients are receiving safe, FDA-approved medications, pharmacists and other health care providers should purchase prescription drugs either directly from the manufacturer or from wholesale drug distributors licensed in the US as advised by FDA. The agency provides a list of state agencies for assistance in verifying licensure at www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm281446.htm.

Another way that pharmacies can be assured of the legitimacy of a wholesale distributor is to look for the National Association of Boards of Pharmacy® (NABP®) Verified-Accredited Wholesale Distributors® (VAWD®) Seal. Those wholesale distributors that achieve VAWD accreditation are in compliance with state and federal laws and NABP's VAWD criteria. NABP has recently revised the VAWD criteria to allow virtual manufacturers and virtual wholesale distributors – a growing segment of the pharmaceutical wholesale industry – to qualify for VAWD, as well as to implement other changes aimed to help to ensure that the drug supply chain remains secure.

The revised VAWD criteria responds to changing business models and helps safeguard drugs in distribution at a time when there is an increased risk of counterfeit and substandard drugs entering the legitimate US drug supply chain. In particular, the criteria have been revised

to provide stronger assurance that drugs diverted from pharmacies and unlawful sources are prevented from entering into the supply chain.

For a listing of VAWD-accredited facilities, please visit www.nabp.net/programs/accreditation/vawd.

Voluntary Recall of Unexpired Sterile Products After Reports of Adverse Events

FDA has announced a voluntary recall of all lots of unexpired sterile products produced by Specialty Compounding, LLC, in Cedar Park, TX. FDA received reports of 15 adverse events at two hospitals (Corpus Christi Medical Center Doctors Regional and Corpus Christi Medical Center Bay Area) potentially related to the use of these sterile products. Affected patients received an intravenous infusion of calcium gluconate supplied by the company.

Patients who were administered the injectable drug products are at risk of life-threatening infections. The recall applies to all unexpired sterile compounded medications dispensed by the company, including all strengths and dosage forms. Recalled products were distributed directly to hospitals and physicians' offices in Texas, and to patients located nationwide (with the exception of North Carolina). No calcium gluconate was shipped outside the state of Texas. Health care providers and patients should stop using all recalled products and return them to Specialty Compounding.

Veterinarians Not Eligible for NPIs, CMS Clarifies

Centers for Medicare and Medicaid Services (CMS) has become aware of cases in which veterinarians are told, incorrectly, that they must provide a National Provider Identifier (NPI) number for prescriptions they have written to be dispensed. The agency has issued a clarification, stressing that veterinarians do not meet the regulatory definition of "health care provider," and thus may not obtain NPI numbers. The clarification also states that "Any entity that insists veterinarians obtain an NPI [is] attempting to require veterinarians to obtain NPIs fraudulently." CMS also notes that "if a veterinarian fulfills the definition of 'health care provider' in a profession other than furnishing veterinary services," such as if they are also a nurse practitioner, "the veterinarian would be eligible for an NPI but would select a Nurse Practitioner code (not a Veterinarian code) from the Healthcare Provider Taxonomy Code Set when applying for an NPI."



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 a National Association of Boards of Pharmacy® (NABP®) e-Profile ID number and date of birth (MMDD) in order to process ACPE-accredited CPE credit.

Visit 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.*

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College of Pharmacy, giving his time, talent, and resources in helping the college achieve success. He has been a terrific supporter of the student chapter of National Community Pharmacists Association. Greg was instrumental in helping the college obtain a \$125,000 scholarship grant from Cardinal Health, and he established the Lonny D. Wilson Endowed Scholarship with the SWOSU Pharmacy Alumni Foundation.

His career has been marked by outstanding professional achievements and tireless service to the profession. Greg has previously served as director of clinical services at Pharmacy Providers of Oklahoma. He currently serves on the Oklahoma State Board of Pharmacy. Greg is president of the Southwestern Pharmacy Alumni Foundation, past district president of Oklahoma Pharmacists Association (OPhA), and a member of the Regional Advisory Board for Cardinal Health. In 2003, Greg was named Distinguished Young Pharmacist of the Year by OPhA.

