newsletter

National Association of Boards of Pharmacy®

February 2008 / Volume 37 Number 2

aid to government
the profession
the public
1904 to 2008

Upcoming Events

April 17-19, 2008
NAPLEX Item-Writing Workshop
NABP Headquarters
Mount Prospect, IL

May 17-20, 2008
NABP 104th Annual Meeting
Baltimore Marriott Waterfront
Baltimore, MD

June 5-7, 2008
MPJE Item-Writing Workshop
NABP Headquarters
Mount Prospect, IL

June 28, 2008
FPGEE Administration
New York City, NY
Northlake, IL
San Mateo, CA

States Adjust Pain Medication Policies to Balance Patient Access, Regulatory Control

Several states recently adjusted their regulations on prescribing and dispensing pain medications to strike a better balance between access and control. Setting such policies has been an eternal balancing act for regulators seeking to curb the diversion and abuse of controlled substance medications without obstructing the legitimate treatment of pain.

Eight States Rated Higher

NABP is aware that the Pain and Policy Studies Group (PPSG) at the University of Wisconsin has been measuring all 50 states' progress in achieving this balance annually since 2000. According to the 2007 report, *Achieving Balance in State Pain Policy: A Progress Report Card*, eight states – Arizona, California, Colorado, Connecticut, Kansas, Massachusetts, New Hampshire, and Wisconsin – received higher "grades" for their pain policies than a year ago. States are rated with a letter grade (A through F) based on the extent to which their laws, regulations, and state-issued guidelines and statements enhance or impede effective pain management.

In 2007, Kansas and Wisconsin joined Michigan and Virginia as having the most balanced pain policies in the nation, and 86% of states received grades better than a "C." Only 49% of states hit that mark in 2000. No state has worsened its grade since 2000.

According to PPSG, a balanced pain management policy embraces "the Central Principle of Balance," which the group describes as "a dual obligation of governments to establish

a system of controls to prevent abuse, trafficking, and diversion of narcotic drugs while, at the same time, ensuring their medical availability."

Such a system, PPSG maintains, "is not intended to diminish the medical usefulness of opioids, nor interfere in their legitimate medical uses and patient care." It includes laws that are consistent with current medical practice and entails state licensing boards encouraging the practice of good pain management in the context of quality patient care and reassuring

(continued on page 22)

In This Issue. . . .

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.

National Association of Boards of Pharmacy
1600 Feehanville Drive
Mount Prospect, IL 60056
847/391-4406
www.nabp.net
custserv@nabp.net

Carmen A. Catizone
Executive Director/ Secretary

Larissa Doucette
Editorial Manager

Pain Medication Policies

(continued from page 21)

practitioners that prescribing and dispensing pain medications for valid medical needs will not result in disciplinary sanctions.

DEA Supports Valid Medical Use

In the September 6, 2006 *Federal Register* (Docket No. DEA-286P), Drug Enforcement Administration (DEA) confirms that its policies are not intended to hamper the legitimate use of controlled substances. DEA states that "the longstanding requirement under the law that physicians may prescribe controlled substances only for legitimate medical purposes in the usual course of professional practice should in no way interfere with the legitimate practice of medicine or cause any physician to be reluctant to provide legitimate pain treatment."

Showing further support for the legitimate use of pain medications, DEA began on December 19, 2007, allowing practitioners to provide an individual patient with multiple prescriptions for a specific Schedule II controlled substance, written on the same date, to be dispensed sequentially. In states where the law is not more stringent this change allows patients to receive over time up to a 90-day supply of the prescribed controlled substance. The Controlled Substances Act does not permit the refilling of Schedule II controlled substances; a new prescription must be issued for each quantity of the substance.

States Adjust Pain Med Policies

To achieve a better balance in controlling the abuse and diversion of pain medications without impeding their use for legitimate medical needs, several states have adopted guidelines based on the *Model Policy for the Use of Controlled Substances for the Treatment of Pain (Model Policy)*, compiled by the Federation of State Medical Boards of the United States, Inc and endorsed by the American Academy of Pain Medicine, DEA, American Pain Society, and National Association of State Controlled Substances Authorities.

The *Model Policy* is provided "to encourage state health care regulatory agencies to adopt policy promoting adequate treatment, including use of opioids when appropriate, for patients with pain." As of March 2007, a total of 29 states had adopted the *Model Policy* either in whole or in part.

The *Model Policy* includes the following tenets:

- Health care practitioners should view pain management as a part of quality medical care for all patients with pain.
- Practitioners should become knowledgeable about effective assessment and treatment of pain, as well as laws on prescribing and dispensing controlled substances.
- Controlled substances, including opioid analgesics, may be essential in the treatment of acute and/or chronic pain.
- Tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.
- Inappropriate prescribing and dispensing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse.
- Practitioners should incorporate safeguards into their practices to minimize the potential for abuse and diversion of controlled substances.
- Practitioners should not fear disciplinary action from the state licensing board for ordering, prescribing, dispensing, or administering controlled substances, including opioid analgesics, for legitimate medical purposes in the course of professional practice.

Arizona: On the PPSG grading scale, Arizona improved from "B" in 2006 to "B+" in 2007 by replacing a previous medical board policy with revised guidelines based on the *Model Policy*. The guidelines note that diversion of controlled substances remains a concern, but that "efforts to stop diversion should not interfere with prescribing opioids when appropriate for chronic pain management." Arizona also repealed provisions mandating that physicians always consult with pain specialists when using controlled substances

to treat patients with pain if they want immunity from disciplinary sanction.

California: Changed from a grade of "C" to "B" by repealing numerous restrictive or ambiguous provisions from its laws. For instance, the state no longer requires physicians to consult with pain specialists when prescribing controlled substances for pain, nor does it prohibit them from prescribing pain medications to patients with chemical addictions. In addition, California's Controlled Substance and Dangerous Drugs Act of 2006 clarifies that "a person whose drug-seeking behavior is primarily due to the inadequate control of pain is not an addict." It also expands upon the state's previous Intractable Pain Treatment Act to allow the prescribing and dispensing of controlled substances to treat pain or a condition causing pain, including, but not limited to, intractable pain.

Colorado: Changed from "C+" to "B" by adopting a law that clarifies for practitioners that there is an important distinction between manslaughter and prescribing controlled substances for palliative care. The revised language identifies this misperception that is reportedly pervasive in end-of-life care and attempts to lessen its impact on patient treatment and the health care practitioners who provide it.

Connecticut: Changed from "C+" to "B" by adopting a law that establishes a prescription monitoring program to curb the illicit use of controlled substances while allowing for their legitimate medical use. The law also establishes a prescription drug monitoring working group and requires prescription monitoring program information to be reviewed by a working group member who is a pain management specialist.

