October 2016

Oklahoma State Board of Pharmacy News

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50-Year Pharmacists Honored

A reception was hosted by the Oklahoma State Board of Pharmacy on September 16, 2016, in honor of the recipients of the 2016 Fifty Year Gold Certificate Award (see award recipients pictured below). Thirty-seven Oklahoma pharmacists achieved 50 years of service to the profession of pharmacy and received the award in appreciation of their service.

Pictured left to right: Willard Holsted; Loreta Stewart; Lionel Cross; James Neal; Loyd Allen, Jr; John Joseph LaReau; and William McDuff.

From the Inspector's Desk

- **16.20. Oklahoma Pharmacy Law Book:** *The Oklahoma Pharmacy Law Book* has been updated to include the changes from the 2016 legislative session and is now available electronically from the Board's website at *https://ok.gov/pharmacy/Laws_&_Rules/Oklahoma_Pharmacy_Law_Book/index.html.*

  The 2016 *Pharmacy Law Book* contains the current laws and rules pertaining to the practice of pharmacy effective as of September 11, 2016, and certain laws effective as of November 1, 2016. Pharmacies will be given one copy each free of charge by their compliance officer upon inspection. Printed law books will also be available for purchase on October 1, 2016, for $10 each while supplies last. Online orders may be placed beginning October 1 via the Board's "Online Store" at *https://pay.apps.ok.gov/OSBP/payments.*
- **16.21. Highlights of 2016 Law Changes:** Patient-specific prescriptions may be delivered to physician offices with certain exceptions, such as if the patient does not have a permanent or secure mailing address, the prescriber is going to administer the medication, the medications require special handling (eg, strict temperature controls), radiopharmaceutical prescriptions, or for Medicare/Medicaid end-stage renal disease patients. Also, invoices for non-controlled drugs may now be maintained electronically.
- **16.22. Naloxone Information:** In an effort to reduce the number of deaths due to opiate overdoses, legislation was passed in November 2014 that allowed pharmacists to dispense naloxone to citizens and/or law enforcement either with a prescription or based upon a protocol from a physician. You may use a local physician or, if you need help locating a physician, you may contact Jessica Hawkins, director of prevention at the Oklahoma Department of Mental Health and Substance Abuse Services. Her email address is jhawkins@odmhsas.org and her phone number is 405/522-5952. Sample protocols, patient education, and other helpful information may be found at *http://takeasprescribed.org/pharmacy-provider-resources.*
- **16.23. Proper Display of Licenses:** During inspections, Board compliance officers often note that permits and licenses are not displayed properly. It is never permissible to photocopy a license. If a license is lost or damaged, a duplicate may be requested from the Board for a $10 fee. Technicians and pharmacists who have renewed online may also reprint their licenses online by logging in to the Board's renewal page at *https://pay.apps.ok.gov/OSBP/renewal/index.php.* Technician permits must have the following: a recent photograph attached; the signature of a pharmacist; the pharmacist's license number; and the pharmacy license number where the technician is employed. A technician permit is only valid at the pharmacy listed on the permit. Pharmacists should post their wallet card on the lower **left-**hand side of their certificate. If pharmacists have immunization certifications, they must also be displayed in the pharmacy.
- **16.24. Pharmacist (DPh) Initials and Date of Filling on Original CDS Prescriptions:** Pharmacist initials and date filled should be on every original hard copy controlled dangerous substance (CDS) prescription. This includes Schedule II, III, IV, and V prescriptions. Some computer software accommodates input of both pharmacist and pharmacy technician initials, which appear on the label. If the pharmacist's initials are not on the label, the pharmacist must physically or manually write his or her initials on the prescription, or the pharmacy and the pharmacist are in violation of the law. Many pharmacists are not aware that this is a requirement on Schedule III, IV, and V prescriptions, in addition to Schedule II prescriptions.

  OAC 475:30-1-4. Manner of issuance of prescriptions states:

  > (d) Upon receiving an oral prescription, the pharmacist must reduce the oral prescription to the form specified in (c) of this Section, including the typewritten name of the prescribing practitioner. **The pharmacist filling any prescription for any controlled dangerous substance must enter the date of filling and handwrite the initials of the pharmacist on the prescription.** If the practitioner is not known to the pharmacist, he/she must make a reasonable effort to determine that the oral authorization came from a registered practitioner. (emphasis added)

  Title 21 Code of Federal Regulations § 1304.22(c) states that each person authorized to dispense CDS must document the date of dispensing and the written or typewritten name or initials of the individual who dispensed the CDS.

