Task Force to Review Laws, Regulations for Safe Use of Pharmacy Technology Systems

Automated dispensing systems and other pharmacy technology systems can be used to perform record keeping, enhance security, and improve efficiency in dispensing. Such benefits can provide pharmacists with additional time and use of resources for the delivery of direct patient care. In addition to hospital pharmacies and long-term care facilities, community pharmacies and pharmacies operating remote facilities are increasingly employing automated pharmacy technologies, such as remote dispensing systems. With new technology constantly emerging, robotic dispensing, automatic dispensing machines, and other dispensing technologies may become even more common as tools in the packaging, storage, delivery, distribution, and dispensing process.

To protect patient health and safety, state laws and rules have been implemented to regulate the use of such technologies and generally include requirements related to pharmacy staff requirements and responsibilities, operation of the technology, security, and record keeping. NABP member boards of pharmacy have adopted a resolution that recognizes the significant advances in pharmacy technologies and also stresses that “the national use of such systems requires greater uniformity to define terms found in the laws and regulations of individual states and avoid disparity and confusion when assessing, authorizing, and applying the use of such systems.” This resolution, approved at the 107th Annual Meeting in May 2011, calls for the establishment of a task force to review existing current state laws and regulations addressing the use of technology systems. The Task Force on Pharmacy Practice Technology Systems, which will meet November 1-2, 2011, is also charged with reviewing relevant language in the Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act), and recommending any needed revisions addressing this issue.

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Pharmacy Technology
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Defining the Terms in Pharmacy Technology Regulations

The Model Act currently defines “automated pharmacy systems” (APS) as including, but not limited to, “mechanical systems that perform operations or activities, other than Compounding or Administration, relative to the storage, packaging, Dispensing, or Distribution of medications, and which collect, control, and maintain all transaction information.”

In some states with laws allowing APS, boards have adopted similar definitions. For example, the Oregon State Board of Pharmacy implemented a rule that adopts the same definition for APS. Oregon rules also distinguish a definition for “Remote Dispensing Machine” (RDM), which in the Oregon code is defined as a “component of an Automated Pharmacy System that contains prepackaged drugs for dispensing,” and definitions for “Remote Dispensing Facility” and “Responsible Pharmacy.” The Florida Board of Pharmacy also uses the Model Act definition of APS, adding that the system is “located within or adjacent to the prescription department.”

Louisiana utilizes the Model Act definition under the term “automated medication system,” and its code makes a further distinction among profile-driven, non-profile driven, and combination systems in setting out its rules regarding pharmacist oversight responsibility and other requirements.

The American Society of Health-System Pharmacists, in a guidance document that reflects the NABP Model Act and expands on certain requirements to provide guidance on safe use of technology, defines “automated pharmacy systems” as an umbrella term and uses “automated dispensing device” as a more specific term meaning a device “located in hospital patient care units, surgical suites, emergency rooms, long term care facilities, physicians’ offices, and other settings.”

In addition, a search of related state laws reveals that the following terms are used synonymously for automated pharmacy systems:

- Automated/robotic pharmacy systems
- Automated drug delivery systems
- Automated drug dispensing systems
- Automated medication dispensing systems
- Automated dispensing and storage systems
- Automated medication management systems

Finally, Drug Enforcement Administration uses “automated dispensing systems” in regulations related to using such technologies for controlled substance dispensing. Other variants of these names, as well as their acronyms, are used in state legal and regulatory language, and the multitude of names, as noted in the NABP resolution, may lead to confusion.

Sorting out, categorizing, and clarifying the various terms and definitions associated with pharmacy technologies may assist in the task of creating uniformity in the state laws and related federal law.

Compliance Issues

In 2009, the South Carolina Board of Pharmacy found during inspections, that technicians were refilling dispensing machines without pharmacist supervision or appropriate documentation, while both are required by the Board’s rules, which also include minimum requirements for maintaining such equipment. Rules in Texas and South Dakota are more strict, requiring that only a pharmacist stock automatic dispensing devices. South Dakota also specifies that a pharmacist must document the information and maintain the stocking records for two years. Yet, like South Carolina, the South Dakota State Board of Pharmacy found that some pharmacies using automated mechanical dispensing devices were not complying with the stocking provisions or maintaining required documentation.

(continued on page 198)
Three PMPs Now Using NABP InterConnect to Treat Patients and Track Drug Use

With the NABP PMP InterConnect™ fully operational as of August 5, 2011, participation continues to grow and progress rapidly with three state PMPs now using the system to track drug abuse and diversion, and 10 states having signed participation agreements.

In early August, Ohio and Indiana began deploying NABP InterConnect to select groups of users, allowing them to securely exchange prescription data between the two participating states. Just a few weeks later, Ohio was able to rollout access statewide. Now, all Ohio authorized prescriber and pharmacist PMP users can access data from the Indiana PMP users. Indiana also expects to conclude its pilot of the system and begin exchanging data on a statewide basis soon, allowing all of its prescriber and pharmacist users to access Ohio PMP data.

In late August, after working with its internal information systems to maximize effectiveness of its communications structure, Virginia also went live with the NABP InterConnect.

The NABP InterConnect is the first and only successful system that facilitates the sharing of data between state PMPs, a key element for early detection, intervention, and prevention of substance abuse and diversion of controlled substances. The NABP InterConnect enables authorized users to request data from other states as easily as if they are requesting it from their own state’s program. This interoperability addresses what was identified as one of the major impediments to the effectiveness of these programs: the inability to connect and share information between PMPs.

“The problem of prescription drug abuse and diversion has become very serious in the last few years and is an acute threat to the health and safety of the American public,” says Malcolm J. Broussard, RPh, NABP president. “While many states have adopted and operated PMPs in an attempt to counter this problem, the inability to share information about patients and prescribers between programs represented a serious obstacle to their effectiveness. NABP, in its role of assisting states in protecting the public health, has invested considerable time and resources to develop and deploy NABP InterConnect, a working solution that addresses this serious public health issue.”

At the request of its member boards of pharmacy as well as state PMP administrators, in just seven months NABP and its technology provider, Appriss Inc, developed and deployed the necessary technology and security infrastructure for a system that connects state PMPs. Additional benefits the NABP InterConnect provides to participating PMPs are simplicity in participation, autonomy, and enforcement of state’s access rules to the data, and required information security. A steering committee made up of representatives from participating programs will meet regularly to make policy and operating decisions, ensuring that the system meets the needs of the state PMPs and protects public health.

NABP believes that access to program information across state lines will significantly enhance the effectiveness of these programs and, therefore, has funded the development of the system and is making it available at no cost to any PMP program that wishes to participate. Additionally, NABP will cover all NABP InterConnect operation costs and state program participation costs for a minimum of five years to encourage rapid adoption across the United States.

NABP continues to work with other state PMPs to facilitate their participation in the NABP InterConnect. Based on current implementation time frames, authorized users of PMPs in Arizona, Connecticut, Kansas, North Dakota, South Carolina, and West Virginia will be able to access data across state lines this fall. Since March, 17 states have agreed to participate in the program, and discussions are ongoing with a number of other states. NABP anticipates that approximately 30 states will be participating in NABP InterConnect in 2012.

More information is available in the Government Affairs section of the NABP Web site at www.nabp.net/government-affairs. Questions may be sent by e-mail to governmentaffairs@nabp.net.
Boards of pharmacy rely upon NABP for expertise and uniformity in the development, implementation, administration, and maintenance of programs designed to assist such member boards in regulating the practice of pharmacy in the interest of public protection. Security in high stakes licensure examinations is paramount and NABP goes to great lengths to protect the integrity of all of its exam programs. Numerous NABP-like associations and federations are currently addressing or have been recently affected by examination breaches causing an unprecedented dedication of resources to uncover the breaches, repair the damage, and pursue legal recourse against the infringing parties to ultimately protect the integrity of the examination and licensure process. In addition, certification programs, referring to voluntary, private sector bestowed recognition of specialty knowledge, are not immune from examination breaches and the significant consequences imposed upon the owner of the program(s).