Kansas: Changed from "B+" to "A" by repealing a single remaining restrictive provision from its Medical Practice Act. Kansas's Pain Patient's Quality of Care Act, effective since mid-2006, identifies pain as a significant health problem and provides that the state has a duty to restrict the inappropriate use of controlled substances while supporting physicians and other health care professionals in providing appropriate pain treatment.

Massachusetts: Changed from "B" to "B+" by adopting a law that establishes a palliative care program to ensure that pain and symptom management is an essential part of care for pediatric patients.

Michigan: Maintained its "A" grade from 2006 to 2007. The Michigan Board of Pharmacy Guidelines for the Use of Controlled Substances for the Treatment of Pain is largely based on the Federation of State Medical Boards' *Model Policy*.

New Hampshire: Changed from "C+" to "B" by adopting a law that establishes pain assessment as an essential part of patient care in residential health care facilities.

Oregon: Maintained its "B+" grade from 2006 to 2007. The state adopted laws mandating continuing education in pain management for pharmacists and establishing a Pain Management Commission as a mechanism to provide health care practitioners with education about pain management.

Wisconsin: Changed from "B" to "A" by adopting a medical board policy statement based on the Federation of State Medical Boards' *Model Policy*. The Wisconsin Pharmacy Examining Board's Position Statement on the Treatment of Pain is also largely based on the *Model Policy*.

National Legislation Proposed

Federal legislators are considering a policy to implement national pain management standards. The National Pain Care Policy Act of 2007 (HR 2994), introduced July 11, 2007, and referred to House Committee on Energy and Commerce, calls for: (1) an Institute of Medicine conference on pain care, (2) a permanent pain consortium at the National Institutes of Health to coordinate pain research across institutes and centers, (3) a grant program to provide health care practitioners with education and training on the assessment and treatment of pain, and (4) a national pain management public awareness campaign.

(continued on page 31)

Executive Committee

Lawrence H. "Larry" Mokhiber
Chairperson
One-year term

Oren M. Peacock, Jr
President
One-year term

Richard A. "Rich" Palombo
President-elect
One-year term

Gary A. Schnabel
Treasurer
One-year term

Karen M. Ryle
Member, District 1
Serving first year of a three-year term

Elizabeth Scott "Scotti" Russell
Member, District 2
Serving first year of a three-year term

Reginald B. "Reggie" Dilliard
Member, District 3
Serving third year of a three-year term

William T. "Bill" Winsley
Member, District 4
Serving third year of a three-year term

Lloyd K. Jessen
Member, District 5
Serving first year of a three-year term

Malcolm J. Broussard
Member, District 6
Serving second year of a three-year term

Cathryn J. Lew
Member, District 7
Serving first year of a two-year term

Patricia F. Harris
Member, District 8
Serving third year of a three-year term

The NABP Executive Committee is elected each year at the Association's Annual Meeting.

Internet, Interstate, International, Interwoven

By Dale J. Atkinson, JD

In this technologically advanced society, the essential public protection mission of all regulatory boards is increasing in importance due to increased availability and exposure of consumers to regulated practitioners. Of course, boards are being asked to enforce the relevant practice acts with increased diligence and decreased financial wherewithal. The Internet has enhanced consumer access to products and services, yet also caused the interpretation of regulatory language that may not coincide with contemporary practice modalities and opportunities. Boards may seek to enforce state laws against licensees who have never (or rarely) maintained a physical presence in their jurisdictions. Consider the following:

A physician residing in New Jersey was licensed by the Washington State Department of Health. Except for temporary work assignments, the licensee never resided in Washington, but maintained licensure to practice medicine in that state. In 2003, the department received two independent complaints regarding the licensee. Specifically, the complaints alleged the licensee had prescribed medications over the Internet solely based upon an online questionnaire and without any physical examination of, or direct communication with, the patient.

After an investigation, the department initiated formal administrative charges against the licensee alleging unprofessional conduct, as defined under the Uniform Disciplinary Act (UDA). The investigation revealed the following regarding the Internet-based business. Customers visit a Web site offering a variety of pharmaceutical medications. The customer applies for a prescription by completing a questionnaire that can be completed without actually reading the document or attestations contained within. The attestations purport to inquire about previous use of the requested medications, recent examinations by a physician, and that "my doctor has informed me that I should use the requested medications."

The role of the licensee in this business arrangement was to review the applications and decide whether to issue the requested prescription. The physician was paid for each application reviewed, irrespective of whether a prescription was approved. Between 2001 and 2004, the licensee reviewed approximately 200,000 requests and issued 180,000 prescriptions. He did not physically examine or personally interview any of the persons receiving the prescriptions.

A hearing was held in February 2005 before the Medical Quality Assurance Commission. Evidence was introduced identifying the business arrangement, the processes followed, and the number of prescriptions authorized. In addition, the Department of Health presented evidence from two patients for whom the licensee authorized prescriptions. Patient one requested and within days received phentermine for weight loss. The label on the bottle listed the licensee as the prescribing physician.

Patient two requested Xenical® for weight loss. In response to the questionnaire, which *required* an answer to the inquiry of identification of the specific medical condition

necessitating the need for the medication, patient two merely wrote "need Xenical."

In addition to the two patients, the department presented evidence from an employee of the Texas State Board of Pharmacy who had investigated consumer complaints about a Texas pharmacy and discovered that the licensee had authorized large numbers of prescriptions for Viagra® and sildenafil. According to records acquired by the Texas Board, the licensee had issued 2,920 prescriptions between 2001 and 2003 to patients in 50 states and territories, including Washington. The licensee testified at the hearing admitting that he never physically saw or examined any of the patients, did not diagnose the patient's condition, and did not select the drug appropriate for the alleged diagnosis. Using the licensee's words, "they [the patients] would choose their medications."

Additional expert testimony was introduced by department witnesses involving the risks of Internet prescribing that can be largely averted through testing and monitoring patients before and during medication. The department expert cited specific contraindication potentials and emphasized the importance of face-to-face assessment of the physical condition and credibility of the patients.

Conversely, the licensee experts testified that Internet prescribing is not only safe, but safer than office or hospital prescribing. The licensee experts testified that adverse reactions to drugs dispensed in office and hospital settings injure over 1 million people and result in approximately 188,000 deaths. By contrast and according to one of the licensee's experts, adverse reactions in his Internet practice are below 1%. This expert concluded that Internet prescribing is 10 times safer than office prescriptions and 100 times safer than hospital prescriptions.

