INNOVATIONS

NABP and Member Boards Partner on Data Sharing Initiatives, Prepare for Future Enhancements to e-Profile Connect
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NABP Executive Committee elections are held each year at the Association’s Annual Meeting.

3

INNOVATIONS®

November/December 2017 innovations | 2

Legal Briefs
Nurse License Up In Smoke

Interactive Forum
With Ongoing Rollout of DSCSA Provisions, NABP Provides Members Guidance for Regulation of Wholesale Distributors

Executive Officers Convene to Discuss Current Challenges During Interactive Forum

114th NABP Annual Meeting
Proposed Amendments to the NABP Constitution and Bylaws Due in March

State Board News
Illinois Adopts New Patient Counseling Rules

Professional Affairs Update
New Study Shows Substantial Variation in the Availability of Pharmacies Across the Country

Feature News
NABP and Member Boards Partner on Data Sharing Initiatives, Prepare for Future Enhancements to e-Profile Connect

Data Security Corner
NABP Cyber Security Initiatives Protect Data
Interview With a Board Executive Director

Alex J. Adams, PharmD, MPH
Executive Director, Idaho State Board of Pharmacy

How long have you served as executive director of the Idaho State Board of Pharmacy? What was your role prior to working with the Board?

I have been executive director for the Idaho State Board of Pharmacy since August 2015. Prior to this role, I served as vice president of a Washington, DC-area health care trade association and as a campaign manager for various local and state legislative campaigns in Ohio.

What is one of the most significant challenges or issues your board addressed in the past year or so?

A top challenge is regulatory accretion. The Board’s rulebook had swelled to 100 pages, with requirements as specific as to delineate what types of hinges may be on a pharmacy door. Many of the Board’s rules have become outdated and disconnected from public safety, and instead stifle the emergence of new technology or practice models that can actually improve patient care. Advancements in technology, education, and training will continue to outpace changes in regulation as it takes roughly nine to 12 months to finalize a regulation in our state. When this regulatory gap occurs, we have seen examples in which the public is deprived of the benefits of increased competition, choice, and access; health care institutions are forced to inefficiently use their scarce resources; health care professionals experience burnout or frustration from not being able to use their full faculties; and public health goals are less likely to be achieved.

What actions were taken by the Board to address the issue?

The Board has embraced a vision of “permissionless innovation” – a concept advanced by Adam Thierer, an economist at the Mercatus Center at George Mason University. Permissionless innovation (PI) refers to the notion that experimentation with new technologies and business models should generally be permitted by default. PI allows for the revealed preferences of thousands of consumers to drive bottom-up solutions within the limits of appropriate sideboards. We have undertaken a two-year initiative to adopt this vision.

In year one, we focused on several discreet topics that we felt were holding back innovation and progress in the profession. First, we significantly expanded the roles that pharmacy technicians may play (eg, injecting vaccines, tech-check-tech, accepting verbal prescriptions, transferring prescriptions). The finalized rules now allow pharmacists the choice of which tasks to delegate, and to whom, rather than supplanting pharmacist judgment with one-size-fits-all state law restrictions. We also significantly expanded our telepharmacy rules, creating more opportunities for innovative models of care to meet the needs of rural Idaho. Lastly, we sought to close the gap between the “clinical ability” of pharmacists and their restrictive scope of practice. The Board of Pharmacy sponsored, and the legislature unanimously passed, bills that allowed pharmacists to prescribe tobacco cessation medications and tuberculin purified protein derivative products. After passing these bills, the legislature put forth House Bill 191, which empowers the Board to create an expanded behind-the-counter (BTC) class of

Idaho State Board of Pharmacy
Number of Board Members: 4 pharmacist members, 1 public member
Number of Compliance Officers/Inspectors: 3
Rules and Regulations Established by: Board of Pharmacy
Number of Pharmacist Licensees: 2,399
Number of Pharmacies: 901 (in-state)
Number of Wholesale Distributors: 702

continued on page 6
Nurse License Up in Smoke

The incongruence between federal law and state law related to the legalization of marijuana presents interesting issues in the licensing arena. Activities that are legal under some state laws remain illegal under federal law. Sooner or later, a board of pharmacy will be presented with the issue of how to treat the use of cannabis by a licensee that arguably was lawful under state law and unlawful under federal law. While not precisely on point to the aforementioned query, consider the following.

A nurse (Licensee) licensed by the West Virginia Board of Examiners for Registered Professional Nurses (Board) interviewed for and was offered a job with a hospital (Employer). The employment offer was contingent on a drug screen. The results of the drug screen indicated a positive showing for marijuana. Based upon this positive result, the Employer rescinded its job offer and, in addition, notified the Board of the results.