National Vaccine Safety Surveillance Program Available for Reporting Adverse Events

The Vaccine Adverse Event Reporting System (VAERS) eSubmitter program, a national vaccine safety surveillance program cosponsored by the Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA), is available for the reporting of any clinically significant adverse event that occurs after the administration of any vaccine licensed in the United States. VAERS information is analyzed by CDC and FDA to identify new safety concerns. VAERS reports can be filed by anyone, including health care providers, manufacturers, state immunization programs, and vaccine recipients. Vaccine recipients are encouraged to seek help from their health care provider when filling out the VAERS form. Health care providers can find information about submitting a report on the VAERS website at *https://vaers.hhs.gov/professionals/index*.

Improper and Unsafe Vaccine Storage

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition *by visiting* www.ismp.org. *ISMP provides legal protection and confidentiality for submitted patient safety data and error reports. Help others by reporting actual and potential medication errors to the ISMP National Medication Errors Reporting Program Report online at* www.ismp.org. *Email: ismpinfo@ismp.org.*

Few issues are more important than proper storage and handling of vaccines, because their ability to prevent disease is dependent on these factors. To maintain stability, most vaccines must be stored in a refrigerator or freezer, and many also require protection from light. Excessive heat or cold – even a single exposure in some instances – can reduce vaccine potency. These temperature excursions are often due to improper refrigeration or freezer units, inadequate thermostat controls, and refrigeration/freezer units with inadequate space to allow good air circulation and even temperatures.

Improper and unsafe storage can also result in serious errors caused by selecting the wrong vaccines, diluents, and other medications with look-alike names and/or labeling and packaging. Storing vaccines close to each other has led to dispensing and administering the wrong vaccine or wrong form of vaccine (eg, adult versus pediatric). Storing vaccines too close to non-biologic medications in a refrigerator or freezer has also led to serious adverse outcomes, particularly when the mix-up involved a vaccine and a high-alert medication. For example, vials of insulin have frequently been mistaken as influenza vaccine, and various neuromuscular blocking agents have been used to reconstitute vaccines or were mistaken as influenza or hepatitis B vaccines.

Store vaccines in their own dedicated refrigeration and freezer units. Regular temperature monitoring is necessary, and technology is available to assist with alarmed, continuous monitoring devices that can alert staff via email and pager if a unit is out of specified range. Separate vaccine vials and syringes into bins or other containers according to vaccine type and formulation, keeping diluents with the appropr iate vaccines. Never store different vaccines in the same containers. Do not store vaccines with similar labels, names, abbreviations, or overlapping components immediately next to each other or on the same shelf. Separate the storage areas of pediatric and adult formulations of vaccines. Label the specific locations where vaccines are stored to facilitate correct age-specific selection and to remind staff to combine the contents of vials. ISMP's March 26, 2015 newsletter[1] contains additional strategies, as does a Vaccine Storage & Handling Toolkit available from CDC.[2]

References

1. ISMP. Recommendations for practitioners to prevent vaccine errors. Part 2: analysis of ISMP vaccine errors reporting program (VERP). *ISMP Medication Safety Alert!* 2015;20(6):1-6.
2. CDC. Vaccine storage & handling toolkit. www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf. June 2016.

Coalition Reports Impact of Educational Efforts on Safe Acetaminophen Use

The Acetaminophen Awareness Coalition reports that progress has been made to increase consumer awareness about the safe use of acetaminophen. The coalition also notes a decline in unintentional overdoses. The National Poison Data System's 2015 report indicates unintentional acetaminophen exposures, including dosing errors and accidental misuse, have decreased through 2013 after a peak in 2009. In addition, a nationwide survey indicates the number of consumers who understand that exceeding the recommended daily dose of acetaminophen may lead to liver damage has increased to 87% in 2013 from 78% in 2010. The survey also reports the number of consumers who think it is important to check the medicine label for the maximum daily dose increased to 98% in 2013 from 93% in 2010.

Developed in 2011, the Know Your Dose campaign encourages pharmacists and other health care providers to talk to their patients about medicine safety and acetaminophen use. The Know Your Dose campaign offers a list of helpful health tips to share with patients, including the following:

(1) Read and follow the label.

(2) Know which medicines contain acetaminophen.

(3) Take only one medicine at a time that contains acetaminophen.
(4) Ask a health care provider or pharmacist about dosing instructions or medicines that contain acetaminophen.