The commission found that the licensee had violated the UDA in that the Internet prescribing constituted unprofessional conduct. It revoked the license indefinitely, prohibited the licensee from seeking relicensure for 10 years, and imposed a fine of $10,000. Unprofessional conduct is defined under the UDA as:

> (1) The commission of any act involving moral turpitude, dishonesty, or corruption relating to the practice of the person's profession, whether the act constitutes a crime or not . . .
> (4) Incompetence, negligence, or malpractice which results in injury to a patient *or which creates an unreasonable risk that a patient may be harmed*. The use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed [emphasis added].

The superior court affirmed the ruling of the commission and the licensee appealed the matter to the appellate court. On appeal, the licensee did not dispute the facts nor that such conduct fell below the standard of care. The licensee challenged the sufficiency of the evidence that his conduct created an unreasonable risk of harm to patients.

After identifying the burden of proof in Washington as clear and convincing, the appellate court turned its attention to the testimony of the parties. In response to the licensee's arguments that the department did not "rebut" the statistical analysis and testimony of his experts, the court noted that the department is entitled to accept and disregard testimony. It held that the department "was persuaded and agreed with the expert testimony provided by [commission witness]," which it is entitled to recognize. In short,

(continued on page 30)

Attorney Dale J. Atkinson is a partner in the law firm of Atkinson & Atkinson, counsel for NABP.

Generic Substitution Raises Questions, Concerns for Some Patient Groups

Since the introduction of generic drugs, controversy has followed. Amidst the science of determining bioequivalence and the approval system managed by the Food and Drug Administration (FDA) are concerns that individual patient variances should be considered when determining medication therapies.

The common belief is that generic medications can take a sizable chunk out of health care costs. And, with that belief, few would quibble over the slight variations observed between different formulations of the same medication.

In some, more sensitive patient populations, however, medical experts say slight variations can make a major difference in patient health and safety. In recent years, studies have been published showing sensitivity to minor differences in drug formulations among organ transplant patients receiving immunosuppressives, epilepsy patients receiving anticonvulsants, cardiac patients receiving antiarrhythmic and anticoagulation treatments, and patients taking medication to treat thyroid disorders.

FDA Requires Bioequivalence

FDA requires manufacturers of generic medications to demonstrate chemical equivalence and bioequivalence of their products with the name-brand drugs they replicate. The two formulations must have equal amounts of the same active ingredient, be of the same dosage form and route of administration, and achieve an AUC and Cmax ranging from 80% to 125% of the branded product. Satisfaction of these criteria is considered indicative of a similar rate and extent of bioavailability of the two formations, such that their efficacy and safety can be expected to be essentially the same.

Some Question Bioequivalence Tests

Health care groups including the American Academy of Neurology, American Association of Clinical Endocrinologists, The Endocrine Society, and American Thyroid Association have raised concerns regarding criteria for determining bioequivalence and, thus, the acceptability of substituting one drug manufacturer's formulation for another in the treatment of conditions such as epilepsy and thyroid dysfunction.

The American Heart Association (AHA) also has raised concerns regarding the safety and efficacy of drug substitutions in antiarrhythmic and anticoagulation treatment, noting that drugs considered bioequivalent may still vary in terms of pharmacokinetics. AHA states on its Web site, "the antiarrhythmic properties or potential toxic effects of the two drugs may not be clinically equivalent."

Some studies have shown that the inactive ingredients contained in variant formulations of the same medication can impact absorption of the drug and, thus, the patient's blood drug level. According to AHA, the common assumption is that these inactive ingredients will not alter the performance of the medication; however, as these ingredients may include lactose or gluten, "they could change gut motility and drug absorption in sensitive patients."

The precise effects of the medication, therefore, may vary in patients with certain medical conditions. In epilepsy patients, for instance, a slightly lower absorption rate of a

variant formulation of an anticonvulsant, and the resulting slightly lower blood drug level, can lead to breakthrough seizures. Likewise, in transplant patients taking immunosuppressive medication, a lower blood drug level can lead to graft rejection.

AHA concludes that, "although generic drug approval requires demonstration of chemical equivalence and bioequivalence . . . published reports and our survey indicate that these equivalencies do not guarantee therapeutic equivalence, which is what caregivers desire and patients expect."

These discrepancies cause some medical experts to question rules authorizing – or, in some states, requiring – pharmacists to substitute a generic formulation for a prescribed name-brand medication. Proponents cite the extensive training pharmacists complete to become medication experts, therefore making them well qualified to make such decisions. Others note, however, that certain patient populations are prone to comorbidities, the existence of which pharmacists may be unaware. Thus, critics stress that pharmacists should not substitute the prescribed medication for another formulation – generic or otherwise – without the consent of the prescriber and the patient, and that substitution should take place only under the close supervision of a physician to ensure efficacy and safety.

> Some studies have shown that the inactive ingredients contained in variant formulations of the same medication can impact absorption of the drug and, thus, the patient's blood drug level.

"For many drugs, especially those with a narrow therapeutic range, therapeutic drug concentration or pharmacodynamic monitoring is necessary to assure the desired clinical response," the American Medical Association (AMA) notes in the June 2007 "Report 2 of the Council on Science and Public Health." "Such monitoring is necessary irrespective of whether the drug is a brand name or generic product." AMA also recommends that, "when a prescription for a generic drug product is refilled (eg, for a patient with a chronic disease), changing the manufacturer should be discouraged, whenever possible, to avoid confusion for the patient."

State Laws Address Generics

According to the 2008 *Survey of Pharmacy Law*, 38 jurisdictions currently give pharmacists the option to substitute generic medications for name-brand drugs, while 14 states require it, in an effort to control state medical costs. Ten states make exceptions to their generic substitution regulations for medications used in the treatment of epilepsy or other medications having a narrow therapeutic index (NTI), defined by FDA as less than a two-fold difference between minimum toxic concentration and minimum effective concentration.

In 2007, several more states considered legislation that would prohibit pharmacists from substituting a prescribed epilepsy medication without the knowledge and/or consent of the prescriber and/or the patient or patient's representative. Among them are Ohio (House Bill [HB] 99), Georgia (HB 127 and Senate Bill [SB] 294), Illinois (SB 1227), Wisconsin (SB 71), and Wyoming (HB 317).

Patent Expirations Fuel Worries

Patient advocacy groups, such as the Epi-

(continued on page 30)

Streamlined Processes Lead to Increase in FPGEE Administrations

In 2007, the number of applicants that sat for the Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®) increased to 3,841, an additional 358 individuals more than in 2006. This 10.3% growth can be directly attributed to the streamlined Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) application process, which has significantly decreased the amount of time applicants must wait for approval to take the FPGEE.