Regardless of the type of assessment mechanism, examination owners will vigorously protect their respective programs and may, in addition to legal action, undertake a public relations approach to supplement already encompassing contracts with examinees in an effort to publicize the importance of exam security and deter the sharing of protected information. Such media campaign is not without its own risks. Consider the following.

In order to lawfully practice medicine, physicians must be licensed by each respective state where such practice occurs. Licensure by the state is mandatory and a prerequisite to practice. Licensees may also seek voluntary “board certification” in one of many specialties. The American Board of Internal Medicine (ABIM or plaintiff) is a private sector, not-for-profit organization that offers subspecialty certification programs, each of which involves the successful completion of an examination as one criterion for recognition. One of its certification examinations is in gastroenterology.

A candidate for certification in the subspecialty of gastroenterology had taken the specialty exam on five previous occasions. On each such test, this candidate, both before and at the conclusion of each exam administration, agreed to abide by ABIM’s policies and procedures and its Pledge of Honesty, promising not to disclose, copy, or reproduce any portion of the materials contained in the examination. Nevertheless, it is alleged that after the fifth attempt at the exam (taken in November 2008), the candidate sent 77 exam items that were substantially similar to live items used on that exam to a review course attended by the candidate prior to multiple administrations of the gastroenterology test. Also, it is alleged that the candidate purchased infringing exam questions from this review course prior to the November 2008 administration. These alleged infringing activities led ABIM to pursue litigation in Federal District Court in the
Eastern District of Pennsylvania against the candidate. In its complaint, ABIM alleged that the candidate unlawfully obtained, copied, and disseminated copyrighted and/or trade secret protected exam questions and sought to obtain injunctive and monetary relief. In separate actions, ABIM also pursued litigation against at least four other alleged infringers, as well as against the review course attended by all such defendants.

In the current case, the candidate filed an answer denying the allegations to the complaint. She also asserted 11 counterclaims against the ABIM. Some of these counterclaims alleged violations of her due process rights, tortious interference with actual and prospective business relationships, commercial disparagement, defamation, false light, unfair competition, and civil conspiracy. ABIM filed motions to dismiss the referenced counterclaims, which were the subject of the recent judicial opinion. Thus, ABIM, as a plaintiff in the original suit, is considered a counter defendant and must defend itself from the counter allegations.

After identifying the standards addressed by a court relative to the motions, the court turned its attention to the counterclaims pursued by the candidate and sought to be dismissed by ABIM.

First, the candidate alleged that her ABIM board certification in gastroenterology created a valuable property right in such recognition and that the suspension of her certificate by ABIM occurred without prior notice and without an opportunity to be heard. The court surmised such counterclaim to be based upon the Fourteenth Amendment of the United States Constitution and that the candidate argued a deprivation of a property right without due process of law.

Noting that the application of due process under the Fourteenth Amendment applies to “state action” or “a person for whom the state is responsible,” the court addressed whether ABIM fits either category. As ABIM is not a state entity, the court reviewed under what circumstances an entity may “fairly be said to be a state actor,” including a public function test, a close nexus test, or a symbiotic relationship test. Unable to find facts alleged in the counterclaim that provide the necessary connection between ABIM and a state entity, including the volunteer nature of board certification, the court held that ABIM is not subject to the due process requirements of the Fourteenth Amendment and dismissed that counterclaim.

Regarding the counterclaim alleging tortious interference with business relationships, the court reviewed the elements of such an allegation which include:

1. the existence of a contract or prospective contract between the counterclaimant and a third party;
2. purposeful action on the part of the counterdefendant intending to harm the existing relationship;
3. the absence of a privilege or justification on the part of the counterdefendant; and
4. actual legal damage caused as a result.

Based upon the fact that the candidate alleged that she has suffered significant loss of income and that hospital privileges require such board certification for admitting and treatment purposes, and that plausible allegation of malicious and wanton activities of ABIM personnel exists, the court denied ABIM’s motion to dismiss this counterclaim.

The candidate also alleged via a counterclaim commercial disparagement which “compensate[s] a vendor for pecuniary loss suffered because statements attacking the quality of its goods have reduced their marketability.” Distinguishing between commercial disparagement and defamation, the court found that the candidate’s allegations, which for motions to dismiss purposes are accepted as true, are sufficiently plausible to withstand the motion. Factually, it is alleged that ABIM accused the candidate of “cheating” on (continued on page 190)
Legal Briefs
(continued from page 189)

her certification exam, notified the Wall Street Journal resulting in the publication of an article, disseminated the Wall Street Journal article to “many, if not all residency programs in the U.S.” suspended her ABIM certification without notice or a right to respond to the allegations, and placed such suspension on its Web site. Based upon these allegations, the court denied the ABIM motion to dismiss this counterclaim.

Addressing the counterclaim for defamation, the court noted the necessary elements which include:
1. defamatory character of the communication;
2. publication by the counter-defendant (ABIM);
3. application of publication to the counter-plaintiff (candidate);
4. understanding by the recipient of the defamatory meaning;
5. understanding by the recipient of the application to the counter-plaintiff (candidate);
6. special harm to the counter-plaintiff (candidate); and
7. abuse of a conditionally privileged publication occasion.

In upholding the counterclaim and denying the ABIM motion to dismiss, the court noted the serious nature of accusing anyone of cheating on an exam. It also held such accusations would “unquestionably harm the reputation of and lower the accused individual in the eyes of his community and would likely deter third persons from associating or dealing with him or her.” The candidate also alleged in her counterclaims a cause of action under false light, which is a tort involving “publicity that unreasonably places the other in a false light before the public.” Elements to establish a false light cause of action include that the false light would be highly offensive to a reasonable person and the publisher had knowledge of or acted recklessly as to the falsity of the published matter. Again, relying on the plausibility of the allegations of the counterclaim and allowed it to proceed.

Next, the court addressed the counterclaim allegations of the candidate related to unfair competition. The candidate alleged that the actions of ABIM in accusing candidates of cheating, suspending their certification, and publishing these activities were intentional and intended to procure an unfair advantage for ABIM and those certificate holders that were not suspended. Based upon the complex elements necessary to substantiate a claim for unfair competition along with the fact that the candidate must allege she is in competition with ABIM in the supply of similar goods and services, the court granted the ABIM motion to dismiss this particular counterclaim.

Finally, the court addressed the counterclaim of the existence of a civil conspiracy whereby ABIM is alleged to have conspired with others to undertake an unlawful act (or carry out a lawful act by unlawful means) causing damage to the candidate. ABIM’s motion to dismiss stated that it cannot conspire with its own employees, thus necessitating dismissal of the claim. The court, recognizing the inability of corporate employees conspiring with one another, agreed to the dismissal, but provided the candidate with an opportunity to amend her counterclaim at her election.

Overall, several counterclaims averred by the candidate were allowed to proceed. Unless settled, there will be a trial on the merits where factual and legal conclusions will be resolved. This case presents an excellent example of how publicizing allegations of wrongdoing can lead to counterclaims and potential damages against the party initiating litigation.

