NASPER Funding Assists States’ Prescription Monitoring Programs

State-run controlled substance monitoring programs got a boost from Congress this spring, when legislators provided $9 million in funding for two grant programs that provide money to states implementing a new prescription monitoring program (PMP) or making improvements to an existing PMP.

In March 2009, Congress appropriated $2 million to fund, for the first time, a grant program established through the National All Schedules Prescription Electronic Reporting Act (NASPER), which was originally enacted (though not funded) in 2005. Through its grant criteria, which were up for comment earlier this spring, NASPER seeks to establish a set of PMP best practices, based on the experiences of existing programs, to assist states in establishing or improving PMPs. It also includes provisions for standardization and interoperability to both enable and require information-sharing between states with PMPs.

The United States Department of Health and Human Services’ Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency in charge of administering the NASPER grant program, planned to review and award grants before the end of the 2009 fiscal year on September 30.

Along with the new NASPER funding, which emphasizes PMPs’ use as a public health intervention tool, Congress appropriated $7 million in fiscal year 2009 for the ongoing Harold Rogers Prescription Drug Monitoring Program run through the Department of Justice (DOJ). The Harold Rogers program is intended primarily to assist regulatory and law enforcement efforts.

PMP Variations

A majority of states have turned or are turning to PMPs as a tool to improve patient care (particularly addressing addiction issues) and simultaneously prevent diversion of controlled substances. According to Drug (continued on page 138)
The NABP Newsletter (ISSN 8756-4483) is published 10 times a year by the National Association of Boards of Pharmacy (NABP) to educate, to inform, and to communicate the objectives and programs of the Association and its 66 member boards of pharmacy to the profession and the public. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of NABP or any board unless expressly so stated. The subscription rate is $35 per year.

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**Feature News**

**NASPER Funding**
(continued from page 137)

Enforcement Administration (DEA), 38 states, at last count, had enacted PMP legislation, and of those, 32 had operating programs.

These programs share a similar broad outline—they track certain controlled substance prescriptions and house the information in a central database. Generally, the information that goes into the system is provided by the pharmacies. The specifics of these programs, however, vary widely on a state-by-state basis. These specifics include, for example, what state agency oversees the program, how often data is submitted, what drugs are reported, and who may access the database information. Likewise, software, format requirements, general parameters, and how the data may be manipulated to generate different information varies, as well.

The National Alliance for Model State Drug Laws (NAMSDL), which assists states with efforts to combat prescription drug diversion, abuse, misuse, and addiction, and offers information and assistance on PMPs, notes that state monitoring programs allow authorized users to identify and investigate cases in two general ways: The program may be reactive, i.e., generating solicited reports in response to a specific query from an authorized source, such as a prescriber, pharmacist, or law enforcement personnel; or proactive, i.e., issuing unsolicited reports based on suspicious data patterns.

In part, the system a state establishes will depend on whether the state places more emphasis on PMPs’ law enforcement or patient care aspects—or tries to balance the two. In Pennsylvania, for example—it which monitors only Schedule II controlled substances and whose program is overseen by the Office of Attorney General—100% of database requests come from law enforcement, according to NAMSDL. In Virginia (program overseer: the Department of Health Professions/Virginia Board of Pharmacy), which monitors Schedule II, III, and IV drugs, 78% of requests come from physicians, 19% from law enforcement, and 3% from licensing boards. In Illinois (program overseer: the Department of Human Services), which monitors Schedule II through V drugs, 50% of requests come from law enforcement, and 50% from licensing boards.

Monitoring programs offer clear benefits to both law enforcement efforts and patient care. From a law enforcement perspective, PMPs allow authorized officials to access controlled substance prescription information from one central place, rather than having to visit multiple individual pharmacies. From a public health standpoint, the ability of prescribers and dispensers to get a more complete view of a patient’s controlled substance prescription activity can help health care providers determine, for example, if a treatment regimen is working, identify early signs of addiction, and tag those individuals who may be “doctor shopping.” Both public health and law enforcement approaches, however, are working toward the same larger goal: the reduction of prescription drug misuse, abuse, and diversion.

NASPER, which was originally proposed as legislation by the American Society of Interventional Pain Physicians, emphasizes PMPs’ use as a public health intervention tool. As the act states, it was enacted to “foster the establishment of State-administered controlled substance monitoring systems to ensure that health care providers have access to the accurate, timely prescription history information that they may use as a tool for the early identification of patients at risk for addiction. With the knowledge gained, health care providers will be able to initiate appropriate medical interventions and avert the tragic personal, family, and community consequences of untreated addiction.”

**Harold Rogers Grant**

While PMPs have been around at least since California began monitoring Schedule II controlled substances in the 1940s, they have gone electronic and become increasingly common in recent years. Much of the growth in PMPs since 2001—when (continued on page 139)
NABP Convenes Task Force to Research Various PMPs, Recommend Uniform Standards

NABP will convene a task force October 28-29, 2009, to research various prescription drug monitoring programs (PMPs) and recommend standards or model rules. The task force came about in response to Resolution No. 105-6-09, passed at the NABP 105th Annual Meeting in Miami, FL, calling for its development.

The resolution identifies a need to standardize PMPs, noting that “many of the state boards of pharmacy have enacted varying statutes and regulations and operational systems and standards related to PMPs.”

As described in the resolution, the task force will “review existing PMPs in light of the current language on PMPs found in the Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act), identify for member boards where variations among programs exist, and encourage states to adopt language and standards to provide uniformity in the various PMP programs across the nation.”

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Through legislative actions, boards of pharmacy are created and empowered to carry out the important mission of public protection through the regulation of the profession of pharmacy. Boards license pharmacists based upon statutorily established criteria designed to ensure applicants (and ultimately licensees) possess the minimum competence and other identified attributes necessary to competently and safely practice pharmacy. Licensure eligibility criteria include an assessment of education, experience, and examination, along with character issues and others. Based upon the promotion of uniformity and the expertise needed to evaluate designated statutory criteria related to education and examinations, legislatures through statutes (and boards through regulations) elect to rely upon (or defer to) entities in the private sector to assist in the assessment of applicants for licensure.