Pharmacists may download or order free educational materials, including posters, flyers, and talking points, to give their patients on the Know Your Dose website, *www.knowyourdose.org*.

FDA Offers Webinars on Online Drug Information Resources for Students and Clinicians

FDA's Division of Drug Information in the Center for Drug Evaluation and Research presents a series of CE webinars targeted toward students and health care providers who wish to learn more about FDA and drug regulation. The webinars are presented by FDA staff and allow participants to interact with staff. Previous webinar topics have included an overview of FDA's expanded access program and the pregnancy and lactation labeling rule. The webinars and presentation slides can be accessed on FDA's website at *www.fda.gov/AboutFDA/WorkingatFDA/FellowshipInternshipGraduateFacultyPrograms/PharmacyStudentExperientialProgramCDER/ucm228391.htm*.

Fresenius Kabi Recalls Sensorcaine-MPF (Bupivacaine HCl) Injection, USP

In April 2016, Fresenius Kabi USA recalled a single lot of Sensorcaine®-MPF (bupivacaine HCl) injection, USP, 0.75%, 7.5 mg/mL, 30 mL fill in a 30 mL vial, because of visible particulate matter characterized as glass observed by the company during inspection of reserve samples. The recalled product was shipped in the US to wholesaler and distributor outlets between March 4, 2016, and March 21, 2016, and has an expiration date of September 2019. The recall affects lot number 6111504, product code 470237, and National Drug Code number 63323-472-37. The product is supplied as 0.75% strength in a 30 mL single-dose flint molded vial and is packaged in units of 25. To date, Fresenius Kabi has not received any reports of adverse events regarding this recall, indicates the press release posted to the FDA website.

Health care facilities that have the affected lot are instructed to immediately discontinue distributing, dispensing, or using the lot and return all units to Fresenius Kabi. Distributors are instructed to immediately notify their customers who have been shipped or may have been shipped the recalled product. Adverse reactions or quality problems may be reported to FDA's MedWatch Safety Information and Adverse Event Reporting program at *www.fda.gov/MedWatch*. Additional details are available on FDA's website at *www.fda.gov/Safety/Recalls/ucm497812.htm*.

Oral Liquid Docusate Sodium by PharmaTech Recalled Due to Contamination

In July 2016, FDA alerted health care providers that PharmaTech, LLC, of Davie, FL, voluntarily recalled all non-expired lots of Diocto Liquid, a docusate sodium solution distributed by Rugby Laboratories of Livonia, MI. The affected product was distributed nationwide in one-pint (473 mL) bottles with a Rugby label. FDA confirmed the product has been contaminated with *Burkholderia cepacia,* a bacteria linked to an outbreak in five states. The safety alert indicates FDA has received several adverse event reports of *B. cepacia* infections in patients, and some of these reports identify liquid docusate sodium products manufactured by companies other than PharmaTech. FDA and CDC continue to investigate the extent of this issue in order to identify other potentially contaminated liquid docusate sodium products. FDA joins CDC in recommending that clinicians not use any liquid docusate sodium product as a stool softener or for any other medical purpose. Adverse events or side effects may be reported to FDA's MedWatch Safety Information and Adverse Event Reporting Program at *www.fda.gov/MedWatch*. More information may be found in the safety alert on FDA's website at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm511528.htm*.

NABP Seeks Pharmacists From Districts 1, 5, and 7 to Serve as Volunteer Item Writers

The National Association of Boards of Pharmacy® (NABP®) is seeking pharmacists who reside in states in the following districts to serve as volunteer item writers:

- **District 1:** Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.
- **District 5:** Iowa, Minnesota, Nebraska, North Dakota, and South Dakota.
- **District 7:** Alaska, Idaho, Montana, Oregon, Washington, and Wyoming.

In an effort to secure more individuals representative of these areas of the country, NABP encourages pharmacists in all areas of practice as well as school and college of pharmacy faculty who reside in these states to apply.

NABP uses volunteer item writers to develop questions for the following examination programs: North American Pharmacist Licensure Examination® (NAPLEX®), Multistate Pharmacy Jurisprudence Examination® (MPJE®), Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®), Pharmacy Curriculum Outcomes Assessment® (PCOA®), and Pharmacist Assessment for Remediation Evaluation® (PARE®).

Interested individuals should complete the online interest form available in the Meetings section of the NABP website. Individuals who are selected will receive further information on opportunities to attend and participate in NABP-hosted workshops.