Muller, Internal Medicine v Von 2011 WL 857337
American Board of
(US District Ct PA 2011)

Newly Accredited VAWD Facilities

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

Bandana Trading, Inc dba CT International
San Luis Obispo, CA

Bell Medical Services, Inc Marlboro, NJ

Cardinal Health 200, LLC dba Cardinal Health
Birmingham, AL

Celgene Corporation
Allentown, PA

H.D. Smith Wholesale Drug Company
Kearny, NJ

Kinray, Inc dba Subsidiary of Cardinal Health
Whitestone, NY

Priority Pharmaceuticals, Inc
San Diego, CA

Slate Pharmaceuticals, Inc
Durham, NC

A full listing of more than 470 accredited VAWD facilities is available on the NABP Web site at www.nabp.net.
Idaho Grants Pharmacists Limited Prescriptive Authority, Amends Definition of ‘Drug Outlet’ to Expand Regulatory Authority

In keeping with nationwide efforts to further integrate pharmacists into the provision of primary care, the Idaho legislature recently approved a number of pharmacy-related statute changes that took effect in July of this year. Two of these changes take a unique spin on otherwise common practices: Idaho pharmacists are now empowered with limited prescriptive authority to provide patients with immunizations and fluoride supplements and the Idaho State Board of Pharmacy has been given the ability to register a number of new drug outlets, including cognitive-care-only pharmacies and dispensing practitioner offices.

Limited Prescriptive Authority

The Idaho statute change granting limited prescriptive authority allows licensed pharmacists to “prescribe agents for active immunization when prescribed for susceptible persons . . . 12 . . . years of age or older for the protection from communicable diseases” and also to “prescribe dietary fluoride supplements when prescribed according to the American Dental Association’s recommendations for persons whose drinking water is proven to have a fluoride content below the United States Department of Health and Human Services’ recommended concentration.”

Almost every state allows pharmacists to administer immunizations, although specifics vary widely. In some states, like Indiana and New York, pharmacists may administer only limited immunizations (including influenza), while in other states, like Connecticut and Washington, pharmacists may administer immunizations pursuant to a collaborative practice agreement with a physician. In Idaho, however, pharmacists may now administer all immunizations provided they follow rules codified by the Board of Pharmacy, including completing initial and ongoing educational courses and following record-keeping and reporting requirements. Further, pharmacists may now prescribe immunizations on a limited basis. And while the immunization administration rules are similar to those found in many other states (Wyoming, for example, has similar educational requirements), “We couldn’t find any other state where pharmacists had prescriptive authority for immunizations specifically,” says Mark Johnston, the Idaho Board’s executive director.

The Idaho Board began laying the groundwork toward achieving limited prescriptive authority for immunizations several years prior to the recent passing of the legislation. In 1999, the Board began formally regulating collaborative practice agreements. Subsequently, the Board implemented an educational campaign to help pharmacists comply with the collaborative practice rules and determined that prescriptive authority would be better. Additionally, the Board promulgated rule changes (subsequently approved by the legislature) for administering immunizations. “In essence,” says Johnston, the Board “imposed on the profession the rule pertaining to administration of immunizations to prove it was regulated, so we could ask for prescriptive authority.”

As it continued on its road toward limited prescriptive authority, the Board sought – and received – the support of Idaho Health District 4 and consulted other interested parties, such as the Idaho Medical Association. “We were proactive,” Johnston notes. The Board was able to retain support by ensuring that concerns were addressed in the statute’s provisions; for example, it was hypothesized that many pediatric patients might not be brought in for regular check-ups if immuizations were separated from the doctor visit, so the minimum age requirement was added to the statute. The Board’s efforts paid off: the state legislature, which includes physicians among its members, unanimously granted the limited prescriptive authority.

The prescriptive authority for fluoride supplements has likewise had a smooth road thus far. “There’s been nothing but support,” says Johnston. That initiative was, in fact, pushed by a dentist who had established a “School Smiles” program in rural school systems that provided fluoride supplements and promoted frequent tooth-brushing. Subsequent studies proved the program’s efficacy in rural, low-income areas, but when volunteer efforts were insufficient to expand the program, the dentist suggested allowing pharmacists to step in with prescriptive authority.

Drug Outlets

Idaho is also forging its own path when it comes to the state’s newly expanded list of drug outlets. What began as “housekeeping” – updating rules to reconcile inconsistencies resulting from past legislative changes – turned into statutes that amended the definition of “drug outlets,” thereby expanding the type and number of entities subject to Board of Pharmacy regulation. The statute now defines “drug outlets” as “all pharmacies, and other facilities with employees or personnel (continued on page 192)
Idaho Statutes
(continued from page 191)

engaged in the practice of pharmacy, in the provision of pharmaceutical care, or in the dispensing, delivering, or distributing, or manufacturing of drugs or devices.” Further, the Board has made the term more specific in developing rules to implement the statutory changes. In drafted rules that are currently in the approval process, the term “prescriber drug outlet” is defined as follows: “A drug outlet in which prescription drugs or devices are delivered directly to patients under the supervision of a prescriber, except where delivery is accomplished only through on-site administration or the provision of drug samples.”

In addition, once the Board drafts the relevant rules and the legislature approves them, the Board may have as many as 100 new drug outlets in the form of prescriber-dispensing sites to inspect and register. Each registered prescriber-dispensing site may have more than one prescriber. While most states allow some form of practitioner dispensing, particularly for medical doctors, regulation is generally for individual practitioners (as in, say, North Carolina or Virginia), not the offices in which they work. This makes Idaho’s statute “kind of unique,” says Johnston. Johnston notes that the most crucial inspection is the one that takes place before a drug outlet approval; due to an increased workload for inspectors, ongoing inspections would likely take place on an every-other-year basis.

Johnston is optimistic that the new definition of “drug outlets” will be implemented after the proposed final rules that establish additional criteria, including registration fees, are approved. While proactive work helped move the limited prescriptive authority law forward, ensuring success with the final approval of rules benefitted from further collaboration. Johnston met with the Idaho Medical Association and other interested groups for support before the Board proposed the relevant rules. The state legislature will have to approve the rules before they take effect; the vote should be held next spring.

One category of drug outlets specified in the new law reflects that Idaho is also looking to the future of pharmacy practice as laws and rules are developed. Specifically, the drug outlet law recognizes pharmacies that offer cognitive services but not medications. These pharmacies’ registration numbers often assist pharmacists in being reimbursed for pharmaceutical care that does not include dispensing. This category was added at the request of pharmacists who offer such care, says Johnston, but who have difficulty obtaining reimbursement if they are not registered as a pharmacy. This category, too, will be formalized after the legislature approves changes to the Idaho Code so that the new definition of “drug outlets” will be implemented.

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Future of Pharmacy

Both the Idaho law supporting pharmacies delivering cognitive services, and the Idaho limited prescribing authority law, are prime examples of pharmacists obtaining the opportunity to further engage in primary health care activities, the subject of an NABP resolution. NABP members recognize that pharmacists may help fill the current and projected primary-care gap that prevents many patients from obtaining optimal health care. At the Association’s 107th Annual Meeting in May 2011, members, noting that “[P]opulation demographics are leading the United States health care delivery system toward an inadequate supply of physicians and other practitioners that provide primary health care to the burgeoning population of aging and underserved Americans,” passed a resolution directing NABP to “encourage and support efforts by the profession to study the primary health care activities in which pharmacists can be engaged.” Further, the resolution states that NABP will work with relevant stakeholders “to facilitate a broader understanding of the potential for pharmacists, as providers, to engage in primary health care activities and ensure appropriate availability of primary health care services for all citizens.”