Many factors are important in validating the public sector’s reliance upon entities in the private sector that provide assistance in determining licensure eligibility, not the least of which is the legal validity of the program upon which the board defers. Examples include the North American Pharmacist Licensure Examination® (NAPLEX®) developed and administered by NABP and the professional degree programs in pharmacy accreditation process developed and administered by the Accreditation Council for Pharmacy Education (ACPE). Numerous other factors may be relevant in determining the legal and practical bases for state pharmacy board deference to non-governmental entities. Such factors include the nonprofit status of the entity, the makeup of the membership, and the authority of the boards of pharmacy to participate in the development and administration processes of the program or service, as well as others. A legal challenge to the processes used by such private sector entities that are relied upon by the respective boards calls into question the licensure process and provides an opportunity for the entity to validate its service or program for use by the regulatory boards. While not relevant to the case outlined below, a board or boards of pharmacy may, under certain circumstances, be a necessary party to such legal proceedings. Consider the following.

ACPE is a not-for-profit organization whose mission is to assure and advance the quality in pharmacy education by, among other factors, establishing and enforcing standards and criteria for the accreditation of pharmacy degree programs and for the accreditation of continuing education providers. In pertinent part, ACPE accredits the pharmacy degree programs upon which boards of pharmacy rely in determining the education criterion toward licensure as pharmacists. Accreditation signifies that such a program meets the ACPE standards and criteria resulting in ACPE accreditation recognition of the program. ACPE is a programmatic accrediting entity and does not accredit institutions.

A university with a pharmacy program (referred
to as plaintiff) accredited by ACPE filed suit in federal court and challenged ACPE’s placement of its pharmacy program on probation. The ACPE probation determination was based upon a finding of noncompliance of an ACPE standard related to the quantitative faculty and staff. A program on probation maintains recognition as an accredited program for purposes of ACPE accreditation, and graduates from the program during this probation period are considered to have graduated from an accredited program for purposes of qualifying for licensure under applicable state law. The program was placed on probation in January 2009 for a period of six months with the continued accreditation of the program to be addressed at the next meeting of the ACPE board of directors in June 2009.

The plaintiff argued that the placement of the program on probation violated plaintiff’s common law due process rights by, among other factors, failing to provide concrete numbers and/or ratios of students to faculty, limiting the time for conformance, treating the program differently from other programs, and failing to provide an appeal mechanism. In short, plaintiff argued that it was “blindsided” by the probation determination in violation of certain due process rights. In addition, the plaintiff argued that ACPE as a “state actor” had violated 42 USC section 1983, which creates rights for unlawful actions taken under color of state law. As part of its request for relief, the plaintiff sought a preliminary injunction that requested that the court provide for certain immediate relief for a limited period of time and ultimately pending the disposition of the trial on the merits. The request for a preliminary injunction resulted in the filing of briefs by the parties and a hearing before a federal district court judge.

In its defense, ACPE provided documentation and arguments relating to its processes and procedures in interacting with the plaintiff and the ongoing communications between a program and the accrediting body. In short, ACPE provided a historical roadmap of the various notices, reports, site visits, plaintiff generated reports, ACPE staff analyses, and ACPE proceedings culminating in the January 2009 ACPE Board of Directors determination that probation was warranted.

After a hearing, the court was confronted with determining whether to issue a preliminary injunction. In its analyses, the court first addressed the facts. It provided a detailed chronology of events documenting the correspondence and communications between the parties that included numerous written notices undertaken in the ordinary course of ACPE operations and that notified the plaintiff of the “concerns” and “grave concerns” through written ACPE-generated reports. Specifically, these ACPE-generated reports related to decreasing faculty numbers coupled with increasing student enrollments.

After establishing the facts, the court turned its attention to the standard of review in deciding a motion for a preliminary injunction. It held that the court must consider the following:

1. the likelihood of irreparable harm to the plaintiff should the court refuse to grant the injunction;
2. the likelihood of harm to the defendant (ACPE) should the court grant the injunction;
3. the likelihood that the plaintiff will succeed on the merits; and
4. the public interest.

Regarding the first factor, the likelihood of irreparable harm to the plaintiff should the court refuse to grant the injunction, the court held the balance of harms to the parties clearly tips in favor of the plaintiff, noting that the case “appears to involve a prime example of potential irreparable harm to a plaintiff.” It noted that the current probationary status and potential loss of accreditation in the future is likely to lead some students to consider transferring and may encourage current faculty to seek positions.

(continued on page 142)
In response to ACPE’s argument that the matter was not ripe for consideration as the internal processes had not yet fully run their course and the probation status was not “final,” the court rejected this argument. It held that the matter was ripe for judicial consideration due to the “real and substantial” harm at stake in the event of withdrawal of accreditation.

Addressing ACPE’s defense that the judicial district, which has jurisdiction over this matter, does not recognize a common law right of due process in that no opinions have yet to hold such a right exists, the court noted that ACPE cited no cases that held that such a right does not exist. The court also noted a United States Supreme Court case whereby the court determined that a certain not-for-profit organization was a state actor and the potential impact of such a holding on the common law due process allegations. Thus, the court held that there is some merit to plaintiff’s argument that common law due process rights may exist, satisfying the third prong. Due to its findings regarding common law due process, the court declined to address the merits of the section 1983 claim.

Finally, the court turned its attention to the fourth prong, public interest. Noting the strong interest in the school to protect its community of students and faculty, the court emphasized the stronger interests of ACPE to protect not only the educational interests of the school and its direct constituents, but the public by ensuring the educational component of the licensure process is enforced. The practice acts of each jurisdiction are enacted with the intent to protect the health and welfare of the consuming public. The court stated: However, it is also not hyperbole to say that where a case involves medical professionals such as pharmacists, who are responsible for preparing and dispensing life-saving (and, in some cases of error, life-threatening) medications in hospitals and directly to the public, the case necessarily also involves issues of life or death. The court believes that entering an injunction that would interfere with ACPE’s ability to enforce its standards would clearly be against the interests of public health and safety implicated in this case.

The court also emphasized the deference afforded to accrediting organizations with respect to their substantive standards and professional judgment. To complete its public interest analysis, the court referenced the potential for the entry of injunctive relief to interfere with ACPE’s obligations as a recognized accrediting entity by the United States Department of Education that maintains criteria ACPE must comply with. The court also noted the realization that an injunction to maintain the status quo of the school’s accreditation would not necessarily do anything to maintain the status quo at the school itself. That is, conditions at the school could, instead of improving, deteriorate while the injunction was in effect. Based upon the importance of the public interest element related to ACPE and the accreditation process, the court denied the plaintiff’s motion for a preliminary injunction.