Every year, approximately 55 countries are represented at the FPGEE administration. Of the 55 countries, approximately 75% of the total applicants who took the FPGEE in 2007 originated from five countries. India had the highest number of applicants, followed by the Philippines, Korea, Egypt, and Nigeria.

With the update of the FPGEE Blueprint in early 2007, the Pre-FPGEE® was temporarily deactivated until the new standard setting was instituted. As a result of this process, the number of individuals who utilized the Pre-FPGEE in 2007 significantly decreased. The Pre-FPGEE was reactivated in fall 2007.

NAPLEX

In keeping with previous years, the annual total number of candidates who sat for the North American Pharmacist Licensure Examination™ (NAPLEX®) increased in 2007. From January 1, 2007 to December 31, 2007, there were a total of 12,785 NAPLEX administrations compared to 12,388 administrations in 2006. Despite the suspension of the NAPLEX in late September, NAPLEX administrations still managed to reach projected numbers. This 3.2% growth (397 administrations) can be attributed to the steady increase in the number of pharmacy school graduates every year.

Examination	2006	2007	% Increase
FPGEE	3,483	3,841	10.3%
NAPLEX	12,388	12,785	3.2%
MPJE	17,168	18,076	5.3%

In 2007, all of the major NABP examinations saw an increase in administrations.

A total of 9,862 candidates took the NAPLEX for the first time in 2007. As in the past, these first-time candidates performed better than those retaking the examination, with a 95.3% passing rate compared to an overall passing rate of 88.9%. Generally, first-time candidates perform better on the NAPLEX because their knowledge and skills related to the practice of pharmacy are most up-to-date.

The number of individuals who utilized the Pre-NAPLEX, the only practice examination for the NAPLEX developed by NABP, also continues to grow. In 2007, a total of 6,258 individuals took the Pre-NAPLEX, an increase of 685, or 12.3%, from the 5,573 individuals who took the practice examination in 2006. As the numbers for the NAPLEX continue to increase, numbers are expected to climb for the Pre-NAPLEX.

MPJE

A total of 18,076 candidates sat for the Multistate Pharmacy Jurisprudence Examination® (MPJE®) in 2007 compared to 17,168 administrations in 2006, representing an increase of 908 individuals, or 5.3%. This growth of MPJE administrations may be attributed to the increase in licensure transfers during 2007. (Details on licensure transfer statistics will be available in the March 2008 *NABP Newsletter.*) In addition to the rise in administrations, the overall passing rate increased from 87% in 2006 to 89.6% in 2007.

December FPGEE Scores Released; June 2008 Date Announced

On Saturday, December 1, 2007, a total of 1,759 applicants sat for the NABP Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®) administration. The FPGEE was administered in three United States locations: Brooklyn (New York City), NY; Northlake (Chicago), IL; and San Jose, CA. Applicants who sat for the December FPGEE received their scores in January 2008. The next FPGEE is scheduled for June 28, 2008, and will be administered in New York, NY; Northlake, IL; and San Mateo, CA.

NABP provides the Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) Certification as a means of documenting the educational equivalency of applicants' foreign pharmacy education and their foreign licensure and/or registration status. Applicants are required to pass the FPGEE, a paper-and-pencil administration that covers pharmacy curriculum subject areas, as well as demonstrate English language proficiency by attaining the combination of the minimum passing Test of English as a Foreign Language™ (TOEFL®) and Test of Spoken English™ (TSE®) scores or the minimum passing TOEFL Internet-based Test (iBT) score. The TSE examination will continue to be administered until the TOEFL iBT is phased in worldwide.

Applicants preparing to sit for the FPGEE can familiarize themselves with the examination by utilizing the Pre-FPGEE, a Web-based practice examination that exhibits the types of questions provided on the actual FPGEE.

Additional information regarding the FPGEE, FPGEC, and Pre-FPGEE is available in the *FPGEC Application Bulletin* and in the frequently asked questions section of the NABP Web site at *www.nabp.net.*

Sterile Compounding 'Checklist' Revised to Better Protect Patient Health; New USP Chapter Effective June 2008

As complex and technical as health care has become, sometimes a few simple, decidedly non-technical precautions can make a considerable difference in patient safety. Many scoffed at this premise when Michigan hospitals implemented a simple checklist in 2003 to ensure that staff followed aseptic procedures to prevent infections. But they couldn't argue with the results – $175 million in medical costs averted, and more than 1,500 lives saved in an 18-month period. And if it worked there, it can work in the pharmaceutical compounding environment, says Eric Kastango, MBA, RPh, FASHP, an elected member of the United States Pharmacopeia (USP) Sterile Compounding Expert Committee.

As a member of the USP Expert Committee, Kastango took part in revising USP General Chapter 797 "Pharmaceutical Compounding – Sterile Preparations." With the recognition of a few simple premises, backed by evidence-based science, the standards have been revised to better protect patient health, says Kastango, president and chief executive officer of Clinical IQ, LLC, a Florham Park, NJ-based pharmaceutical consulting firm.

Explaining how the revised chapter improves patient safety, Kastango cites an *Annals of Medicine* article printed December 10, 2007, in *The New Yorker,* which explains how a simple checklist reduced the incidence of hospital-acquired infections in Michigan's intensive care units (ICUs) by 66% within three months. The program was implemented in 2003 at the request of the Michigan Health and Hospital Association to ensure that ICU staff in Michigan hospitals consistently followed all prescribed infection prevention procedures. Results of the program, published December 2006 in *The New England Journal of Medicine,* indicated that, on average, the Michigan ICUs cut their quarterly infection rate to zero, outperforming 90% of ICUs nationwide, and sustained their successes for almost four years (at which time the results were published).

USP Chapter 797 is, essentially, the authoritative checklist for sterile compounding. It sets official, minimum practice standards for the preparation, storage, and handling of compounded sterile preparations to ensure that patients receive sterile, safe, and accurate compounded medications.

Recently, the USP Expert Committee assessed the chapter to ensure that all procedures described therein are based on the most current knowledge and constitute the most effective means of ensuring product quality and patient safety. By adjusting their sterile compounding procedures accordingly, Kastango says, practitioners can bring about a dramatic reduction in adverse events associated with sterile compounding.

Published on the USP Web site on December 3, 2007 and effective June 1, 2008, the revised chapter is the culmination of 30 months of work by the USP Expert Committee, involving the review of more than 500 comments from health care professionals and other stakeholders, evaluation of clinical evidence, and consultation with special advisory panels. "This thing was really vetted out," Kastango says. He credits the dedication of the Expert Committee's 11 members, along with the leadership of its chairman, David W. Newton, PhD, who coordinated their efforts. The revisions will be included in *USP 32–NF 27* and in the second edition of the *Pharmacists' Pharmacopeia,* which will be published in March 2008. The revised standards have been published online to give the compounding community time to implement changes before the effective date.