Newly Accredited DMEPOS Facilities

The following facilities were accredited through the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) program:

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>State</th>
<th>City</th>
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<tbody>
<tr>
<td>Shree Pharmacy Inc</td>
<td>IL</td>
<td>Chicago</td>
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<tr>
<td>The Medicine Shoppe Pharmacy</td>
<td>IA</td>
<td>Newton</td>
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A full listing of the nearly 1,000 accredited DMEPOS companies representing close to 30,000 facilities is available on the NABP Web site at www.nabp.net.
NABP President Appoints Members to Serve on 2011-2012 Committees and Four Single-Issue Task Forces

NABP provides guidance on current topics of interest to the state boards of pharmacy through the commissioning of single-issue task forces. When an issue arises that requires special expertise or a commitment of time and funds, a task force is appointed to address an explicit charge and to report its findings to the Executive Committee. The task force reports are posted on the NABP Web site. This year, NABP has commissioned four single-issue task forces pertaining to the following topics:

1. The control and accountability of prescription drugs
2. The use of pharmacy practice technology systems
3. Recommended revisions to the Controlled Substances Act (CSA)
4. The standards for Internet pharmacy practice

NABP President Malcolm J. Broussard, RPh, has finalized his appointments for the following task forces and standing committees for the 2011-2012 year.

2011-2012 Task Forces

The Task Force on the Control and Accountability of Prescription Medications is scheduled to meet October 26-27, 2011, at NABP Headquarters. The task force came about in response to Resolution No. 107-3-11, passed at the NABP 107th Annual Meeting, calling for its development. The resolution acknowledges that “prescription medications, including controlled substances, that are diverted from licensed pharmacies contribute to drug abuse, including abuse by children, adolescents, and teens.”

Further, the resolution notes that “preventing and detecting diversion is an important responsibility of state boards.” The task force is charged with the following objectives:

1. Review existing state laws and regulations addressing the control and accountability of prescription drugs, the Report of the Task Force to Review and Recommend Revisions to the CSA, as well as relevant sections of the Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act).

2. Recommend revisions, if necessary, to the NABP Model Act addressing this issue.

Chairperson of this task force is John Kirtley, PharmD, executive director, Arkansas State Board of Pharmacy. Individuals appointed to serve as members include:
- Buford Abeldt, RPh, Texas
- Herbert Bobo, RPh, Alabama
- Danna Droz, RPh, JD, Ohio
- William Fitzpatrick, RPh, Missouri
- Virginia Herold, MS, California
- Douglas Lang, RPh, Missouri
- Earl McKinstry, RPh, MS, South Dakota
- Alice Mendoza, RPh, Texas
- Leo Richardson, PhD, South Carolina
- Joanne Trifone, RPh, Massachusetts

The Executive Committee liaison is Edward G. McGinley, RPh, MBA, member, New Jersey State Board of Pharmacy.

The Task Force on Pharmacy Practice Technology Systems is scheduled to meet November 1-2, 2011, at NABP Headquarters. The task force was established in response to Resolution No. 107-1-11, passed at the NABP 107th Annual Meeting. The resolution acknowledges that “significant advances in technologies, including the use of automated pharmacy systems, remote dispensing systems, electronic prescribing systems, and other methodologies have rapidly emerged to support the preparation (including storage and packaging), delivery or distribution, dispensing, and administration of medication to patients in the pharmacy and other health care settings.” The resolution stresses that “the national use of such systems requires greater uniformity to define terms found in the laws and regulations of individual states and avoid disparity and confusion when assessing, authorizing, and applying the use of such systems,” and notes that “the boards of pharmacy are uniquely positioned to create or influence greater specificity and uniformity of federal and state laws and regulations” that address the use of such systems.

Further, the resolution notes that “security and accuracy related to the use of these systems are primary concerns of the state boards of pharmacy in protecting the public health and safety” and that there is “a need for NABP to review and possibly revise the sections of the Model Act that address this important subject.” The task force is charged with the following objectives:

1. Review existing current state laws and regulations addressing the use of technology systems and relevant Model Act language.

2. Recommend revisions, if necessary, to the NABP Model Act addressing this issue.

3. Propose a mechanism for researching, advising state boards of pharmacy, and updating the Model Act on future innovations and changes in technology.

Chairperson of this task force is Patricia D'Antonio, RPh, MS, MBA, CGP, executive director, District of Columbia Board of Pharmacy. Individuals appointed to serve as members include:
- Jeannine Dickerho, MS, RPh, Colorado
- Nadia Bhatti, RPh, PharmD, New York
- Lee Ann Bundrick, RPh, South Carolina
- Amy Mattila, RPh, Wisconsin
- Dennis McAllister, RPh, FASHP, Arizona
- Michael Podgurski, RPh, Pennsylvania
- Kenneth Saunders, RP, Nebraska

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Committees, Task Forces
(continued from page 193)

- Joyce Tipton, RPh, MBA, FASHP, Texas
- Julie Geason, RPh, Minnesota, will serve as an alternate member and James T. DeVita, RPh, member, Massachusetts Board of Registration in Pharmacy, is the Executive Committee liaison.

The Task Force to Review Recommendations to the Controlled Substances Act is scheduled to meet January 24-25, 2012, at NABP Headquarters. The task force was established to follow-up on issues raised by the 2010-2011 Task Force to Review and Recommend Revisions to the Controlled Substances Act that met in January 2011.

The task force is charged with the following objectives:

1. Review the recommendations made by the 2010-2011 Task Force to Review and Recommend Revisions to the Controlled Substances Act.
2. Recommend additional revisions, if necessary, to the CSA or accompanying Code of Federal Regulations.
3. Present recommendations to Congress. Individuals appointed to serve as members include:
   - Susan DeMonico, RPh, JD, Rhode Island
   - Rebecca Deschamps, RPh, Montana
   - W. Benjamin Fry, RPh, FIACP, FACA, Texas
   - Caroline Juram, RPh, Virginia
   - Suzan Kedron, JD, Texas
   - Susan Martin, RPh, PharmD, Colorado
   - Suzanne Neuber, RPh, Ohio
   - Jerry Moore, JD, Alabama
   - Frank Whitcher, RPh, Kansas
   - The chairperson and Executive Committee liaison is William T. Winsley, MS, RPh, executive director, Ohio State Board of Pharmacy.

The Task Force on Internet Pharmacy Practice Standards is scheduled to meet March 6-7, 2012, at NABP Headquarters.

The task force is charged with the following objectives:

1. Review existing Internet pharmacy practices.
2. Review current state laws and regulations, Verified Internet Pharmacy Practice Sites® (VIPPS®) program standards, and NABP Model Act language.
3. Examine future opportunities and challenges in an emerging global environment.

Chairperson of this task force is Jeanne Waggener, RPh, president, Texas State Board of Pharmacy. Individuals appointed to serve as members include:

- Wendy Anderson, RPh, Colorado
- Jeffrey Firlik, RPh, Vermont
- Ronald Guse, Manitoba, Canada
- Steven Haiber, RPh, Arizona
- Lenna Israbian-Jamgochian, PharmD, Maryland
- Nina Smothers, DPh, MBA, Tennessee
- Charles Wetherbee, JD, Texas
- Luis Rivera-Lleras, RPh, Colorado
- Stanley Weisser, RPh, California

Matt Sneller, PharmD, Minnesota, will serve as an alternate member and William J. Cover, RPh, member, Indiana Board of Pharmacy, is the Executive Committee liaison.

2011-2012 Standing Committees

As authorized by the NABP Constitution and Bylaws, the Association’s standing committees annually perform specific responsibilities that are essential to the success of NABP’s programs. Once a committee has explored its assigned issues, the members submit recommendations or resolutions to the NABP Executive Committee for consideration.