This opinion is an important ruling related to the accreditation community and the regulatory boards that rely upon the expertise of accrediting entities. Not only did the court recognize the importance of deferring to the accrediting body and protecting the integrity of the accreditation process, the court recognized and emphasized the essential role accrediting entities play in assisting state boards of pharmacy to protect the public through the licensure process. The court’s emphasis and reasoned analysis of the “public interest” factor in determining whether to grant a preliminary injunction recognizes the important public protection role of the licensure process. While the judicial opinion only addressed the plaintiff’s motion for a preliminary injunction, thus not ruling on the merits of the matter, the case has been since dismissed by the plaintiff based upon its removal from probation status due to subsequent compliance with accreditation standards.

**Hampton University v Accreditation Council for Pharmacy Education, 2009 WL 1180875 (US DC VA 2009)**
Electronic Licensure Transfer Program Paper-Based Preliminary Applications to be Eliminated as of January 2010

In an effort to streamline the licensure transfer process, NABP will be eliminating paper-based preliminary applications for the Electronic Licensure Transfer Program® (ELTP®) beginning January 1, 2010. As of this date, only online applications will be accepted from those wishing to transfer their license.

The benefit for eliminating the paper-based ELTP application is to provide a more efficient and faster process for transmitting applicants’ license information to NABP and the applicable state board of pharmacy.

One factor that currently reduces the efficiency of the license transfer process is the number of ELTP paper-based preliminary applications that contain errors when submitted to NABP for processing. In 2008, approximately 50% of the paper-based preliminary applications submitted to NABP contained errors or the information was not legible, resulting in lengthier processing periods as staff spends time rectifying the errors.

The online application process prevents such errors from occurring by immediately notifying applicants when information is missing from a required field. The online application also will not let the applicant move on to the next step of the application until the proper fields and information are completed.

As an added benefit, online submission of applications allows for a secure transmission, which prevents any opportunity of forgery or altering of information.

As NABP moves forward with the elimination of all ELTP paper-based applications, room for further advancements in the ELTP process will be available. Eliminating paper-based applications eliminates data entry and processing time, thus allowing NABP to focus on further streamlining the steps needed to complete a license transfer request.

Please note that although the paper-based ELTP application will be eliminated, there will be exceptions made for individuals who are unable to complete an application electronically. Those individuals should contact NABP for further instruction on how to complete their license transfer request.

Additional information about the ELTP process is available in the Licensure Programs section of the NABP Web site at www.nabp.net.

Newly Accredited VAWD Facilities

The following facilities were accredited through the NABP Verified-Accredited Wholesale Distributors® (VAWD®) program:

- **Accredo Health Group, Inc**
  Memphis, TN
  Accredited May 29, 2009

- **AmerisourceBergen Drug Corporation**
  Salt Lake City, UT
  Accredited May 26, 2009

- **Exel, Inc**
  Lancaster, PA
  Accredited May 29, 2009

- **Gulf South Medical Supply, Inc**
  Sacramento, CA
  Accredited May 12, 2009

- **MedVantx, Inc dba Ameripharm, Inc**
  Sioux Falls, SD
  Accredited May 29, 2009

- **Walgreen Company**
  Moreno Valley, CA
  Accredited May 29, 2009

A full listing of more than 350 accredited VAWD facilities is available on the NABP Web site at www.nabp.net.
NABP Provides Document Backup Assistance in Case of Emergency

On April 30, 2009, the computer systems of the Virginia Department of Health Professions, of which the Virginia Board of Pharmacy is a part, became temporarily unoperational after hackers broke into the department’s prescription monitoring program (PMP) database. The hackers left a ransom note on the PMP’s Web site claiming the theft of more than 8 million patient records.

All of the department’s computer servers were quickly shut down while the security breach was assessed, impeding for days the department’s ability to conduct business electronically (including e-mail and electronic license renewals) and, for a brief period, even the telephone system was turned off.

NABP was able to assist the Virginia Board of Pharmacy during the time period that its licensees and the public could not access its Web site, by creating an area on the NABP Web site with vital documents: references such as rules and regulations, for example, or license renewal forms that could be filled out and sent to the Board.

With daily board of pharmacy business so dependent on electronic systems in every locale, losing access to a Web site can pose a serious problem, whether the loss is due to cyber crime, natural disaster, or anything else. And scrambling to find a backup plan – taking the time to determine what's vital, trying to access files when a computer system is down, obtaining necessary approvals – in the midst of a crisis is not anyone’s ideal scenario.

To combat this problem and add another tool to the boards’ emergency preparedness kit, NABP offers the boards of pharmacy the option to set up “dark pages” containing backup board-related documents, such as rules and regulations, licensure forms, or any other information deemed necessary by the board, on the NABP Web site. These “dark pages” would be on the NABP Web site, but without an active link accessible to the public (although the board would be able to view their page and provide NABP with updates or changes as necessary). If a board’s Web site becomes disabled, NABP could instantly activate the board’s information on the NABP Web site, providing a link from the NABP home page. If the board is a member of the NABP electronic state newsletter program and utilizes the e-alert option, NABP could also disseminate information by e-mail to board licensees.

Boards of pharmacy interested in using NABP’s Web site as backup for vital documents may contact NABP Chief Operating Officer Robert Cowan at 847/391-4400, or via e-mail at custserv@nabp.net.
Symposium Returns to Tucson to Address Medical Marijuana,
Partnership between Public and Private Organizations

Offering valuable and interactive continuing pharmacy education (CPE) sessions, this year’s NABP Symposium will address timely topics including medical marijuana and the development of partnerships between public and private organizations, while providing attendees the opportunity to earn up to 11.25 hours (1.125 CEUs) of Accreditation Council for Pharmacy Education-approved CPE credit.

Returning to the J.W. Marriott Starr Pass Hotel in Tucson, AZ, the Symposium will take place December 3-4, 2009.

Board of pharmacy executive officers, members, and compliance officers are invited to attend the meeting to hear from experts in pharmacy as well as network with their peers. Additionally, state and federal regulators and stakeholders in the practice of pharmacy will be in attendance.