He is a member of OPhA, Clinton Chamber of Commerce, Clinton Rotary Club, and the American Association of Diabetes Educators.

Greg and his wife, Lori, have two sons, Conley and Colton.

From The Inspector's Desk

- ♦ **13.32. Compounders Beware:** All compounded products that contain hydrocodone should be treated as Schedule II drugs. This would require a hard copy prescription written by the physician. Since these products are not Food and Drug Administration (FDA) approved, Drug Enforcement Administration (DEA) states that its rule is to go with the higher schedule for the compound. The Code of Federal Regulations that DEA operates under is based solely on FDA approval.
- ♦ **13.33. Physician Agents:** Nursing home and hospice employees must be "agents of the physician" to call in controlled prescriptions to pharmacies. The physician must use a form to designate who may call in prescriptions on his or her behalf. A sample form may be found at www.pharmacy.ok.gov under "Forms for Download" and then "Pharmacies." DEA recommends that the original agreement be kept by the practitioner during the term of the relationship and for a reasonable time after revocation. A signed copy should be provided to the practitioner's designated agent, his or her employer, and any pharmacies that regularly receive communications from the agent pursuant to the agreement. Non-controlled prescriptions are not required to have this agreement, but the pharmacists are required to exercise due diligence on all prescriptions.
- ♦ **13.34. CDS Prescriptions Put on Hold:** If a controlled prescription is put on hold, the original prescription must be pulled when it is filled so the date of filling and pharmacist's initials may be recorded.

Disciplinary Actions

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

13.35. June 27, 2013 Board Hearing

Impaired Pharmacist #10336 – Case No. 1102: License removed from suspension and placed on probation for life.

Jennifer Dawn Ford, Technician #15989 – Case No. 1184: Admitted guilt on three violations including theft. **Revoked.**

April Guinn, Technician #17519 – Case No. 1185: Found guilty of five violations including theft of CDS. **Revoked.**

Yolanda Rodriquez, Technician #16769 – Case No. 1188: Found guilty of three violations including theft. **Revoked.**

Alexis Vinavong, Technician #16681 – Case No. 1189: Found guilty of three violations including theft. **Revoked.**

Impaired Pharmacist #14726 – Case No. 1190: Admitted to guilt on five violations including theft of CDS. **License placed on probation indefinitely. Respondent must enter into a 10-year contract with Oklahoma Pharmacists Helping Pharmacists (OPHP), attend a law seminar in 2013, and all continuing education (CE) required for license renewal must be live for 2014 and 2015.**

Bivens Drug, Inc, #70-5920 – Case No. 1193: Admitted guilt on seven violations including permitting the practice of pharmacy by someone other than a licensed pharmacist or assistant pharmacist. **Fine: \$3,000.**

Jerry Lee Dennis, DPh, #9252 – Case No. 1194: Admitted guilt on 55 violations including allowing someone other than a licensed pharmacist to certify the finished prescription, as defined by the Board, before delivery to the patient or the patient's agent or caregiver. **License placed on probation for five years until June 27, 2018. Fine: \$12,500. Additional 45 hours of CE required by December 31, 2013. All required CE during 2014-2018 must be live.**

Flourish Integrative Pharmacy, LLC, #1-5179 – Case No. 1195: Respondent neither admitted nor denied guilt on two violations including misfilling a prescription or drug order that departs from the standards of care ordinarily exercised by a registrant. **Fine: \$3,000.**

Christopher Darwin Rice, DPh, #14993 – Case No. 1196: Respondent neither admitted nor denied guilt on three violations including misfilling a prescription in a manner that departs from the standards of care ordinarily exercised by a pharmacist. **Fine: \$3,000.**