The Committee on Law Enforcement/Legislation will meet on February 29, 2012, at NABP Headquarters. The committee is charged with the following tasks:

1. Review and comment on existing legislation and rules for the practice of pharmacy, legal distribution of drugs, and related areas within pharmacy, including impaired pharmacists.
2. Develop model regulations for pharmacy as assigned by the Executive Committee, or from resolutions adopted by the members of the Association, or from reports of the other committees of the Association.
3. Recommend to the Executive Committee areas where model regulations are needed in pharmacy for improving the protection of the public health.

Kevin Borcher, RP, chairperson, Nebraska Board of Pharmacy, is the committee chairperson. Committee members include:

- Patrick Adams, RPh, Hawaii
- Gay Dodson, RPh, Texas
- Patricia Donato, RPh, New York
- Edith Goodmaster, Connecticut
- Lawrence Mokhiber, MS, RPh, New York
- Nona Rosas, CPhT, Arizona
- Dennis Wiesner, RPh, Texas

The Executive Committee liaison is Cathryn J. Lew, RPh, of Oregon.

The Committee on Constitution and Bylaws will meet in April 2012. The charge of this committee, as defined by the NABP Constitution and Bylaws, is to review proposed amendments to the Constitution and Bylaws, suggest changes where appropriate, and issue a recommendation for each proposed amendment.

Ronald Klein, RPh, executive director, Montana Board of Pharmacy, is committee chairperson. Committee members include:

- Philip Burgess, RPh, MBA, Illinois
- Judy Gardner, PharmD, Georgia
- Kevin Mitchell, RPh, Ohio
- Rich Palombo, RPh, New Jersey
- Hal Wand, MBA, RPh, executive director, Arizona State Board of Pharmacy is the Executive Committee liaison.
Since 2009, NABP surveyors have conducted more than 3,350 on-site surveys per year on behalf of the state boards of pharmacy and for the NABP accreditation programs. The surveyors are a key element to NABP’s ability to further expand and improve the services offered to the boards. They play an integral role in ensuring the protection of public health. With a vast array of knowledge and experience, the surveyors apply their wide skill sets to NABP assignments to verify that the proper standards and procedures are in place through meticulous policy review and survey processes.

Survey Service Types

Through its Government Affairs and Accreditation Departments, NABP currently provides wholesale drug distributor, pharmacy, and controlled substance registrant survey and inspection services. These services can be broken down into two basic types of surveys, the first of which supports the NABP accreditation programs. In these cases, surveyors utilize specific NABP criteria and standards to perform on-site facility-level surveys, corporate-level surveys, or both depending on the program. These surveys are conducted with the ultimate goal of confirming the implementation of approved operating processes that fully meet the accreditation program’s standards and criteria. This first type of survey can be further separated into two categories: those that are required by state or federal law such as for the Verified-Accredited Wholesale Distributors® or the durable medical equipment, prosthetics, orthotics, and supplies accreditation and those that are optional such as for the community pharmacy accreditation program.

The second type of survey conducted by NABP is the one performed on behalf of a state agency. In this case NABP acts as a support mechanism for compliance efforts specified by the state and conducts surveys or inspections as necessary. The surveyors act as the state’s on-site eyes and ears. Utilizing the state’s criteria and forms, NABP surveyors conduct the surveys or inspections and turn all findings over to the state for its interpretation. NABP is making this low cost service available as a benefit to the boards of pharmacy, especially in those instances where resources are minimal.

A Look at the Surveyor Team

Thirty-five individuals from 20 different states currently serve as NABP surveyors. These high caliber individuals have a vast array of skill sets, and their diversity in past employment experience allows NABP to tailor its services to meet the needs and specifications of each survey conducted. Ranging from pharmacists to law enforcement officials, current and past surveyor backgrounds include:

- Board of pharmacy investigator

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NABP is currently accepting applications from board of pharmacy members interested in serving on the NABP Advisory Committee on Examinations (ACE), which oversees the development and administration of all NABP examination and certification programs. Board members are those individuals who are board of pharmacy members or administrative officers and are currently serving on an active member board. In addition, individuals who have served within the last five years as a member or chief administrative officer of an active member board are also considered board-affiliated members.

ACE typically convenes two to three times per year, and considers policy matters, evaluates long-range planning strategies, and recommends appropriate action to the NABP Executive Committee. ACE is composed of representatives from boards of pharmacy as well as faculty and/or staff of schools and colleges of pharmacy, and practicing pharmacists who exemplify the diversity in pharmacy practice. Board members chosen to serve on ACE must hold an active, unrestricted pharmacist license in any state or territory of the United States. Each ACE appointment is for a three-year term beginning June 1, 2012.

Interested individuals must submit a written statement of interest and a current resume or curriculum vitae to NABP Executive Director/Secretary Carmen A. Catizone at NABP Headquarters, 1600 Feehanville Drive, Mount Prospect, IL 60056 or exec-office@nabp.net no later than December 31, 2011.

Please contact the NABP Competency Assessment Department at NABP_comp_assess@nabp.net with any questions regarding ACE.

NABP Surveyor
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- Board of pharmacy executive director
- Hospital, chain, or independent pharmacist/pharmacy manager
- University instructor
- Pharmaceutical company business systems manager
- Food and Drug Administration Office of Criminal Investigation special agent
- Drug Enforcement Administration compliance manager
- Law enforcement executive
- Federal agent
- Expert witness
- Expert in the field of forensic accounting

In addition to this expertise, NABP is currently in the process of interviewing surveyor candidates with nursing and other health care backgrounds. By employing surveyors with a variety of backgrounds and skill sets, NABP can better ensure that it is prepared to take on a diverse pool of survey applicants.

Ongoing Training

NABP utilizes various means to ensure that its surveyors are appropriately trained and prepared for each survey. The Association focuses on keeping its surveyors up to speed on new regulations and procedures, making certain that they maintain and continue to build skill sets and expertise in the necessary survey fields or programs and operate consistently with the applicable standards throughout the nation, no matter how geographically dispersed. NABP accomplishes this through continuing education sessions, training events, Webinars, and conference calls; sending out reminders to surveyors whenever necessary; and providing tips, tools, and new information as available, typically six to eight times per year. Quality assurance checks are also used to help ensure consistency among surveyors.

In addition, NABP utilizes the knowledge of its more seasoned surveyors to enhance the skills of others. Though cross training does occur, not all surveyors are trained for all programs as the Association recognizes that certain survey fields require a very specific level of expertise.

Surveyors also travel to NABP to attend a comprehensive annual training event focused on the essentials of the NABP accreditation programs. This year, the surveyor training will be held in conjunction with the NABP Compliance Officer Forum in December (see sidebar on page 195). This will provide surveyors with the opportunity to better understand the processes of state board of pharmacy compliance officers, inspectors, and investigators, thereby improving the compatibility of the services NABP offers to the boards.

NABP surveyor assistance is available to all of the boards of pharmacy. Questions may be directed to the NABP Government Affairs Department at governmentaffairs@nabp.net.
Nominees Sought for 2012 Awards to Be Presented at the NABP 108th Annual Meeting in Philadelphia

Individuals who know an exemplary colleague or a board of pharmacy that represents the mission of NABP – protecting the public health – may nominate the eligible person or board for a 2012 NABP award to be presented at the 108th Annual Meeting, to be held May 19-22, 2012, at the Sheraton Philadelphia Downtown Hotel in Philadelphia, PA.

Nominations are currently being accepted for the following awards: 2012 Lester E. Hosto Distinguished Service Award (DSA), 2012 NABP Honorary President, 2012 Fred T. Mahaffey Award, and 2012 John F. Atkinson Service Award.