For more information about NABP item writing, visit the Meetings section of the NABP website at *www.nabp.pharmacy*, or contact CompAssess@nabp.pharmacy.

Disciplinary Actions

For more information, you may view hearing minutes at *http://ok.gov/pharmacy/Board/Minutes/index.html.*

16.25. June 15, 2016 Board Hearing

Aaron Morrow, DPh #16104 – Case No. 1403: Admitted to guilt on 10 counts including failing to be a pharmacy manager who is a licensed pharmacist; failing to work sufficient hours in the pharmacy to exercise control and meet the responsibilities of the pharmacy manager; failing to supervise all employees as they relate to the practice of pharmacy; and making a false representation in procuring or attempting to procure for himself, or for another, licensure under the Oklahoma Pharmacy Act. **$4,000 fine.**

Martin-Tipton Pharmacy, #99-6012 – Case No. 1405: Admitted to guilt on four counts including failing, as a nonresident pharmacy, to submit on initial licensure the name and license number of an Oklahoma-licensed pharmacist-in-charge (PIC) who is responsible for the nonresident pharmacy's compliance with Oklahoma laws; and failing, as PIC in an Oklahoma-licensed nonresident pharmacy, to be currently licensed as a pharmacist in the state in which he or she is practicing and in Oklahoma. **$5,000 fine. Pharmacy shall not ship drugs into Oklahoma until an Oklahoma-licensed PIC is hired.**

R. Allen Martin, DPh #7720 – Case No. 1406: Admitted to guilt on 13 counts and neither admits nor denies guilt on the remaining 11 counts, including engaging in drug compounding without being familiar with all details of United States Pharmacopeia (USP) compounding standards; willfully making a false representation in procuring or attempting to procure for itself, or for another, licensure under the Oklahoma Pharmacy Act; failing to have sufficient knowledge, education, and/or experience in the practice of sterile compounding preparation pharmacy; failing to ensure preparations are of acceptable strength, quality, and purity; failing to verify all critical processes; failing to ensure appropriate stability evaluation is performed or establishing reliable beyond-use dating; failing to perform the final check of preparations prior to their release from the pharmacy; failing to ensure that all compounders who compound sterile pharmaceuticals meet all requirements for training, testing, and education; failing to have available written policies and procedures for all steps in the compounding of preparations; and failing to use total aseptic techniques, including gowning, mask, and hairnet when preparing high-risk level compounded sterile preparations (CSP). **$5,000 fine. License placed on probation for five years until June 15, 2021. Must attend eight-hour law seminar in 2016 and 2017. All live continuing education (CE) during probation.**

PPM Pharmacy, #1-6190 – Case No. 1407: Admitted to guilt on 1,279 counts including manufacturing without a license; failing to dispense only those prescription drugs legal to sell in the United States; failing to purchase prescription drugs only from entities licensed to sell such drugs; compounding sterile preparations without having a sterile compounding preparation pharmacy permit; failing to train all individuals who compound sterile preparations; failing to conduct annually for every individual involved in sterile preparation compounding testing involving media challenge tests; failing to require personnel to follow proper procedures for personnel cleansing and garbing prior to compounding and maintain proper competency of aseptic work practices; failing to do routine disinfection and air quality testing of the direct compounding environment; failing to use total aseptic techniques; failing to do sterility testing (bacterial and fungal), bacterial endotoxin (pyrogen) testing, and testing to ensure that they are of labeled potency when preparing high-risk level CSP; failing to install a pressure gauge or velocity meter to monitor the pressure differential or airflow between the clean room and the general environment outside the compounding area; and failing to prepare hazardous drugs within a certified Class II, Type A (exhaust may be discharged to the outdoors) or Class II, Type B (exhaust may be discharged to the outdoors) laminar flow biological safety cabinet. **$125,000 fine. License placed on probation for five years until June 15, 2021.**

Qualgen, LLC, #1-M-4255/#1-B-4469 – Case No. 1408: Admitted to guilt on 65 counts including failing to have and follow a diversion detection and prevention plan that includes all prescription drugs; engaging in the manufacturing of drugs and selling, bartering, brokering, or transferring drugs to a person not authorized to purchase drugs; and failing to include on the label of the drug the statement "Not for Resale" and, if the drug is dispensed or distributed other than pursuant to a prescription for an individual identified patient, the statement "Office Use Only." Respondent neither admits nor denies guilt on the remaining 978 counts. **$100,000 fine. License placed on probation for five years until June 15, 2021.**