"The Sterile Compounding Expert Committee made every effort during their revision process to take into consideration the ultimate goal of maintaining sterility in the process of compounding sterile preparations so that the patient would benefit and not be harmed," says Shawn C. Becker, MS, BSN, RN, of the USP Center for the Advancement of Patient Safety. "Chapter 797 provides a foundation for the development and implementation of essential procedures for the safe preparation of compounded sterile preparations, which are classified according to the potential for microbial, chemical, and physical contamination."

Most of the revisions are based on improved technology and new information regarding effective measures for preventing contact contamination and maintaining air quality during sterile compounding. Evidence shows that practitioners, themselves, are the primary source of contamination, the committee found. This basic premise underlies many of the changes. "Special emphasis was placed on the use of sterile 70% isopropyl alcohol, special cleaning and disinfecting of the sterile compounding areas, and proper garbing and gowning to ensure patient safety," Becker says.

Other revisions highlight the importance of staff training on proper garbing and disinfection techniques, clarify appropriate use of technology to maintain sterility during compound preparation, and harmonize the sometimes conflicting quality standards of various US federal health agencies with each other and with international standards. The revised chapter also includes new sections addressing hazardous drugs, radio pharmaceuticals, and allergen extracts. A new appendix summarizes the usage and properties of several disinfectant chemicals, and three new performance checklists, presented as Appendices III-V, assess hand hygiene and garbing, aseptic technique and practices for compounding personnel, and cleaning and disinfection procedures.

(continued on page 34)

Legal Briefs

(continued from page 25)

there was nothing for the department to rebut.

The court also emphasized that the commission was the ultimate fact finder and was entitled to weigh the credibility of each witness and determine the weight given to each opinion, if any. The court may not reevaluate the record to make an independent determination.

Furthermore, the court referenced why the commission found the licensee experts to be unconvincing. It noted that the statistics relied upon were based upon voluntary reporting in response to e-mail solicitations. While the expert used the entire sample figures for calculating percentages, in actuality less than half of 1% responded to the surveys. Also, the court noted that both licensee experts had been disciplined in other jurisdictions for Internet prescribing. Indeed, one expert had his license to practice medicine revoked in 19 of 20 states, and was reticent to disclose that his remaining license in Delaware would soon be revoked under reciprocal discipline.

The court also rejected arguments propounded by the licensee related to the lack of intent of the two patients to actually take the prescribed medications and due process related to prejudgment of the commission based upon established guidelines for Internet practice. The court held that the intent of the patient, which is subject to change, is not the issue and that merely possessing the medication posses the risk. Regarding the prejudgment or bias of the commission, the court rejected that combined prosecutorial, investigative, and adjudicative roles in the regulatory process offend the due process rights of licensees. The commission-adopted guidelines, using American Medical Association policies, were within the authority of the regulatory body, and their enforcement promotes public protection.

Accordingly, the court upheld the revocation of the license in all respects. Many important issues from this opinion can benefit boards of pharmacy including the role of expert witnesses, the weight placed upon such testimony, and the potential for significantly differing opinions. In addition, the fact that licensees may not reside in a particular jurisdiction, but practice through technologically advanced modalities may challenge the scope of practice within state laws. Finally, the importance of Washington's pursuit of the licensee and the public protection impact upon his licenses elsewhere must be emphasized.

Ancier v State of Washington, Department of Health, 166 P 3d 829 (App Ct WA 2007)

Substitution

(continued from page 27)

lepsy Foundation, advocate this type of legislation across the board. In a statement posted on its Web site, the Epilepsy Foundation "advises that all rule-making bodies . . . address the potential adverse effects of changing from one formulation of an antiepileptic drug to another, by requiring the prior expressed permission of the treating physician and the patient." Such legislation is especially pertinent given the impending expiration of patents for several antiepilepsy drugs, including Keppra® and Lamictal® in July 2008, Topamax® in September 2008, and Felbatol® in September 2009.

Likewise, the impending expiration of certain immunosuppressant medications indicated for the treatment of transplant patients has raised similar worries regarding generic substitution in this population. In 2008, the patent for Prograf ® (tacrolimus) will expire, and generic versions of the medication will become available. Greater than 80% of lung transplant recipients, greater than 50% of heart transplant patients, and the majority of abdominal transplant (liver, kidney, pancreas) patients are prescribed Prograf as part of their maintenance immunosuppression. Dosing is based on serum tacrolimus levels and it is considered an NTI medication. In 2009, the patent on CellCept® (mycophenolate mofetil) will also expire. CellCept comprises another part of the maintenance immunosuppression in the majority of organ transplant patients in the United States.

Transplant Patients Shown Vulnerable

Transplant patient groups have expressed concerns regarding the assumed equivalence of different formulations, noting that equivalency testing is performed on a limited number of healthy individuals, and not on patients who may have altered metabolism or drug clearance after a liver or kidney transplant.

In many cities, the wait for a kidney transplant can be five years or longer. Thus, ensuring the viability of the transplanted organ for as long as possible is no small matter for health care providers and patients alike. Given the critical nature of this circumstance and the demonstrated sensitivity of transplant patients, medical experts have indicated that the safest

(continued on page 35)

Optional Events Provide Networking Opportunities for Attendees

The NABP 104th Annual Meeting continues to provide attendees with the opportunity to network and share information with their fellow board members and other pharmacy professionals. Held May 17-20, 2008, at the Baltimore Marriott Waterfront in Baltimore, MD, attendees will be able to attend important business sessions as well as have the opportunity to participate in the Optional Tour, the Fun Run/Walk, and the Annual Meeting Orientation.

The Baltimore Charm City Tour

Attendees and their guests will experience Baltimore's history and culture during the optional Baltimore Charm City Tour, to be held Monday, May 19 at 1:30 PM. Beginning at Fells Point, an old port characterized by cobblestone streets, participants will have a chance to shop at the local boutiques and food venues. Next, knowledgeable tour guides will provide commentary and narration during the bus portion of the tour, which winds through the Inner Harbor. As attendees view the sites, the guides relate the history of the harbor and significant landmarks. Time permitting, participants will ride through the neighborhood of Mount Vernon, including the Walters Art Museum, the Peabody Institute, the Engineers Club, and other historical sites. The bus will then proceed past the Baltimore Basilica and Edgar Allen Poe's home and grave before traveling to Fort McHenry, the final stop in the tour and Francis Scott Key's inspiration for writing "The Star Spangled Banner." The tour of the fort will begin with a 20-minute movie. Guides from each bus will narrate the sites of the fort to attendees as they walk through the building and grounds.