13.36. August 21, 2013 Board Hearing

Tiffany Jerrell, Technician #16225 – Case No. 1186: Found guilty of four violations including possession of a CDS without a valid prescription. **Revoked.**

Carolina M. Marroquin, Technician #16353 – Case No. 1187: Found guilty of three violations including theft. **Revoked.**

Brandi Johnson, Technician #6628 – Case No. 1202: Found guilty of four violations including possession of a CDS without a valid prescription. **Revoked.**

Sarah Delosier, Technician #17136 – Case No. 1203: Found guilty of four violations including possession of a CDS without a valid prescription. **Revoked.**

Carl Peterson, Jr, Technician #15204 – Case No. 1204: Admitted guilt on three violations including furnishing false or fraudulent material in an application made to the Board. **Permit placed on probation until the court determines that he has satisfactorily completed his deferred sentence. Fine: \$500.**

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Geoffrey Miller, Technician #15563 – Case No. 1205: Admitted guilt on four violations including abusing alcohol or drugs, using an illegal CDS substance, and/or testing positive for such substance or its metabolite. **Revoked.**

Lucas Agee, Technician #17085 – Case No. 1206: Admitted guilt on four violations including possession of a CDS without a valid prescription. **Revoked.**

Skyler Verzilli, Technician #15455 – Case No. 1207: Found guilty of four violations including possession of a CDS without a valid prescription. **Revoked.**

Heritage Pharmacy, #54-5587 – Case No. 1208: Admitted to guilt on three violations including filling or refilling a prescription for a dangerous drug without the authorization of a licensed practitioner. **Fine: \$6,000.**

Dennis Satchell, DPh, #8217 – Case No. 1209: Admitted to guilt on three violations including filling or refilling a prescription for a CDS without the authorization of a licensed practitioner. **Respondent placed on probation for two years until August 21, 2015. Fine: \$6,000. All required CE during 2014 and 2015 must be live.**

CVS/Pharmacy #5959, #1-5376 – Case No. 1197: Neither admits nor denies guilt on 15 violations including failing 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, specifically prescriber's DEA registration number. **Fine of \$2,991.45 per count.**

CVS/Pharmacy #6004, #1-5450 – Case No. 1198: Neither admits nor denies guilt on 15 violations including failing 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, specifically prescriber's DEA registration number. **Fine of \$2,991.45 per count.**

CVS/Pharmacy #6022, #1-5386 – Case No. 1199: Neither admits nor denies guilt on 15 violations including failing 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, specifically prescriber's DEA registration number. **Fine of \$2,991.45 per count.**

CVS/Pharmacy #6230, #1-5399 – Case No. 1200: Neither admits nor denies guilt on 15 violations including failing 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, specifically prescriber's DEA registration number. **Fine of \$2,991.45 per count.**

CVS/Pharmacy #8312, #26-5406 – Case No. 1201: Neither admits nor denies guilt on 57 violations including failing 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, specifically prescriber's DEA registration number. **Fine of \$2,991.45 per count. Respondent CVS/Pharmacy #8312 placed on probation for one year until August 21, 2014.**

CVS total fine of \$350,000. CVS will host a three-hour training session for pharmacists-in-charge (PICs) in Oklahoma City, OK, and Tulsa, OK, within the next 12 months wherein training is conducted by the Oklahoma State Board of Pharmacy. CVS's current PICs will attend the one-day OPhA Law Seminar before August 21, 2015, which will count toward the pharmacists' yearly CE requirement.

Calendar Notes

The Board will meet on **October 24**, and **November 21**. The Board will be closed Monday, **November 11**, for Veterans Day; Thursday and Friday, **November 28 and 29**, for Thanksgiving; Tuesday and Wednesday, **December 24 and 25**, for Christmas; and Wednesday, **January 1**, for New Year's Day. Future Board dates will be available at www.pharmacy.ok.gov and will be noted in the January 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.

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