Jacob Grammer, Technician #20333 – Case No. 1409: Admitted to guilt on four counts including committing theft while working as a registrant and possession of a CDS without a valid prescription. **Revoked.**

Daniel Kent, DPh #15601 – Case No. 1410: Admitted to guilt on three counts including failing to have received registration for immunizations with the Board prior to administering immunizations and failing to conduct business as a pharmacist at all times in conformity with all federal, state, and municipal laws. **$1,500 fine. Must attend eight-hour law seminar in 2016 plus 15 hours live CE.**

Stephen Summers, DPh #10608 – Case No. 1411: Admitted to guilt on six counts including failing to keep every inventory and other record required to be kept by the Uniform Controlled Dangerous Substances Act and OAC 475, Chapter 25; failing to properly maintain the required inventories and records of CDS; failing to make a separate inventory of CDS kept at the registered location and maintain that inventory at the location; failing, as pharmacy manager, to be responsible for all aspects of the operation related to the practice of pharmacy; failing to record dates of receipt on invoices on which the CDS are actually received; and failing to have retrievable by the prescription number the initials of the dispensing pharmacist for each refill. **$1,200 fine. Must attend eight-hour law seminar in 2016 and complete 15 hours live CE in 2017.**

Impaired Pharmacist, DPh #10905 – Case No. 1412: Found guilty of four counts including violating a voluntary or Board-ordered rehabilitation program for the impaired contract and providing fictitious information, fraud, or misrepresentation in applying for or procuring a pharmacist license or other permit. **Suspended for 10 years until June 15, 2026. Oklahoma Pharmacists Helping Pharmacists (OPHP) 10-year contract. Eight-hour law seminar in 2016 and 2017. All live CE during OPHP contract. May appear and request probation after fit-for-duty finding.**

Kourtney Crane, Technician #16479 – Case No. 1413: Admitted to guilt on four counts including committing theft while working as a registrant; possession of a CDS without a valid prescription; and abusing alcohol or drugs, using an illegal or CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Wellston Clinic Pharmacy, #31-5799 – Case No. 1414: Admitted to guilt on 3,001 counts including failing to ensure the proper prescribing and dispensing of a prescription for a CDS; failing to ensure that all prescriptions for CDS filled by respondents are dated as of, and signed on, the day when issued and bear all the required information of a prescription for a CDS; and failing to ensure that all prescriptions for Schedule II CDS filled by respondents are written prescriptions and signed by the practitioner. **$10,000 fine.**

Katherine Dossey, DPh #10322 – Case No. 1415: Admitted to guilt on 3,002 counts including failing to ensure the proper prescribing and dispensing of a prescription for a CDS; failing to ensure that all prescriptions for CDS filled by respondents are dated as of, and signed on, the day when issued and bear all the required information of a prescription for a CDS; and failing to ensure that all prescriptions for Schedule II CDS filled by respondents are written prescriptions and signed by the practitioner. **$5,000 fine. Must attend eight-hour law seminar in 2016 and 2017 in addition to 15 hours live CE.**

Chase Parsons, Technician #21032 – Case No. 1416: Found guilty of four counts including committing theft while working as a registrant; possession of a CDS without a valid prescription; and abusing alcohol or drugs, using an illegal or CDS, and/or testing positive for such substance or its metabolite. **Revoked.**

Bobby Gee, DPh #8191 – Case No. 1417: Admitted to guilt on 18 counts including failing to be familiar with all details of USP

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compounding standards and with patent regulations; failing to ensure that preparations are of acceptable strength, quality, and purity; failing to ensure appropriate stability evaluation is performed or establishing reliable beyond-use dating; failing to ensure the proper maintenance, cleanliness, and use of all equipment used in a prescription compounding practice; failing to ensure that all compounders who compound pharmaceuticals meet all requirements for training, testing, and education set forth in Board regulations and contained in the regulations set forth in USP standards; failing to have available written policies and procedures for all steps in the compounding of preparations; failing to have labeling on the outer container separating hazardous from nonhazardous drugs; failing to document and have available for Board inspection documentation of training of a currently permitted pharmacy technician within 10 days of hire at the pharmacy; failing to have proof of annual technician training maintained in the pharmacy and available for Board inspection; failing to require all staff to wear personal protective equipment (PPE) while working with hazardous drugs; failing to establish and maintain effective controls against the diversion of prescription drugs; failing to supervise all employees as they relate to the practice of pharmacy; allowing a non-pharmacist to unlock the pharmacy area or any additional storage areas for dangerous drugs; failing to be proficient in compounding and to continually expand his compounding knowledge by participating in seminars and/or studying appropriate literature; and allowing a non-pharmacist to perform duties reserved to a pharmacist. **License is revoked effective the date of the sale of Turner Drug (#47-6211) or, at the latest, 120 days from June 15, 2016. Respondent must have a contract for the sale of Turner Drug signed within 120 days from June 15, 2016.**