The cost of the tour is $36. Advanced registration is required by April 25, as space is limited.

Annual Fun Run/Walk

For the 10th consecutive year, NABP will offer its Fun Run/Walk, which will take place on Sunday, May 18 from 6:30 to 7:30 AM. Sponsored by Pfizer Inc, the run/walk will begin at the Katyn Memorial, the circle park in front of the Baltimore Marriott Waterfront, and follow the Inner Harbor Promenade, covering the most scenic area of the Harbor, to the Rusty Scupper on the edge of Federal Hill and then back to the hotel, providing participants with both a historic view of the surrounding area as well as a chance to warm up for the day's Annual Meeting activities. Participants will receive their Fun Run/Walk T-shirt when they check in for the meeting at the Registration/Information Desk, and bottled water and granola bars will be provided the morning of the event. Participants are asked to register (at no charge) by April 25.

Annual Meeting Orientation

Recently appointed board of pharmacy members or those members attending their first NABP Annual Meeting are encouraged to attend the Annual Meeting Orientation from 5 to 6 PM on Saturday, May 17, where they will hear about the procedures followed during the Annual Meeting.

Registration and more information about the 104th Annual Meeting are available on the Meetings section of the NABP Web site at *www.nabp.net.*

Pain Medication Policies

(continued from page 23)

Also pending, the Veterans Pain Care Act of 2007 is designed to ensure improvements in pain care services, research, education, and training for the benefit of active duty and veteran patient populations.

New Formulations Investigated

At a National Institute on Drug Abuse (NIDA) conference in March 2007, pain medication experts discussed ways that opioid medications can be formulated to minimize the risk of abuse, such as extended-release or crush-resistant formulations. A new class of opioids developed by NIDA-funded researchers targets functionally paired receptors in the brain and may provide pain treatment with fewer side effects and less potential for abuse. Researchers are also investigating genetic and behavioral characteristics that predispose patients to opioid abuse.

Many pain care experts agree that further research is needed to support the development of pain treatments with little or no risk of abuse and the identification of patients who may be vulnerable to opioid abuse and addiction. Further information will ultimately provide evidence-based guidance on pain management that minimizes the risks of opioid abuse and addiction.

May 17-20, 2008 Baltimore Marriott Waterfront Baltimore, MD

Saturday, May 17, 2008

10 AM - 7 PM
Registration/Information Desk Open

2 - 4 PM
Pre-Meeting CPE Programming
Teen Addiction – Prescription Medications: The New Heroin?
ACPE #205-000-08-001-L04-P
(0.2 CEU – 2 contact hours)

5 - 6 PM
Annual Meeting Orientation

7 - 10 PM
President's Welcome Reception
Dinner will be served.
Dress: business casual

Sunday, May 18, 2008

6:30 AM - 5:15 PM
Registration/Information Desk Open

6:30 - 7:30 AM
Fun Run/Walk
Sponsored by Pfizer Inc

8 - 11:30 AM
Hospitality Brunch
(Same area as Poster Session.)

8 - 11:30 AM
Joint CPE Programming
Educational Poster Session
ACPE #205-000-08-002-L04-P
(0.1 CEU – 1 contact hour)

12 - 4 PM
First Business Session

- Welcome Remarks
  - -Call to Order
  - -Presentation of Colors
  - -National Anthem
  - -Greetings from the Host State
- Keynote Address: **Tom Daschle**, Former Senate Majority Leader
- Report of the Executive Committee
- President's Address
- Report of the Treasurer
- Report of the Committee on Constitution and Bylaws
  - -Reading of Proposed Amendments
- Announcement of Candidates for Open Executive Committee Officer and Member Positions

4 - 5 PM
Joint CPE Programming
Legislative and Regulatory Update
ACPE #205-000-08-003-L03-P
(0.1 CEU – 1 contact hour)

Monday, May 19, 2008

7 AM - 2 PM
Registration/Information Desk Open

7 - 8 AM
NABP/USP Breakfast
Sponsored by United States Pharmacopeia

8:15 - 10:15 AM
Joint CPE Programming
Pedigree Update: RFID and Diversion from Common Carriers
ACPE #205-000-08-004-L04-P
(0.2 CEU – 2 contact hours)

10:30 AM - noon
Second Business Session

- Report of Executive Director/Secretary
- Report of the Committee on Resolutions
  - -First Reading of Resolutions
- Vote on Proposed Amendments to the Bylaws
- Candidate Speeches for Open Executive Committee Officer and Member Positions

Noon - 12:30 PM
Informal Member/Candidate Discussion

1:30 - 5 PM
Optional Tour
Baltimore Charm City
(Afternoon free.)

Tuesday, May 20, 2008

7:30 AM - 4:15 PM
Registration/Information Desk Open

8 - 9 AM
Continental Breakfast

9 - 10:30 AM
Executive Officer and Board Member CPE Programming
Medicaid Fraud: Tamper-Resistant Prescription Pads and Beyond
ACPE #205-000-08-005-L04-P
(0.15 CEU – 1.5 contact hour)

9 - 10:30 AM
Compliance Officer CPE Programming
Case Strategy: How to Investigate an Internet Pharmacy
ACPE #205-000-08-006-L04-P
(0.15 CEU – 1.5 contact hour)

10:45 AM - 12:15 PM
Joint CPE Programming
Compounding Update: Where is USP 797?
ACPE #205-000-08-007-L04-P
(0.15 CEU – 1.5 contact hour)

12:15 - 1:30 PM
Lunch Break
On your own.

1:30 - 4 PM
Final Business Session

- Election of 2008-2009 Executive Committee Officers and Members
- Remarks of the Incoming President
- Installation of Executive Committee Officers and Members
- Final Report of the Committee on Resolutions
  - -Discuss and Vote on Resolutions
- Invitation to the 2009 Annual Meeting

5:45 - 6:45 pm
NABP/NACDS Reception
Sponsored by the National Association of Chain Drug Stores

7 - 10:30 PM
Annual Awards Dinner
Dress: semiformal

Program subject to change.

NABP and the NABP Foundation is accredited by the Accreditation Council for Pharmacy Education (ACPE) as a provider of continuing pharmacy education. ACPE Provider Number: 205. Participants may earn up to nine hours of ACPE-approved continuing pharmacy education credit from NABP. Participants in continuing pharmacy education programs will receive credit by completing a "Statement of Continuing Pharmacy Education Participation" and submitting it to NABP. A validated Statement of Continuing Pharmacy Education Credit will be sent as proof of participation within approximately six weeks. Full attendance and completion of a program evaluation form for each session are required to receive continuing pharmacy education credit and a Statement of Continuing Pharmacy Education Credit.