A 15-minute drive from downtown Tucson, the J.W. Marriott is surrounded by the 50,000-acre Tucson Mountain Park. For attendees planning to extend their stay through the weekend, the scenic backdrop of cactus forests, hills, and mountains, offers a variety of adventurous activities including escorted horseback or bike rides along desert trails and geocaching, a GPS-based treasure hunt in the Tucson mountains. (See sidebar for links to activities in Tucson and the surrounding area.)

Early Registration Available

NABP offers an early registration rate for registrants who sign up for the Symposium on or before Friday, October 16. Online registration is available August 3, and can be accessed in the Meetings section of the NABP Web site at www.nabp.net. A printable registration form can also be downloaded and faxed, e-mailed, or mailed to NABP Headquarters. Both types of registration offer attendees three payment options: (1) mailing in the payment, (2) using a credit card (American Express, MasterCard, or Visa), or (3) paying in Tucson.

Hotel and Transportation

NABP has confirmed a special meeting rate at the J.W. Marriott Starr Pass Hotel of $159 single/double occupancy plus 12.05% state and local tax and a $1 fee. Attendees may make their room reservations by contacting the hotel on or after August 3, at 1-888/527-8989 and identifying themselves as participants of the NABP 2009 Symposium. To ensure reservations at the special rate, reservations must be received by the hotel no later than Monday, November 9.

The hotel is located just 15 to 20 minutes from the Tucson International Airport. There are shared-ride van services and taxis available from the airport to the hotel. The Arizona Stagecoach, which operates the shared-ride van service, costs approximately $30 per person and reservations can be made by calling 520/889-1000 or 1-877/782-4355 or by visiting www.azstagecoach.com. The registration desk is located in the center of the baggage claim area. Taxis are also available and are located on the commercial roadway on the lower level of the airport in front of the terminal and cost between $35 and $40.

For airfare and car rental rates, registrants may contact the NABP official travel agency, Options Travel, at 1-800/544-8785. When calling Options Travel it is recommended that attendees identify themselves as registrants for the NABP Symposium.

Tucson Links

Arizona-Sonora Desert Museum  
www.desertmuseum.org
Colossal Cave  
www.colossalcave.com
Geocaching Site  
www.geocaching.com
J.W. Marriott Starr Pass Hotel  
www.jwmarriottstarrpass.com
Metropolitan Tucson Convention and Visitors Bureau  
www.visittucson.org
Old Tucson Studios  
www.oldtucson.com
Pima Air and Space Museum  
www.pimaair.org
Tucson Botanical Gardens  
http://tucsonbotanical.org
Tucson Museum of Art  
www.tucsonarts.com
Interconnectivity of Electronic PSE Tracking Systems Shown to Reduce Illegal Manufacture of Meth

Much like bacteria that mutate to resist antibiotics, methamphetamine traffickers have adapted their methods to evade the restrictions that, for a while, weakened their operations. In response to these tactical mutations, regulatory and law enforcement authorities are augmenting their curative strategies. The use of interconnected electronic tracking systems to record and monitor pseudoephedrine sales at the point of purchase has proven effective in reducing diversion of these products. A study published in 2009 in *Drug and Alcohol Review*, which followed diversion trends by jurisdiction in Australia, confirms the efficacy of this technological remedy.

In the few years following implementation of the Combat Methamphetamine Epidemic Act of 2005 in the United States, which restricted consumer purchases of pseudoephedrine-containing products and required pharmacists to log all such purchases, the illicit production of methamphetamine in the US declined. After a significant drop in 2007, however, “methamphetamine availability stabilized and possibly increased after the first half of 2008,” according to the National Drug Threat Assessment 2009 compiled by the National Drug Intelligence Center of the US Department of Justice (DOJ). The report ties the increased availability to escalated domestic production of the drug.

DOJ attributes the resurgence in US methamphetamine production, in part, to producers obtaining the precursor ingredients from local retail sources. To buck the tracking system, methamphetamine traffickers are known to acquire large quantities of pseudoephedrine, the precursor chemical used in the manufacture of methamphetamine, by organizing multiple, successive purchases of pseudoephedrine-containing products in quantities at or below legal limits in multiple retail locations — a practice known as “smurfing.” Pseudoephedrine tracking systems that are not interconnected generally fail to flag these multiple purchases.

To address this shortfall, several states in recent years have implemented or shown interest in implementing electronic tracking systems that record the sales of pseudoephedrine-containing products. Such systems enable retailers to transmit information on pseudoephedrine sales to an electronic database accessible to appropriate law enforcement and regulatory agencies at the state level. Information from these systems can be used by enforcement authorities to reduce the number of domestic methamphetamine labs by preventing the sale of pseudoephedrine in excess of legal limits, and to identify and prosecute individuals involved in smurfing and others involved in methamphetamine production.

Both Kentucky and Arkansas have demonstrated success with linked electronic monitoring systems in reducing pseudoephedrine diversion. The implementation of MethCheck in 15 Laurel County, KY pharmacies in 2005, and of LeadsOnlabs MethMontior in 18 North Little Rock, AR pharmacies in 2006, both led to increased numbers of local illicit laboratory seizures, increases in methamphetamine-associated arrests, and savings in law enforcement resources. In 2008, Kentucky and Arkansas became the first two states to legislate linked monitoring systems to be installed in pharmacies for recording and tracking pseudoephedrine purchases.

To support states in their efforts to set up linked tracking systems, and to encourage and support planning for interconnectivity between state systems, the DOJ Office...
of Justice Programs’ Bureau of Justice Assistance (BJA) in spring 2009 was accepting grant applications for a Methamphetamine Precursor Chemical Diversion Training and Technical Assistance provider. Applications were due June 23 for the grant, which is being funded under the Edward Byrne Memorial Justice Assistance Grant Program.

The recently published results of the aforementioned study conducted in Australia support the theory that interconnectivity between tracking systems reduces methamphetamine production. The study, undertaken by researchers at two Australian universities, found linked electronic tracking systems to be successful in preventing pseudoephedrine diversion in Queensland, Australia.

The study evaluated the effectiveness of a linked electronic medication recording system (LEMS), implemented into Queensland pharmacies in 2005 as part of the Pharmacy Guild of Australia’s “Project STOP” initiative to prevent the diversion of pseudoephedrine. The LEMS is a Web-based system that electronically records pseudoephedrine purchase information at the point of sale and instantaneously transfers the data to a central collection system. A global positioning system depicts the location of the pharmacy where the data were entered. The system enables authorized pharmacists, law enforcement officials, and health department staff to view the data to identify cases of suspected diversion and to compare pseudoephedrine purchases with wholesaler supplies to pharmacies.