**Lester E. Hosto DSA**

This award is the highest honor bestowed by the Association. Originally known as the Distinguished Service Award, it was renamed by NABP to serve as a memorial to the 1990-1991 NABP President Lester E. Hosto, whose motivating presence in the practice of pharmacy was recognized by practitioners of his state, pharmacy leaders across the nation, and former United States President Bill Clinton.

The Lester E. Hosto DSA recognizes those individuals whose efforts to protect the public health greatly furthered the goals and objectives of NABP. Any individual who meets these criteria may be nominated for the DSA, regardless of his or her member affiliation with NABP.

**Honorary President**

Nominees who will be considered for the position of honorary president must meet the following criteria:

- service on one or more NABP committee or task force;
- participation in NABP/ American Association of Colleges of Pharmacy District Meetings and NABP Annual Meetings;
- exemplary services for, or on behalf of, NABP;
- strong commitment to NABP, the mission of the Association to protect the public health, and the practice of pharmacy; and
- affiliation (either current or past) as a board member or as an administrative officer of an active or associate member board.

**Fred T. Mahaffey Award**

This award was named after the late NABP Executive Director Emeritus Fred T. Mahaffey, who held the executive director position from 1962 to 1987. His leadership and contributions to NABP, state boards of pharmacy, and the protection of the public health were significant and established NABP as one of the leading pharmacy organizations. The award recognizes a member board of pharmacy that has made substantial contributions to the regulation of the practice of pharmacy over the past year.

**John F. Atkinson Service Award**

Named in honor of former NABP general counsel John F. Atkinson, who recently retired after serving as NABP legal counsel for more than 40 years, the John F. Atkinson Service Award replaced the Lester E. Hosto Inspector DSA and was first awarded at the 105th Annual Meeting. Recipients of this award are individuals who have provided NABP with exemplary service in protecting the public health and have shown significant involvement with the Association related to pharmacy law and compliance.

**Henry Cade Memorial Award**

In addition to the aforementioned awards, the Henry Cade Memorial Award will also be presented during the Annual Meeting. The NABP Executive Committee selects a recipient(s) for the Henry Cade Memorial Award who has supported the goals and objectives of the Association and the state boards of pharmacy to protect the public health and advanced the safety and integrity of the distribution and dispensing of medications. Nominations are not accepted for this award.

The Henry Cade Memorial Award is named in honor of the late Henry Cade, who served as NABP president from 1987 to 1988. Tireless in his efforts on behalf of NABP and the Illinois Division of Professional Regulation – State Board of Pharmacy, Cade was also a long time pharmacy practitioner.

For more information, please contact Dana Oberman, executive meeting planner, via e-mail at doberman@nabp.net.

Nominations must be received at NABP Headquarters no later than **December 31, 2011**. To submit a nomination, individuals are asked to send a letter explaining why the nominee should be considered for the award, as well as a brief biography. A current resume or curriculum vitae of the nominee is also required. Please submit your nomination to NABP Executive Director/Secretary Carmen A. Catizone at NABP Headquarters, 1600 Feehanville Dr, Mount Prospect, IL 60056. The NABP Executive Committee will review the nominations and select the honorary president and award recipients.
Pharmacy Technology (continued from page 186)

Florida rules allow technicians and interns to be involved in the restocking process and require that a pharmacy using such a system develops a policy and procedure manual. The manual must include a method for identifying the registered pharmacy technicians and registered pharmacy interns involved in the dispensing process, the process for filling and stocking the machine, methods for ensuring security, compliance with a continuous quality improvement program, and a method to ensure patient confidentiality, among other required policies and procedures. The rules detail the pharmacist’s responsibilities for supervising the machine.

Reviewing the various states, rules regarding the pharmacist’s responsibility related to overseeing automatic dispensing machines, may assist boards as they develop or amend rules, and as they develop inspection and compliance processes. Currently, the Model Act includes oversight of APS in the duties and responsibilities of the pharmacist-in-charge (PIC). Related to APS, the Model Act language requires the PIC to develop a quality assurance program that monitors performance of the APS; to ensure that the APS is in good working order and accurately dispenses the correct strength, dosage form, and quantity of the drug prescribed while maintaining appropriate record keeping and security safeguards; and to provide the board with notice of the installation or removal of such a system, among several other responsibilities.

Regulating Specific Uses and Specific APS Technology

In Massachusetts, the Department of Public Health and Board of Registration in Pharmacy, along with the Drug Control Program, and the Division of Health Care Quality, jointly issued guidelines for APS that dispense only Schedule VI controlled substance refill prescriptions to patients during or after pharmacy hours of operation. (Under Massachusetts law, all prescription drugs not included in Schedules II through V are considered Schedule VI. Schedule VI drugs include those with no addiction potential such as penicillin, and those which may have a low potential for addiction such as tramadol.) Prior to operating such a system, a pharmacy must notify the Board and the Department of Public Health and develop an on-site policy and procedure manual. The rule details requirements for patient consultation and patient choice, security, record keeping, access, and stocking.

In 2008, ISMP published a guidance document addressing the safe use of automated dispensing cabinets (ADCs), which the organization categorizes as one kind of APS. ISMP notes that ADCs can have many benefits in a hospital setting such as decreasing delivery time to patients by providing nurses with access to medications needed in patient care areas; facilitating security; and reducing medication errors, among other benefits.

ISMP indicates a number of areas, addressed in various ways by the state statutes and regulations previously discussed, that can impact safe use of ADCs, such as establishing security processes to ensure control of medications and reduce potential for diversion, and defining safe restocking practices.

ISMP also identifies several other areas that are important for ensuring the safe use of ADCs that may be worth considering when developing regulations for automatic dispensing technologies. These areas include:

- Determining the location that will increase effective use for patient safety and help to reduce errors
- Ensuring that ADCs display the most pertinent patient and medication information on the screen
- Configuring the ADC appropriately
- Using profile technology for pharmacists to validate medication orders

Remote Dispensing Systems

The North Dakota State Board of Pharmacy helped pave the way for telepharmacy practice in order to serve rural populations and other patient populations. The North Dakota Board was the first to develop and pass administrative rules allowing retail pharmacies to operate in certain remote areas with a technician on site and a pharmacist present by television for supervision and patient consultation.

In 2006, the Minnesota Board of Pharmacy implemented rules and guidelines for dispensing with remote distribution via telepharmacy, described in the Board rules as a situation where “a continual, two-way audiovisual link between the central pharmacy and each remote site” is established. Guidelines include recommendations for the maximum number of prescriptions that may be remotely certified. Similar rules were implemented in Montana in 2006 and Wisconsin in 2010, and both states require certain qualifications.

NABP Resolution 107-11

"[B]oards of pharmacy are uniquely positioned to create or influence greater specificity and uniformity of federal and state laws and regulations addressing the use of pharmacy technology.

NABP Resolution 107-11"
CPE Monitor Service Advances with Support from Boards of Pharmacy

With more than 70,000 NABP e-Profiles created, the CPE Monitor™ service is well on its way to becoming fully operational. The executive directors and their state boards of pharmacy have been instrumental in the continued development of CPE Monitor. Many of the boards have offered their assistance and support by distributing information about CPE Monitor through their state newsletters and on their Web sites. These continued efforts to inform licensees about CPE Monitor and the importance of setting up an NABP e-Profile have helped to quickly and successfully establish the CPE Monitor service.

Working with the Accreditation Council for Pharmacy Education (ACPE), NABP has successfully tested the CPE Monitor system’s ability to process data automatically. Soon, ACPE will begin working with a select group of volunteer continuing pharmacy education (CPE) providers and NABP to test the transmission of pharmacists’ and technicians’ CPE credit. It is anticipated that CPE providers will eventually phase out the issuance of paper-based certificates once the CPE Monitor service is fully functional. At that point, e-Profiles, which will be maintained by NABP and will include licensee CPE records, will become the accepted record for licensees to verify compliance with their board of pharmacy CPE requirements for coursework by ACPE-accredited providers.