Continuing Legal Education (CLE) Policy: NABP staff will be available to assist attendees on an individual basis to apply for CLE credit for attending conference CPE sessions. To apply for CLE credit, attendees must initiate the program approval process in their own states by completing and submitting the appropriate application materials and forms. NABP will provide documentation as necessary.

Hospitality Brunch and Educational Table Top Display Offer Participants Chance to Network, Gain Knowledge

Attendees of the 104th Annual Meeting will have yet another chance to network during the Hospitality Brunch on Sunday, May 18, 2008. From 8 to 11:30 AM, attendees will be able to gather with colleagues supportive of the objectives of the boards of pharmacy, while partaking in a full buffet brunch.

In addition, educational table top displays by NABP, federal regulatory agencies and other associations will highlight important issues and programs, and will be set up in the area. During this time, attendees will also have the opportunity to meet members of the Maryland Board of Pharmacy and get a local perspective on the must-see sites surrounding the area at the host state table top display.

The Educational Poster Session will also be held in the same area as the Hospitality Brunch. Displays will contain information, such as a board of pharmacy's best or most noteworthy legislative issues, policy development, disciplinary cases, and researched results that fall within the theme, "Protecting the Public Health." Universities and colleges of pharmacy will also display educational posters.

By attending the Poster Session, participants have the opportunity to earn one contact hour (0.1 CEU) of Accreditation Council for Pharmacy Education-approved continuing pharmacy education (CPE) credit. Attendees will need to spend a minimum of 50 minutes in the Poster Session area, discussing the poster displays with presenters in order to earn CPE credit.

To reserve a display area, all interested boards, universities, and colleges of pharmacy can contact NABP Professional Affairs Manager Eileen Lewalski via e-mail at elewalski@nabp.net by **Monday, March 3, 2008**. More information about the Educational Poster Session is also available in the January 2008 issue of the *NABP Newsletter.*

Register Now for 104th Annual Meeting to Receive Early Rate

Registrants who sign up for the 104th Annual Meeting on or before **Friday, April 4, 2008**, will be eligible to receive the early registration rate. The meeting will take place May 17-20 at the Baltimore Marriott Waterfront in Baltimore, MD. Attendees can register directly online by visiting the Meetings section of the NABP Web site at *www.nabp.net.* A printable registration form is also available to download. Both types of registration offer attendees three payment options: (1) mailing in the payment, (2) using a credit card, or (3) paying on site. Those individuals eligible for the board of pharmacy group rate may also take advantage of online registration; those whose board will be processing the payment and sending it to the NABP at a later date, may simply choose "Mail in Payment."

During the Annual Meeting attendees will have the opportunity to assist in defining the direction of NABP by participating in business sessions during which officers and members of the NABP Executive Committee will be elected and resolutions will be voted upon. In addition, participants may earn up to nine hours of credit by attending Accreditation Council for Pharmacy Education-approved continuing pharmacy education sessions led by educators, regulators, and others who will share their knowledge, experience, and insight of pharmacy regulation.

NABP is offering a special meeting rate at the Baltimore Marriott Waterfront for $199 single/double occupancy plus 13.5% state and local tax. Rooms may be reserved online by visiting the Meetings section of the NABP Web site and clicking on the hotel special group page link created specifically for attendees of the Annual Meeting. Attendees may also make their room reservations by calling the hotel directly at 410/385-3000 or by utilizing the central reservations number at 1-800/228-9290. Attendees are asked to mention that they will be attending the NABP 104th Annual Meeting. To ensure accommodations, reservations must be received by the Baltimore Marriott Waterfront no later than Thursday, April 17. The last event of the 104th Annual Meeting is the Annual Awards Dinner, which will take place from 7 - 10:30 PM on Tuesday, May 20.

Special airfare and car rental rates are available by calling the NABP official travel agency, Options Travel, at 1-800/544-8785, and mentioning the NABP meeting code number, NABP104.

Around the Association

Board Member Appointments

- **Jeannine G. Dickerhofe, RPh, MS,** was appointed a member of the Colorado State Board of Pharmacy. Dickerhofe's appointment will expire on July 1, 2011.
- **Leonard L. Hierath, BA, BS,** was appointed a member of the Colorado State Board of Pharmacy. Hierath's appointment will expire on July 1, 2011.
- **John Croce, BS,** was appointed a member of the New York State Board of Pharmacy. Croce's appointment will expire on January 31, 2012.
- **Fernando Gonzalez, BS,** was appointed a member of the New York State Board of Pharmacy. Gonzalez's appointment will expire on January 31, 2012.

Board Member Reappointments

- **E. Katherine Edelblut, RPh,** has been reappointed as a member of the Colorado State Board of Pharmacy. Edelblut's appointment will expire on July 1, 2011.

(continued on page 35)

DEA Rule Allows Multiple Rxs For Controlled Meds

Drug Enforcement Administration (DEA) recently published in the *Federal Register* a final rule titled "Issuance of Multiple Prescriptions for Schedule II Controlled Substances." Effective December 19, 2007, the rule amends DEA regulations to allow practitioners to provide an individual patient with multiple prescriptions for a specific Schedule II controlled substance, written on the same date, to be filled sequentially.

In states where the law is not more stringent this change will allow patients to receive over time up to a 90-day supply of the prescribed controlled substance. The Controlled Substances Act does not permit the refilling of Schedule II controlled substances; a new prescription must be issued for each quantity of the substance.

More information is available in the *Federal Register* (Docket No. DEA-287) at *http://a257.g.akamaitech.net/7 /257/2422/01jan20071800/edocket.access.gpo.gov/2007/E7-22558.htm.*

FDA Targets Sales of Unapproved Hydrocodone Products

FDA is taking action against companies that market unapproved medications containing hydrocodone. The vast majority of antitussive products containing hydrocodone have not been approved.

FDA is particularly concerned about the use of unapproved hydrocodone cough medicines in children. No hydrocodone cough suppressant has been shown safe and effective for children younger than 6; yet some of these unapproved products have dosing instructions for children as young as 2.

In addition, FDA has received reports of medication errors associated with changes in the formulation of unapproved hydrocodone products, as well as name confusion between approved and unapproved products.

