March 2014

Vermont Board of Pharmacy News

Published to promote compliance of pharmacy and drug law

Vermont Secretary of State, Office of Professional Regulation, Board of Pharmacy
89 Main Street, Third Floor • Montpelier, VT 05620-3402 • *http://vtprofessionals.org*

Proposed Administrative Rules

The Vermont Board of Pharmacy has filed proposed revisions to its administrative rules.

A copy of the current rules and proposed rules can be found on the Office of Professional Regulation's website at *http://vtprofessionals.org*. Go to the drop-down menu of "Select a Profession" and select "Pharmacy." On the right side of the page click "Current Rules" and, to see the proposed changes, click "Proposed Rules: Annotated Version." New language in the proposed rules is underlined. Deleted language is ~~stricken.~~

You are invited to comment; written comments are most helpful. You are encouraged to submit written comments to the Board. When commenting, please refer to rules by number and section (eg, Regarding Rule 4.1(a) . . .).

They can be mailed to:

Vermont Board of Pharmacy
Office of Professional Regulation
89 Main St, Third Floor
Montpelier, VT 05620-3402

E-mailed comments are encouraged. There is a link on the Board's website that says, "To send comments, click here."

Public Hearing: Interested parties may comment on the proposed rules at a public meeting on March 26, 2014, at 1 PM, at the Office of Professional Regulation Conference Room located at 89 Main St, Third Floor, Montpelier. The final deadline for comments is April 15, 2014, but the Board hopes to review comments at its March 26 meeting. Once the Board considers all of the comments received, it will make final revisions and file the rules with the Vermont Legislative Committee on Administrative Rules.

If you have any questions, please do not hesitate to contact the Board.

New Board Members

The Board is pleased to announce that Governor Peter Shumlin has appointed **Robert Carpenter, RPh,** and **Stephanie Ibey, PharmD,** as members of the Board. They replace Julia Eaton, RPh, and Steven Vincent, RPh, whose terms on the Board expired on December 31, 2013. Both Mr Carpenter and Ms Ibey will serve a five-year term on the Board from January 1, 2014 to December 31, 2018.

Mr Carpenter is a native of Rutland, VT, where he lives and works as manager of a community pharmacy. He is a graduate of the University of Connecticut School of Pharmacy. During his professional career, he has worked as staff pharmacist, pharmacy owner, and pharmacy manager in both hospital and community pharmacies. He has been an active member of the Vermont Pharmacists Association, serving on the Board of Directors for 20 years, and serving a three-year term as president.

Mr Carpenter is married with three grown children. He enjoys any outdoor activity.

Ms Ibey is a native of Central Vermont and works as a community pharmacist in Barre, VT. She attended the Massachusetts College of Pharmacy and Health Sciences in Boston, MA, where she earned a doctor of pharmacy degree in 2007. She began working for her present employer in 2011, and was active in the development and implementation of a telepharmacy pilot program that is providing pharmaceutical care and pharmacy services to underserved and remote parts of Vermont.

When not working, Ms Ibey enjoys spending time with her family and riding her motorcycle with her husband.

Board Members

The members of the Board and their term expiration dates are as follows:

- **Jeffrey P. Firlik, RPh,** chair, Williston, VT (December 2014)

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Changes to Fentanyl Pain Patch Warnings Required by FDA

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

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

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. *ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also an FDA MedWatch partner. Call 1-800/FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at* www.ismp.org. *ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.*

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

Here are a few excerpts from a recent issue.

Immediate Vs Extended Release Error

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

Errors Occur During Transitions of Care

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

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

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

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

FDA Recommends Schedule II Classification for Hydrocodone Combination Products

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

New FDA Drug Info Rounds Training Videos Available

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

CPPA Developing Specialty Pharmacy Accreditation Program

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

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

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

National Association of Boards of Pharmacy Foundation, Inc
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- **Larry Labor, RPh,** vice chair, Morgan, VT (December 2015)
- **Judith Wernecke,** public member, secretary, West Berlin, VT (December 2015)
- **King Milne, RPh,** Charlotte, VT (December 2017)
- **James Arisman, Esq,** public member, Marshfield, VT (December 2017)
- **Robert Carpenter, RPh,** Rutland (December 2018)
- **Stephanie Ibey, PharmD,** Williamstown, VT (December 2018)

Board members may be contacted by writing to:

Vermont Board of Pharmacy
Office of Professional Regulation
89 Main St, Third Floor
Montpelier, VT 05620-3402

Main phone number: 802/828-1505

Staff: Ronald Klein, RPh, executive officer; and Aprille Morrison, licensing board specialist

Website: *http://vtprofessionals.org/opr1/pharmacists/*

On the website you will find statutes, rules, applications, disciplinary actions, announcements, and text of proposed rules. You may also print your own license following the instructions on the website.

Pharmacy Technician Registration

The Board is pleased to announce that initial registration for pharmacy technicians is now available online. Pharmacy technicians may not work in any capacity in a pharmacy until they are registered with the Board and have received documentation of the same from the Board. There is no temporary registration of technicians as this provision has been repealed by the legislature. The Board generally processes applications in three to five business days. To apply for registration as a pharmacy technician in Vermont, please follow the steps below.

1. Go to *http://vtprofessionals.org.*
2. In the Announcements box on the right, click on "Online Access."
3. At the main menu, select "To Apply for a NEW License – Click Here."
4. Register for a new account.
   a. Create your own user ID and password.
   b. Next, an e-mail verification will be sent to you. To complete the verification process, you must click on the link within your e-mail notification.
5. Click on "Apply for a New License" in the left-hand column
6. Click "Start" next to "Board of Pharmacy – Pharmacy Technician."
7. Complete the online application following the instructions provided.

The *Vermont Board of Pharmacy News* is published by the Vermont 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.

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