With this in mind, it is incumbent upon NABP to take the necessary steps to help ensure the accuracy of the data within its systems. The use of the Social Security number (SSN) as the unique national identifier is the way for NABP to help ensure that each individual is correctly identified. Any errors in an individual’s e-Profile may result in unrecorded or mis-recorded CPE, with possible adverse consequences for licensees when renewing their licenses.

NABP is aware that some boards may still be facing resistance from licensees in regard to the request for a SSN to set up their e-Profile. To further assist with any questions or concerns regarding this, NABP has created informational flyers available at www .MyCPEmonitor.net on the right side of the Web page.

For more information regarding CPE Monitor and to set up an NABP e-Profile, visit www .MyCPEmonitor.net.

Pharmacy Technology
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ifications of technicians that staff remote sites. Boards in Montana, as well as Hawaii, also implemented a separate rule to regulate the use of computerized dispensing machines at remote pharmacy sites. Idaho, Illinois, Iowa, South Dakota, Texas, and Wyoming have also adopted laws and regulations to support the use of remote dispensing technologies.

The Model Act includes language detailing qualifications for a pharmacist to engage in telepharmacy as well as related licensure requirements. In addition, Model Act language for the operation of remote pharmacy services is provided.

Looking to the Future

The NABP resolution establishing the Task Force on Pharmacy Practice Technology Systems notes that “boards of pharmacy are uniquely positioned to create or influence greater specificity and uniformity of federal and state laws and regulations addressing the use of” pharmacy technology. Further, such “laws and regulations . . . facilitate optimal patient care and safety in pharmacy and other health care settings,” as stated in the resolution.

With new pharmacy technologies continually emerging, continued guidance on necessary legislation and regulations is needed. For example, some clinics and surgical centers have begun using automatic dispensing machines that dispense medications directly to patients. The prescription is sent electronically, and the patient enters a code provided by the prescriber to have the medication dispensed by the machine before leaving the clinic. While proponents of the technology believe the convenience will encourage patients to get their prescriptions filled, others are concerned that the patient may not receive needed pharmacist counseling. With the implementation of future technologies in mind, task force members will also be charged with proposing a mechanism for researching, advising state boards of pharmacy, and updating the Model Act on future innovations and changes in technology.

The NABP resolution “Task Force on Pharmacy Practice Technology Systems” (107-1-11) is available in the Members section of the NABP Web site at www.nabp.net/members/resolutions.
In October 2011, in observance of American Pharmacists Month, the Arizona Pharmacy Foundation (APF) will launch a statewide AWARXE™ campaign to raise awareness about the dangers of prescription drug misuse and abuse and the role of prescription drug disposal events in preventing misuse and abuse. Good Neighbor Pharmacy has signed on to the Arizona AWARXE campaign as a signature sponsor. Plans for the APF inaugural Arizona campaign include:

- Outdoor media/digital billboards
- Bus/transit advertising
- Television and radio public service announcements
- Print advertising
- Web presence
- Community outreach events
- Drug take back events
- Social media

In addition to the public awareness campaign, the Student Pharmacist Academy of the Arizona Pharmacy Alliance will spearhead the development of a school-based educational program directed at students, teachers, and parents to warn of the dangers of prescription drug abuse and misuse.

APF and Pharmacy Students Introduce AWARXE to Arizona

On April 28, 2011, the Arizona Pharmacy Foundation (APF) participated in a multi-agency press conference addressing prescription drug abuse and the importance of safe drug disposal. Student pharmacists from Midwestern University College of Pharmacy Glendale and the University of Arizona College of Pharmacy also participated and promoted the Arizona AWARXE campaign by dressing in red and black and wearing AWARXE logo baseball caps. Press conference participants included the Arizona Department of Public Safety, the Phoenix office of the Drug Enforcement Administration (DEA), and the Arizona Affiliate of the Partnership for a Drug-Free America and the event helped to promote the April 30, 2011 DEA National Prescription Drug Take-Back Day. At the press conference, APF also made the initial announcement about the AWARXE campaign in Arizona, laying the groundwork for future collaborations with community partners.

APF is the 501(c)(3) non-profit corporation under the auspices of the Arizona Pharmacy Alliance. Its mission is to promote and educate the public concerning the delivery of pharmaceutical care. APF is a licensee of AWARXE. ©

Newly Accredited VIPPS Facility

The following Internet pharmacy was accredited through the NABP Verified Internet Pharmacy Practice Sites™ (VIPPS®) program:

BioPlus Specialty Pharmacy Services, Inc
Altamonte Springs, FL
www.bioplusrx.com

A full listing of the accredited VIPPS pharmacy sites representing more than 12,000 pharmacies are available on the NABP Web site at www.nabp.net. ©
AWARxE National Campaign Encourages Proper Disposal of Prescription Drugs to Prevent Diversion and Abuse

To support local AWARxE™ campaigns and activities, the AWARxE consumer protection program is launching a national advertising campaign in October.

Using the “Does a Drug Dealer Lurk in Your Medicine Cabinet?” theme, the national advertising effort encourages seniors and other readers of the AARP Bulletin to protect their families by properly disposing of unused, unneeded, and unwanted medications to ensure the drugs are not misused by family or friends. AWARxE, through its Web site, www.AWARERx.ORG, educates consumers about the importance of safe medication disposal and encourages participation in the Drug Enforcement Administration National Drug Take-Back Day events.

You can help bring these important messages to consumers by encouraging them to visit www.AWARERx.ORG for information and resources. If you would like to run the AWARxE ad in a community publication – such as a church, rotary club, or chamber of commerce newsletter – please contact Larissa Doucette, NABP communications manager, at AWARERx@nabp.net to obtain the complimentary artwork for the ad shown on left. Please note, it is also available as a three-color ad with text in black, white, and red.

GET INFORMED | www.AWARERx.ORG

Third DEA National Prescription Drug Take-Back Day in October

The next Drug Enforcement Administration (DEA) National Prescription Drug Take-Back Day will take place Saturday, October 29, 2011, from 10 AM to 2 PM, and will be the third event coordinated by DEA to help consumers safely dispose of unused, unneeded, and expired prescription medications, including controlled substances. More than 309 tons of pills were turned in at collection sites across the United States during the first two DEA National Prescription Drug Take-Back Days held September 25, 2010, and April 23, 2011, illustrating the continued need for a safe, convenient means for consumers to dispose of unwanted medications. Nearly 4,000 state and local law enforcement agencies throughout the nation partnered with DEA to provide take-back sites. Disposing of unwanted medications helps prevent the drugs from being misused or diverted from the home.

Pharmacists interested in volunteering at a collection site, and pharmacies interested in coordinating an event with local law enforcement, may contact their local DEA division office. DEA has posted a list of division contacts on its Web site and will provide an online drug take-back site locator in the fall at www.deadiversion.usdoj.gov/drug_disposal/takeback/index.html. Additional consumer information about how disposal of unwanted medications and proper storage of needed prescription medications help to prevent drug misuse and abuse is available on www.AWARERx.ORG.

Got Drugs? Turn in your unused or expired medication for safe disposal.
2011-2012 Influenza Vaccines Approved

Food and Drug Administration (FDA) announced that it has approved the 2011-2012 influenza vaccine formulation for all six manufacturers licensed to produce and distribute influenza vaccine for the United States. The vaccine formulation protects against the three virus strains that surveillance indicates will be most common during the upcoming season and includes the same virus strains used for the 2010-2011 influenza season. The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommends that everyone six months of age and older receive an annual influenza vaccination. Details about the new vaccines are available in an FDA news release at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm263319.htm, and information about the ACIP recommendations are available on the CDC Web site at www.cdc.gov/media/pressrel/2010/r100224.htm.