To measure the impact of the LEMS program on Queensland pharmacies, the study tracked the number of illegal laboratories seized in Australia by jurisdiction from 1996-1997 to 2005-2006. Based on the historical trends for lab seizures in each jurisdiction over the span of years, researchers were able to measure actual results against projected results that follow historical trends.

Results indicated that the total numbers of illegal laboratories seized yearly in Australia by jurisdiction from 1996-1997 to 2005-2006 appeared to stabilize – except in Queensland. The reported number of illegal seizures in Queensland in 2005-2006 was significantly lower than that predicted from historical data. Nationally, however, the number of labs seized was not significantly different from predictions. In other words, the study found a significant decline in the number of illegal methamphetamine labs in Queensland in 2005-2006 compared to that of other Australian jurisdictions that did not use a LEMS. The authors point to this decline as suggestive of the effective use of LEMS in Queensland pharmacies to reduce pseudoephedrine diversion.

While an increased raw number of seizures in a single year would suggest improved enforcement, as it did in Kentucky and Arkansas, the decline seen in Queensland compared to projections based on historical trends and actual results seen in other jurisdictions, on the other hand, points to a reduction in the existence of these illegal labs in the first place.

“For the 12-month period ending June 2006,” the study authors report, “the Australian Crime Commission attributed Project STOP with part of the reduction in illegal laboratories in Queensland and with more than 30 arrests following electronic communications from participating pharmacies.”

While the study authors note that the “reliance on total yearly results of just one indicator, namely a reduction in the number of seized illegal laboratories, is insufficient in drawing firm conclusions,” the trends were indicative enough that in April 2007, 85% of Queensland’s community pharmacies were enrolled in Project STOP. In 2008, the Pharmacy Guild of Australia began implementing the LEMS nationally through pharmacies with the assistance of a government grant.

Thus far, the evidence points to interconnectivity between pseudoephedrine tracking systems as a promising remedy to the societal ill brought on by the illegal production of methamphetamine.
Some States Exempt Medical Gases from Electronic Pedigree, VAWD Requirements

While medical gases, like other prescription medications, are regulated by Food and Drug Administration (FDA), they are exempt in some states from certain rules that apply to distributors and manufacturers of other pharmaceuticals. Specifically, medical gas industry stakeholders argue, and some states agree, that requirements pertaining to electronic pedigree and Verified-Accredited Wholesale Distributors® (VAWD®) accreditation are not appropriate to extend to entities that prepare and distribute compressed gases for medical use.

The case, however, is far from closed. Questions have been raised on both sides of the issue: Should medical gases be considered prescription medications at all? And if so, does it make sense to exempt them from safety regulations that apply to other prescription medications? What’s more, as FDA moves toward establishing federal standards for the nationwide implementation of track-and-trace technology, it will be FDA, and not the states, that will determine whether these requirements will apply to medical gases.

Exemptions for Medical Gases

Though more than half of the states have some form of pedigree laws or rules in place or in the works to protect the pharmaceutical supply chain from counterfeiting and diversion, Florida has led the way among states in this area and exempts medical gases from these requirements. Such requirements, as they apply to the manufacture and distribution of most prescription products, mandate pedigree records for certain prescription drug transactions from manufacturer to distributor to dispensing pharmacy.

California recently enacted a drug-pedigree law that requires serialization, e-pedigree, and track-and-trace systems. After the effective date was twice delayed to provide stakeholders – particularly manufacturers – with sufficient time to prepare, e-pedigree standards established by the California State Board of Pharmacy will require that companies produce an electronic document that tracks the ownership of a drug product as it moves through the supply chain.

The regulations will be implemented on a graduated schedule – manufacturers must have 50% of drugs serialized by 2015 and 100% by the following year. For wholesalers, the deadline is 2016, and pharmacies must become compliant by 2017. The regulations provide for a specific list of drugs that would not require a pedigree – drugs that are labeled for veterinary use only, intravenous solutions, and medical gases.

Likewise, Florida’s pedigree law, enacted in 2006, applies to all prescription drugs except veterinary legend drugs and medical gases.

Other states, including Indiana and North Dakota, which require pharmaceutical wholesale distributors conducting business in those states to be VAWD-accredited, exempt distributors of medical gases from this requirement. Oklahoma is considering implementing pedigree rules for wholesale distributors, excluding distributors of medical gases.
Industry Seeks Universal Exemption

Medical gas industry representatives are actively seeking exemption from e-pedigree requirements across the board due to characteristics they say set these products apart from other pharmaceuticals. “The unique aspects of medical gases are typically not well known at the state regulatory level,” the Gases and Welding Distributors Association (GAWDA) states in its September 2008 GAWDA Edge. While GAWDA does not dispute the value of pedigree documentation for other prescription medications, the group says “it simply adds cost and complexity to the medical gas supply chain without any value added to either the health care facility or the end-user.”

According to a statement prepared by the Compressed Gas Association (CGA), “[m]edical gases are rarely sold in the traditional pharmacy distribution chain. The unique aspects of manufacturing, container weight, reusable containers, special apparatus needed to use the product, and patient training requirements dictate a need for a separate supply chain model.”

After expending concerted effort convincing the states that pedigree rules should not apply to medical gases, industry representatives are preparing to take up the issue with FDA, which is working toward developing federal e-pedigree regulations.

FDA Eyes Federal e-Pedigree Requirement

For years, FDA has recommended that pharmaceutical companies employ radiofrequency identification or other technology to create an e-pedigree that would curtail the drug counterfeiting problem, which historically has affected highly sought-after or expensive prescription medications, not medical devices or gases.

With the passage of the Food and Drug Administration Amendments Act of 2007, which was signed into law on September 27, 2007, FDA is on track to establish technology standards for the pharmaceutical supply chain by 2010. As of yet, FDA has not indicated how or whether e-pedigree rules would apply to medical devices or gases.

The FDA Amendments Act requires the Secretary of the Department of Health and Human Services to develop standards and identify and validate effective technologies for purposes of “securing the drug supply chain against counterfeit, diverted, subpotent, substandard, adulterated, misbranded, or expired drugs.” The law further requires the Secretary to develop a standardized numerical identifier to be applied to a prescription drug at the point of manufacturing and repackaging at the package or pallet level sufficient to facilitate the identification, validation, authentication, tracking, and tracing of the drug no later than 30 months from the enactment of the act.