Turner Drug, #47-6211 – Case No. 1418: Admitted to guilt on 8,500 counts including failing to have a sterile compounding preparation pharmacy permit as required; failing to test all high-risk level CSP for administration by injection to ensure they are sterile, do not contain excessive bacterial endotoxins, and are of labeled potency before they are dispensed or administered; failing to have written procedures for the compounding of drug preparations to ensure that the finished products have the identity, strength, quality, and purity they purport to have; failing to document a listing of the components, their amounts (in weight or volume), the order of component mixing, and a description of the compounding process (eg, log, formula worksheet, original prescription); failing to follow written procedures in the execution of the compounding procedure; failing to prepare hazardous drugs within a certified biological safety cabinet; failing to store hazardous drugs separately from other drugs; failing to require all staff to wear PPE while working with hazardous drugs; failing to compound hazardous drugs inside a ventilated cabinet designed to prevent hazardous drugs from being released into the work environment; failing to retain any procedures or other records required to comply with USP compounding standards for the same period of time as required for retention of prescription records; failing to assign every compounded preparation an appropriate beyond-use date; failing to label any excess compounded preparation; not properly labeling and documenting preparations prepared in anticipation of a prescription prior to receiving a valid prescription; failing to train and document training for every individual who prepares compounded preparations; failing to comply with all aspects of USP compounding standards and OAC 535; failing to document and have available for Board inspection documentation of training of a currently permitted pharmacy technician within 10 days of hire at the pharmacy; allowing a non-pharmacist to unlock the pharmacy area or any additional storage areas for dangerous drugs; failing to establish and maintain effective controls against the diversion of prescription drugs; supplying legend drugs to licensed practitioners for office administration without having a drug supplier permit; and selling, offering for sale or barter, or buying any professional samples except through a program pursuant to the Utilization of Unused Prescription Medications Act. **$75,027 fine.**

16.26. August 3, 2016 Board Hearing

Impaired Pharmacist, DPh #15171 – Case No. 1262: Request for probation was granted. License will be placed on probation upon reinstatement until February 19, 2024.

Oklahoma State Board of Pharmacy vs Sue Ann Rogers, DPh #10308 – Case No. 1333: Found guilty of failing to comply with the Board's orders issued on April 22, 2015. Respondent has until October 3, 2016, to pay the remainder of the fine assessed on April 22, 2015, or the stay of suspension of her pharmacist license will be removed resulting in the suspension of her license.

Oklahoma State Board of Pharmacy vs Camp Pharmacy, #12-5726 – Case No. 1334: Found guilty of failing to comply with the Board's orders issued on April 22, 2015. Respondent has until October 3, 2016, to pay the remainder of the fine assessed on April 22, 2015, or the stay of suspension of the pharmacist license of Sue Ann Rogers, DPh #10308, will be removed resulting in the suspension of her license.

Ronda Horn, Technician #16856 – Case No. 1419: Admitted to guilt on four counts including committing theft while working as a registrant and possession of a CDS without a valid prescription. **Revoked.**

Jordan Harmening, Technician #17799 – Case No. 1420: Admitted to guilt on four counts including failing to report to the Board an arrest, charge, plea of nolo contendere, or conviction, or deferred sentence, for any misdemeanor or felony offense; furnishing false or fraudulent material in an application; and failing to be forthright and open in the provision of information to the Board in the application process. **Revoked.**

David Ritchey, Technician #21014 – Case No. 1421: Found guilty on three counts including conducting business in a registrant's capacity without reasonable skill and safety by reason of illness, use and/or abuse of drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical condition. **Revoked.**

Calendar Notes

The Board will meet on Wednesday, **November 2, 2016.** The Board will be closed Friday, **November 11** for Veterans Day; Thursday and Friday, **November 24-25** for Thanksgiving; Monday and Tuesday, **December 26-27** for Christmas; and Monday, **January 2** 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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