Uniform Standards for e-Prescribing

Centers for Medicare and Medicaid Services (CMS) recently published a notice in the *Federal Register* proposing the adoption of final uniform standards for an electronic prescription drug program, as required by §1860D-4(e)(4)(D) of the Social Security Act. It also proposes the adoption of a standard identifier for providers and dispensers for use in e-prescribing transactions under §1860D-4(e)(3) and §1860D-4 (e)(4)(C)(ii), and §1102 of the act.

More information is available in the *Federal Register* (Docket No. CMS–0016–P) at *http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-5681.pdf.*

New USP Chapter Effective June 2008

(continued from page 29)

Similar to the reaction of some Michigan ICU staff members when the checklists were introduced there, many compounding practitioners are resistant to change, Kastango notes. "They fight it. But it is a part of continuing professional development," he says. To reduce the incidence of adverse events associated with sterile compounding, practitioners must improve their practice procedures to account for advances in technology and knowledge, as reflected in the revised chapter, Kastango says.

To familiarize practitioners with the revised standards, USP is offering eight 90-minute educational Web-based seminars in February through June 2008, as well as three two-day workshops scheduled for March 31-April 1, April 17-18, and May 22-23 at USP headquarters in Rockville, MD. All workshops will provide attendees with Accreditation Council for Pharmacy Education-approved continuing education credit.

"Our goal is to create a culture of quality," Kastango says. "It requires vigilance, practice, and perseverance." The end result, he says, will be a considerable reduction in adverse events and a notable improvement in patient safety.

More information and the complete revised Chapter 797 are available via the USP Web site at *www.usp.org/USPNF/pf/generalChapter797.html.*

WA Board Adopts Rule for Reporting Suspicious PSE Transactions

The Washington State Board of Pharmacy has adopted a rule to further deter the purchase of pseudoephedrine (PSE) products for use in the illegal manufacture of methamphetamine. Effective December 10, 2007, the rule establishes criteria under which pharmaceutical manufacturers and wholesalers should report to the Board any suspicious transactions involving the sale, transfer, or finishing of products containing PSE, ephedrine, or phenylpropanolamine to retailers.

The rule defines a "suspicious transaction" as one that would lead a "reasonable person" to believe the substance will likely be used to illegally manufacture a controlled substance, that involves cash payment of more than $200, that meets Drug Enforcement Administration criteria for suspicious orders, and that includes regulated products exceeding 10% of nonprescription drugs contained in the order.

The rule is posted on the Board's Web site at *https://fortress.wa.gov/doh/hpqa1/hps4/pharmacy/default.htm.*

California Passes Law on Standardized Rx Medication Labeling

The California legislature recently passed legislation to adopt standardized labeling for prescription medications. The legislation requires the California State Board of Pharmacy to promulgate regulations mandating a "standardized, patient-centered" label on all prescription medications dispensed via outpatient community pharmacies and mail-order pharmacies to patients in California by January 1, 2011.

The legislation (Senate Bill 472) also requires the Board to hold public meetings statewide to solicit input from consumer and professional groups, and to consider factors including medical literacy research, improved directions for use, improved font types and sizes, placement of patient-centered information, the needs of patients with limited English proficiency, the needs of senior citizens, and technology requirements necessary to implement the standards.

More information is available via the California State Senate Web site at *http://info.sen.ca.gov/pub/07-08/bill/sen/sb_0451-0500/sb_472_cfa_20070702_111127_asm_comm.html.*

Substitution

(continued from page 30)

course of action for a patient with stable graft function is to continue using the prescribed medication from the same manufacturer. If a formulation is substituted, the patient would need additional blood tests to ensure a consistent blood drug level.

Prescriber Can Prohibit Substitution

Ultimately, the prescriber has the authority to determine whether the prescribed medication may be substituted. The required wording and format of this directive vary from state to state, but by indicating on the prescription that the medication should not be substituted, or should be dispensed as prescribed, the physician can specify whether the pharmacist is authorized to substitute a less expensive formulation.

With certain patient sensitivities in mind, some health care experts advise pharmacists authorized or required by law to substitute generic for brand-name medications, or one generic formulation for another, to consult the prescriber and patient before substituting medications prescribed for life-threatening conditions. They stress that the conversion to an alternate drug formulation, particularly in sensitive patient populations, is a decision that needs to be planned and monitored to ensure patient safety.

Around the Association

(continued from page 34)

- **Averil Strand, RN,** has been reappointed as a member of the Colorado State Board of Pharmacy. Strand's appointment will expire on July 1, 2011.

Board Officer Changes

The Michigan Board of Pharmacy elected the following officer to the Board:

- **Suhair Farida, RPh**, Chairperson

The Montana Board of Pharmacy elected the following officers to the Board:

- **Mark Meredith, RPh,** President
- **James Cloud, CPhT,** Vice President
- **Colette Bernica,** Secretary

The Nevada State Board of Pharmacy elected the following officer to the Board:

Barry Boudreaux, RPh, President

The New York State Board of Pharmacy elected the following officers to the Board:

- **Susan Ksiazek, RPh,** Chairperson
- **John Carlo, RPh,** Vice Chairperson

NEWLY ACCREDITED VAWD FACILITIES

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

Abbott Laboratories
Abbott Park, IL
Accredited December 13, 2007

Becton, Dickinson and Company, dba BD Distribution Center
Swedesboro, NJ
Accredited December 14, 2007

Factor Health Management, LLC
Boca Raton, FL
Accredited November 30, 2007

Gulf Coast Pharmaceuticals
Ocean Springs, MS
Accredited December 14, 2007

Letco Medical, Inc dba The Letco Companies
Decatur, AL
Accredited December 13, 2007

Prasco, LLC dba Prasco Laboratories
Mason, OH
Accredited November 29, 2007

Priority Air Express, LLC dba Priority Solutions International
Swedesboro, NJ
Accredited November 30, 2007

ProCare Pharmacy Direct, Inc dba PharmaCare Specialty Pharmacy #2921
Pittsburgh, PA
Accredited December 13, 2007

Seacoast Medical, LLC dba Seacoast Medical
Omaha, NE
Accredited November 29, 2007

Triplefin, LLC dba Triplefin
Cincinnati, OH
Accredited December 13, 2007

Wyeth Pharmaceuticals Division of Wyeth
Sparks, NV
Accredited November 29, 2007

A full listing of accredited VAWD facilities is available on the NABP Web site at *www.nabp.net*.

nabp newsletter

National Association of Boards of Pharmacy

1600 Feehanville Drive

Mount Prospect, IL 60056

First Class
U.S. POSTAGE
PAID
Permit #583
Schaumburg, IL 60173

NABP 104th ANNUAL MEETING
Registration now available at *www.nabp.net*.