In the March 20, 2008 Federal Register, FDA published two requests (Docket No. FDA-2008-N-0120 and -0121) for public comment on the standards and technologies for the e-pedigree of prescription drugs. FDA is in the process of analyzing the information provided and is researching several options received and is working toward developing a standardized numerical identifier. According to the act, FDA is to present its recommendations by March 2010.

Meanwhile, the existing patchwork of state regulations prevails. NABP will continue to monitor FDA’s activities as they pertain to medical gases and e-pedigree systems.
NABP, FDA Discuss Collaborative Efforts to Advance Patient Safety Initiatives

NABP met with Food and Drug Administration (FDA) representatives in April 2009 to determine ways in which the two groups can support each other in a number of patient safety initiatives currently under development. Discussions focused on the establishment of pharmacy accreditation standards, the availability of medication guides, and the dissemination of patient safety information regarding tainted dietary supplements and the illicit distribution of prescription medications over the Internet.

Pharmacy Accreditation Standards

As part of its development of the pharmacy accreditation program, NABP will seek comments from FDA in regard to the establishment of best practice standards for patient safety and quality of care. Drawing on the expertise of FDA and other stakeholders to supplement its own proven capabilities in the area of accreditation, NABP is developing the pharmacy accreditation program to assist the boards of pharmacy in their efforts to implement continuous quality improvement programs and patient care standards to guide the practice of pharmacy and to ensure that pharmacies are meeting those standards.

NABP is currently engaged in a pilot study to evaluate the program criteria and to determine how best to implement it. Following the completion of this pilot study, NABP will provide draft program standards to FDA for review and comment. Also after the pilot, NABP will invite FDA and other stakeholders to participate in a meeting to solicit comments from the profession on the development of these standards.

NABP also will explore possible ways to address Risk Evaluation and Mitigation Strategies (REMS) in these program standards or through other avenues. Under the Food and Drug Administration Amendments Act of 2007, FDA has authority to require REMS when deemed necessary to ensure that the benefits of certain drugs outweigh the risks.

In March 2008, FDA published a Federal Register notice to notify holders of certain prescription new drug and biological license applications that they are required under the FDA Amendments Act to establish approved REMS, incorporating elements to assure safe use of these medications.

Medication Guides

In response to reports that pharmacies are having difficulty obtaining the required medication guides for distribution, NABP will survey boards of pharmacy later this year to determine whether this is in fact the case.

In December 1998, FDA issued a final rule that included provisions requiring the distribution of FDA-approved written patient information, ie, medication guides, for certain prescription drug and biological products deemed by FDA to pose a serious and significant public health concern. The rule requires manufacturers that ship these medications to ensure that the medication guides are provided in sufficient numbers to allow distributors, packers, or authorized dispensers to provide them to all patients who receive the medication. Alternatively, manufacturers may provide the means for distributors, packers, or authorized dispensers to produce and provide medication guides to patients. The rule also requires authorized dispensers of these medications to provide them to patients when dispensing the products.

In June 2007, FDA held a public hearing to obtain
feedback on the FDA Medication Guide program to solicit information and views on specific issues associated with the development, distribution, comprehensibility, and accessibility of the guides. FDA posted another notice in the Federal Register in March 2008, again soliciting comments on regulations requiring the distribution of medications guides.

**Dietary Supplements**

NABP will continue to assist FDA in disseminating information about dietary supplements adulterated with prescription drugs. NABP has published an article in its National Pharmacy Compliance News publication, which is available on the NABP Web site and is included in each of the state board of pharmacy newsletters that are distributed to pharmacists in their jurisdictions, in addition to other communication vehicles to spread the word to health care professionals and patients.

In December 2008, FDA issued a nationwide alert to consumers about 28 different products marketed for weight loss that contain undeclared, active pharmaceutical ingredients. In January 2009, FDA expanded its warning to include an additional 41 tainted weight-loss products, some of which are marketed as “dietary supplements,” sold online and in some retail stores. Some of the products claim to be “natural” or to contain only “herbal” ingredients but actually contain potentially harmful ingredients not listed on the product labels or in advertisements.

An FDA analysis found that the undeclared active pharmaceutical ingredients in some of these products include sibutramine (a controlled substance), rimonabant (a drug not approved for marketing in the United States), phenytoin (an anti-seizure medication), phenolphthalein (a solution used in chemical experiments and a suspected cancer-causing agent), and bumetanide (a diuretic). Some of the amounts of active pharmaceutical ingredients far exceeded the FDA-recommended levels.

FDA has inspected a number of companies associated with the sale of these illegal products and is currently seeking product recalls. The list of tainted products is posted on the FDA Web site at [www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2008/ucm116998.htm](http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2008/ucm116998.htm).

**Internet Partnership Agreement**

NABP and FDA will again renew their Internet Partnership Agreement this year. Objectives of the agreement, initiated in 1999, include sharing information and working cooperatively to enforce federal and state laws and regulations relating to illegal domestic prescribing and dispensing of prescription drugs over the Internet.

Both NABP and FDA are concerned about the proliferation of rogue Internet drug outlets selling prescription medications out of compliance with pharmacy laws and practice standards and the threat this trend poses to the public health. Another concerning fact is that many such Web sites facilitate the trafficking of counterfeit medications, further endangering patient health. In response, both NABP and FDA have undertaken initiatives to educate consumers as to the dangers of rogue Internet drug outlets and on the safest ways to purchase medications online, such as patronizing those sites that are accredited through the Verified Internet Pharmacy Practice Sites™ (VIPPS®) program.

Through its Internet Drug Outlet Identification program, NABP continues to review and monitor Internet drug outlets and provide information to empower patients to choose safely when buying medications online. NABP also provides its findings on rogue Internet drug outlets to FDA, as well as to the boards of pharmacy and other stakeholders.

Since NABP and FDA began meeting annually in 1985, these meetings have provided a forum for NABP to represent the state boards of pharmacy and act as a liaison between the boards and FDA to further the common goal of protecting the public health.
Professional Affairs Update

Around the Association

Executive Director Changes

K. Philipp Wickizer, JD, has been appointed the board director of the Indiana Board of Pharmacy, effective May 18, 2009. He replaces Marty Allain. Prior to his position with the Board, Wickizer served as special counsel for the Office of Corporation Counsel, City of Indianapolis. He has in-depth experience in Indiana state and local government regulations, operations, and the financial services industry. He is also well versed in administrative compliance, and ethics laws. Wickizer earned a bachelor of arts degree in history and in government and foreign affairs from the University of Virginia and received his juris doctor degree from the Indiana University School of Law.