New Acetaminophen Dosing Instructions

To decrease the potential of accidental overdose, McNeil Consumer Healthcare Division of MCNEIL-PPC, Inc has announced that single-ingredient Extra Strength Tylenol® (acetaminophen) products sold in the US will include new dosing instructions beginning in fall 2011. The new dosing instructions will lower the maximum daily dose from 8 pills per day (4,000 mg) to 6 pills per day (3,000 mg). McNeil also plans to lower the maximum daily dose for Regular Strength Tylenol and other adult acetaminophen-containing products beginning in 2012. The manufacturer notes that consumers can continue to use their Tylenol and other adult acetaminophen-containing products as currently labeled. More information is available at www.tylenol.com/getreliefresponsibly.

FDA Updates for Safe Administration of Acetaminophen to Children

To help prevent acetaminophen overdose in children, FDA has provided consumers with updated information on the safe use of the drug for treating fever and pain in infants and children. FDA stresses to consumers that “improper dosing is one of the biggest problems in giving acetaminophen to children.” FDA provides consumers with several tips including the following:

- Never give your child more than one medicine containing acetaminophen at a time.
- Choose the right over-the-counter medication based on your child’s weight and age, and use the “Directions” section of the Drug Facts label to determine if the medicine is right for your child and how much to give.
- Never give more of an acetaminophen-containing medicine than directed.
- If the medicine is a liquid, use the measuring tool that comes with the medicine, not a kitchen spoon.
- Keep a daily record of the medicines you give to your child.

The FDA Web page “Reducing Fever in Children: Safe Use of Acetaminophen” provides additional details for consumers and may be accessed at www.fda.gov/ForConsumers/ConsumerUpdates/ucm263989.htm.

Methylene Blue and Linezolid May Interact With Certain Psychiatric Medications

FDA has issued two safety communications regarding adverse drug reactions in patients taking certain psychiatric medications, and also given methylene blue or linezolid (Zyvox®). Specifically, FDA has received reports of serious central nervous system reactions in patients taking serotonergic psychiatric medications who are also given methylene blue or linezolid (Zyvox®). Specifically, FDA has received reports of serious central nervous system reactions in patients taking serotonergic psychiatric medications who are also given methylene blue or linezolid (Zyvox®). FDA advises that “Methylene blue should generally not be given to patients taking serotonergic drugs.” Exceptions and more information for health care providers and patients are available in an FDA Drug Safety Communication available at www.fda.gov/Drugs/DrugSafety/ucm263190.htm. Similar reports of interactions between certain serotonergic psychiatric medications and the antibacterial drug, linezolid (Zyvox) have also been reported to FDA. FDA has published a list of the serotonergic psychiatric medications that can interact with linezolid and advises that it “should generally not be given to patients taking serotonergic drugs.” Exceptions and more information for health care providers and patients are available in an FDA Drug Safety Communication available at www.fda.gov/Drugs/DrugSafety/ucm265305.htm.
Oklahoma Board Approves Safe Medication Disposal Pilot Program

The Oklahoma State Board of Pharmacy has approved a pilot program for the safe disposal of unused/unwanted/expired (UUE) medications in conjunction with the National Community Pharmacists Association and DisposeMyMeds.org. The pilot program will allow Oklahoma in-state licensed pharmacies to establish a drop-off location in their pharmacy for UUE medications, and then dispose of them through the DisposeMyMeds.org program. For more information about the pilot program, visit the Announcements section on the Oklahoma State Board of Pharmacy Web site at www.ok.gov/OSBP/Announcements/index.html.

South Dakota Board New Policies Regarding Changing Quantity Dispensed

The South Dakota State Board of Pharmacy approved a policy statement that details the expectations of pharmacists when exercising professional judgment if they determine a change in quantity to dispense is needed. The Board stresses that the pharmacist has the responsibility to serve the best interest of the patient provided it is within applicable laws and/or regulations. The Board’s policy statement notes that patients often benefit when the pharmacist dispenses either a greater or lesser quantity than indicated on the prescription. Dispensing additional quantities of medication up to the total number of dosage units authorized by the prescriber on the original prescription order including refills is often appropriate. The policy statement also notes that changing the quantity dispensed may lead to enhanced compliance and a potential decrease in health care costs. Specific guidelines provided by the Board are included in the July 2011 South Dakota State Board of Pharmacy Newsletter available at www.nabp.net/publications/assets/SD072011.pdf.

South Dakota Board Prepares for PDMP

The South Dakota State Board of Pharmacy has adopted administrative rules for the prescription drug monitoring program (PDMP) that was implemented in summer 2011. More information about the laws and rules pertaining to the practice of pharmacy can be found on the Board of Pharmacy Web site at http://doh.sd.gov/boards/pharmacy.

Retail pharmacies licensed by the Board that dispense prescriptions to South Dakota residents will be required to submit information on all controlled drug prescriptions. Pharmacists and prescribers will be able to access information from the database in order to help manage patients’ medications.

Virginia Board Begins New Inspection Process for Pharmacies

Beginning in July 2011, the Virginia Board of Pharmacy began a new inspection process for all pharmacies. The Board will perform routine inspections that will be unannounced. Inspections resulting in cited deficiencies may lead to the inspector leaving a pre-hearing consent order at the conclusion of the inspection, which may involve a monetary penalty. A monetary penalty is associated with each major deficiency. Although individual minor deficiencies are not associated with a monetary penalty, a $250 monetary penalty will be imposed if three minor deficiencies are cited during a routine inspection. A $100 penalty is added for each additional minor deficiency. During a June 8, 2011 meeting, the Board approved changes to deficiencies listed in its Guidance Document Section on inspection process may be accessed by visiting the Guidance Document Section on the Board of Pharmacy’s Web site at www.dhp.virginia.gov/pharmacy.

Around the Association

New Executive Officer

John Kirtley, PharmD, has been selected as the new executive director for the Arkansas State Board of Pharmacy effective July 1, 2011. Kirtley takes the place of Charles S. Campbell. Prior to this new position, Kirtley served as the assistant director for the Board since December 2004.

Board Member Appointment

• Penny Reher, RPh, has been appointed a member of the Oregon State Board of Pharmacy. Reher’s appointment will expire on June 30, 2015.

Board Member Reappointment

• Berk Fraser, RPh, has been reappointed a member of the Idaho State Board of Pharmacy. Fraser’s reappointment will expire on June 30, 2016.

Board Officer Changes

The Arkansas State Board of Pharmacy has elected the following officers to the Board:

• Marilyn Sitzes, PD, President
• Ronald Norris, PD, Vice President
• Steve Bryant, PD, Secretary
Wyoming Board Staff Meets Update Deadline, Wins Survey Luncheon Drawing

NABP congratulates the Wyoming State Board of Pharmacy staff for winning the 2012 Survey of Pharmacy Law Luncheon Drawing. The Board was awarded $125 toward a Board member and staff luncheon for returning their updated Survey of Pharmacy Law data by the July 22 deadline. Pictured from left to right: Joshua Jons, PharmD candidate, University of Wyoming School of Pharmacy, and Wyoming Board staff Beverly Fontaine, administrative specialist; David Wills, MBA, records and data management specialist; Phyllis Chapman, senior office support specialist; and Mary Walker, RPh, executive director, worked as a team to update Wyoming-related material in the Survey.