Board Member Appointments

- James M. Koppen, RPh, has been appointed a member of the Minnesota Board of Pharmacy. Koppen’s appointment will expire on January 7, 2013.
- Mark M. Anliker, RPh, has been appointed a member of the Iowa Board of Pharmacy. Anliker’s

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SAMHSA, FDA Join Forces to Educate Public on Safe Use of Methadone

Substance Abuse and Mental Health Services Administration (SAMHSA) and Food and Drug Administration (FDA) recently launched an initiative to help ensure the safe use of methadone. A prescription drug best known as a treatment for addiction and dependence on heroin and other narcotic pain medicines, methadone is also prescribed to treat moderate to severe chronic-pain patients. The campaign responds to concerns about an escalating number of poisoning deaths linked to the improper use of this medication. Read more on the SAMHSA Web site at www.dpt.samhsa.gov/methodonesafety.

Webinar Addresses Risk Evaluation and Mitigation Strategies, Opioid Analgesics

The FDA Center for Drug Evaluation and Research (CDER) and Office of Special Health Issues have developed a Webinar to better inform stakeholders about general issues related to Risk Evaluation and Mitigation Strategy (REMS) and specific issues related to REMS for certain opioid analgesics. Read more on the CDER Web site at www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm163655.htm.

Amplified Warnings Required for Testosterone Gel, Botulinum Toxins, OTC Pain Relievers

FDA is requiring the manufacturers of several prescription and over-the-counter (OTC) drug products to turn up the volume on their warning labels.

- **Testosterone Gel:** FDA is requiring manufacturers of two prescription topical testosterone gel products, AndroGel® 1% and Testim® 1%, to include a boxed warning on the products’ labels. FDA has received reports of adverse effects in children who were inadvertently exposed to testosterone through secondary exposure to these products. Read more in the May 7, 2009 FDA news release at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm149580.htm.

- **Botulinum Toxins:** Prompted by reports of serious adverse events, FDA is requiring safety label changes, including a boxed warning and REMS for all botulinum toxin products. Read more in the April 30, 2009 FDA news release at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm149574.htm.

- **Pain Relievers:** FDA has issued a final rule requiring manufacturers of OTC pain relievers and fever reducers to revise their labeling to include warnings about potential safety risks, such as internal bleeding and liver damage. Products of concern include acetaminophen and nonsteroidal anti-inflammatory drugs (eg, aspirin, ibuprofen, naproxen, and ketoprofen), as well as products containing these ingredients. Read more in the April 28, 2009 FDA news release at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm149573.htm and in the April 29 Federal Register at http://edocket.access.gpo.gov/2009/pdf/E9-9684.pdf.

ISMP: Do Not Store Insulin Vials in Open Cartons Due to Risk of Mix-up

The Institute for Safe Medication Practices (ISMP) warns that storing insulin vials inside their cardboard cartons after the packages have been opened can lead to mix-ups, and potential medical emergencies, if vials are accidentally returned to the wrong carton after being used. The next patient care worker looking for a particular insulin product could read the label on the carton, assume that it accurately reflects what is inside, and end up administering the wrong product. To avoid such a mishap, ISMP recommends that the cartons be discarded, either in the pharmacy before the insulin is dispensed, or when it is received at the nursing station.
OH Board E-Mail Blast Brings Positive Response to Ending Latest Drug Scams

In March 2009, the Ohio State Board of Pharmacy issued a request for information and a warning about a drug scam involving prescriptions issued by Florida doctors for Ohio patients. The Board sent an e-mail to every pharmacist subscribed to Ohio Automated Rx Reporting System (OARRS), as well as to almost 14,000 Ohio pharmacists whose e-mail addresses the Board had in its licensing system.

The Board received an extraordinary response of over 300 telephone calls and faxes over the first three-day period from pharmacists who had seen these prescriptions; several of whom had the person standing at the pharmacy counter at the time. On further checking, many of those individuals had criminal records for drug-related activities, making it clear that the majority of these prescriptions were not issued for a legitimate medical purpose. In addition, the Board heard from pharmacists in the surrounding states as well as in states between Ohio and Florida.

Many pharmacists thanked the Ohio Board for notifying them of this new scheme and were more than willing to assist the Board in bringing it to a halt. At the time of the writing of the Ohio State Board of Pharmacy May 2009 Newsletter, both the number of individuals visiting Ohio pharmacies with these questionable prescriptions and the number of telephone calls to the Board have decreased.

Once again, however, this issue points out the need for pharmacists to exercise diligence as they fill prescriptions, notes the Board. Pharmacists are required to use judgment every time a prescription is presented for filling. The pharmacist must determine, to the best of his or her knowledge and experience, whether or not the prescription was issued for a legitimate medical purpose. When the patient-prescriber-pharmacy relationships are separated by multiple states, the Board recommends that pharmacist should question the validity and do more than just call the physician to verify the prescription. According to the Ohio Board, while not mandated, one of the best ways to assist in making the determination of “legitimate medical use” is by accessing the OARRS database. Pharmacists who use the OARRS system have told the Board how useful it is in their practice. The Board encourages Ohio pharmacists who are not signed up for OARRS to do so, or if their employer does not allow access to OARRS, to continue asking for it. The Board will continue to encourage them about it as well.

MO Board Releases Compounded Drug Testing Report for Fiscal Year 2008

As part of a program initiated in 2003, the Missouri Board of Pharmacy continues to test drug preparations compounded by pharmacies. Preparations are collected by inspectors and sent to certified laboratories for potency testing, and if applicable, sterility/endotoxin testing. The following tables summarize the dosage forms, number of tests performed on the various compounds, and failure rates. Complete fiscal year 2008 results can be found on the Board’s Web site at http://pr.mo.gov/pharmacists-compounding.asp.

Potency of compounds that failed testing ranged from 21.3% to 373.7%. An acceptable potency range is considered +/- 10% of the expected potency, unless a United States Pharmacopeia monograph states a different range for a specific preparation. Pharmacies with unsatisfactory results are asked to complete a quality assurance review detailing their compounding practices and to provide a corrective action plan.

### MO Board Testing Report

<table>
<thead>
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<th>Dosage Form</th>
<th>Tests Performed</th>
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<tbody>
<tr>
<td>Capsule</td>
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<tr>
<td>Injection</td>
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<tr>
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<table>
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<td>75.3</td>
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<tr>
<td>Unsatisfactory</td>
<td>46</td>
<td>24.7</td>
</tr>
</tbody>
</table>

(continued on page 154)
In its continuing efforts to hold down costs, a significant portion of which are associated with enforcement of laws and regulations, the Virginia Board of Pharmacy is testing new processes to streamline the handling of certain noncompliance issues. In regard to compliance with continuing education (CE) requirements, the Board approved Guidance Document 110-42, creating a new process for enforcing CE requirements. With CE, there is little room for interpretation as to whether the licensee complied. Additionally, there are very few circumstances that should impact a decision to hold a hearing if the licensee fails to comply. In past Virginia Board policy, the new CE requirements, the Board states that the licensee must submit certificates for five hours of CE gained in each calendar year, totaling 10 hours for the previous two-year audit period, and pharmacy technicians must submit certificates for five hours of CE gained in each calendar year, totaling 10 hours for the previous two-year audit period.

If a licensee's response to the audit does not show compliance with CE requirements, Board staff will send a letter to the licensee offering resolution of the matter by consent, payment of an established monetary penalty, and proof of late compliance with CE requirements, along with an additional opportunity for the licensee to furnish proof that CE requirements were actually met during the specified time period. If the letter is signed and returned to the Board by the licensee, the letter will constitute an order that the Board and the licensee's consent to the imposition of a monetary penalty and an agreement to the submission of documentation of late CE compliance.

The monetary penalty is $250 for each year a pharmacist does not meet CE requirements. Because the maximum audit period is two years, the maximum penalty would be $500. The monetary penalty offered for each year that a pharmacy technician does not meet CE requirements will be $50, for a maximum penalty of $100.

Pharmacists or pharmacy technicians who do not want to use this new consent process may request an informal conference before a committee of the Board. Persons who fail to respond to the consent letter will automatically be scheduled for an informal conference. Guidance Document 110-42 is available in its entirety, on the Board’s Web site at www.dhp.virginia.gov/pharmacy/pharmacy_guidelines.htm.

South Carolina Board Approves Guidelines Regarding 30-Minute Meal Breaks

At its March 2009 meeting, the South Carolina Department of Labor, Licensing, and Regulation – Board of Pharmacy approved the following guidelines for 30-minute meal breaks.

If a permitted facility allows its pharmacist to participate in a 30-minute meal break, the Board states that the following guidelines must be in place:

1. Policies and procedures must be present which define the approval and eligibility, and procedures on how to handle before, during, and after the 30-minute meal break.
2. Pharmacist must be in the permitted facility and have a sign posted that the pharmacist is on break.
3. The permitted facility should attempt to have the break occur at a consistent time each day and give proper notice to the public.
4. In permitted facilities with overlapping pharmacists, breaks should be taken while other pharmacist coverage is available.
5. Pharmacist must be available to handle any emergency situations that may arise.

6. Pursuant to the Board of Pharmacy, technicians may perform the following duties while a pharmacist is on break:
   - Assemble prescriptions to be checked by the pharmacist when the break is over.
   - Provide prescriptions to the patients for pick up that have been previously prepared and checked by a pharmacist. A log must be completed for all transactions, including new prescriptions and refills, that occur while the pharmacist is on break.
   - Receive and assemble prescriptions. The pharmacist must check all prescriptions before they are dispensed to the patient pursuant to the Board’s practice act.

The Board also states that any drug utilization review messages must be reviewed and resolved by the pharmacist.

7. When requested by the patient, the pharmacist must call the patient within a reasonable timeframe after the prescription is picked up to review any counseling issues that may be appropriate for any prescriptions sold in the absence of a pharmacist.

Adequate training on how to handle 30-minute meal break coverage should be provided to all pharmacy personnel.
NABP Executive Committee Seeking ACPE Representatives, Application Deadline Approaching Fast

The deadline for individuals interested in serving a six-year term as one of the Association’s three representatives to the Board of Directors of the Accreditation Council for Pharmacy Education (ACPE) is Tuesday, September 1, 2009.

Interested active board of pharmacy members, administrative officers, or individuals who have served within the last five years as members or administrative officers of an active board of pharmacy are encouraged to submit a current curriculum vitae and a letter of interest to NABP Executive Director/Secretary Carmen A. Catizone at NABP Headquarters, 1600 Feehanville Dr, Mount Prospect, IL 60056, by the September 1 deadline. Appointees must be available to attend two to three board meetings per year, three to four college or school of pharmacy on-site visits, an ACPE annual meeting, and an orientation program to be held in January 2010. The term will officially begin on July 1, 2010.

Letters of interest should be a short narrative, no longer than one page, highlighting the following:
- relevant experiences and talents that qualify the candidate for service;
- candidate’s views on educational and accreditation issues facing the ACPE Board of Directors;
- why the candidate wishes to serve; and
- what the candidate would contribute as an appointee of NABP.

On June 30 of every even-numbered year, the six-year term of one NABP representative expires. A subcommittee of the Executive Committee will present a recommendation for the appointee to the full Executive Committee at its November 2009 meeting for final approval.

For more information, please contact the Executive Office at exec-office@nabp.net.

Members Write, Discuss New MPJE Items During Workshop

Multistate Pharmacy Jurisprudence Examination® (MPJE®) Review Committee Member John D. Taylor, RPh, (center), lends support as Florida Board of Pharmacy Members Carl Hayes, BPharm, (left) and Stephen Melvin, PharmD, (right) discuss and write new test items for the MPJE during a recent item-writing workshop held at NABP Headquarters.
Save the Date!

NABP invites board of pharmacy executive officers, members, and compliance officers, as well as state and federal regulators and other stakeholders to unite December 3-4, 2009, for the NABP 2009 Symposium. The fast-paced, one-and-a-half-day workshop will offer attendees the opportunity to discuss current issues in pharmacy as well as earn continuing pharmacy education credit. More information will follow in future issues of the NABP Newsletter and on the NABP Web site at www.nabp.net. See page 145 for details.