The Board initiated a complaint and the Licensee denied the allegations. The Licensee was charged with engaging in activities that are “derogatory to the morals or standing of the profession of registered nursing.” He was also charged with being “unfit or incompetent by reason of negligence, habits or other causes . . .” After an investigation, the matter went to a hearing presided over by a hearing officer. At the hearing, the Licensee maintained his denial, testified that he had not smoked marijuana, and argued that test results were a false positive due to his ingestion of other pharmaceuticals. On behalf of the Board, an expert witness contradicted the Licensee and testified that none of the drugs ingested by the Licensee contained THC, the compound found in marijuana. The Licensee offered no rebuttal witnesses.

The hearing officer found that the Board met its preponderance burden of substantiating violations of the practice act, specifically engaging in activities that are derogatory to the morals or standing of the profession of nursing or that he was unfit or incompetent by reason of negligence, habits, or other causes.

On March 30, 2015, the Board entered its final order adopting the hearing officer’s decision in its entirety and suspended the Licensee’s license for one year with such suspension stayed contingent upon compliance with certain terms and conditions. The Board also assessed administrative costs and fines totaling $2,000. The Licensee appealed.

On appeal, the Licensee argued 10 assignments of error. The court of appeals quickly disposed of nine of those arguments, finding they involved issues easily resolved in favor of the Board. However, a few important rules of law were cited, in the opinion that they are relevant to the pharmacy and regulatory communities. First, the court held that marijuana is illegal in West Virginia and that use of an illicit drug constitutes unprofessional conduct. As a result, the Board was justified in finding his conduct to be derogatory to the morals or standing of the profession and, thus, the findings and sanction were sustainable.
The Licensee additionally argued that his constitutional rights to effective counsel and privacy of drug screening results were violated. Addressing the effective counsel argument, the court held that the Licensee does not have a constitutional or other right to effective counsel in an administrative proceeding. Any remedy available to the Licensee related to his counsel would have to be pursued through a legal malpractice claim(s). Regarding a privacy right, the court noted that “[a]n employee’s right to privacy yields when an employer has a good faith suspicion of an employee’s drug usage or when an employee’s job involves public safety or the safety of others.” With no right to privacy under these circumstances, the court rejected this point on appeal.

The court did give considerable attention to the Licensee’s allegation that the Board failed to comply with a time limitation required for the entry of a final order. West Virginia law requires entry of a final order within 45 days, “following the submission of all documents and materials necessary for the proper disposition of the case, including transcripts, and shall contain findings of fact and conclusions of law.” In the end, the court found that the Board must receive the hearing officer’s decision before triggering the 45-day period. Indeed, such hearing officer’s decision was provided for under law and the Board could not act without receipt thereof. Because the Board produced its final order within 45 days of receipt of the hearing officer’s decision, the Board acted within the scope of the law.

The court did, however, take exception to the fact that a significant period of time elapsed from complaint to disposition, specifically the time period from the hearing to the hearing officer’s decision. The hearing was held on October 9, 2014, and the decision was received by the Board on February 24, 2015. The court held that although the Board did comply with the 45-day period in entering the final order, the time period from hearing to hearing officer’s findings of fact, conclusions of law, and recommendations was lengthy. In fact, the court strongly noted that the lengthy time periods from hearing to hearing officer’s findings has been contended in previous litigation.

In at least two previous cases, such an argument has been advanced by petitioners and addressed by the court. In both prior cases, the court upheld the Board action but admonished the Board for the processes and time periods. In those previous cases and emphasized in the current case, the court noted the need for a rule to be promulgated requiring hearing officers to submit findings and conclusions within a specified period of time. In the current case, the court stated:

Although we conclude that, in the absence of a specific timeframe regulation governing the hearing examiner’s actions, no error meriting reversal of the circuit court’s order exists, we note our concern with the extensive amount of time it took the hearing examiner to submit findings of fact, conclusions of law and a recommended order to the Board in this case. The absence of a specific time requirement for the hearing examiner to submit his/her recommended order to the Board should not serve as an excuse for unnecessary delay in moving these contested cases to resolution in a timely fashion. As the Board is well aware, we have previously expressed our concerns with delays in resolving these cases and the effect that such delays have on the livelihood of the nurses working in our State.

Because there was no violation of any statutes or other rights of the Licensee, the court upheld the findings and sanctions imposed by the Board.

This opinion not only addresses the timeliness and efficiencies of regulatory boards, it also tackles an issue that will likely surface in a more complex manner in the near future. With the legalization of marijuana in several states, this fact pattern will grow in significance and complexity. In a state where marijuana is legal, what options are available to boards of pharmacy where its use is detected through a drug screen but, perhaps, not related to job performance or impairment?

Alex Adams  
continued from page 3

drugs that pharmacists may prescribe within defined categories (eg, no new diagnosis needed, minor and self-limiting conditions). We will be working to implement this bill in an evidence-based fashion over the next year, with an emphasis on moving select drugs BTC that can improve public health.

In year two, we are focusing on paring back our law book from 100 pages to roughly 50. As we reduce regulation, the goal is to create laws that allow room for experimentation and growth. We are emphasizing “what” must occur, as opposed to “how” it occurs or “where” it occurs, and focusing on the “practice” of pharmacy, not the “business” of pharmacy. Gone are the days in which we intend to draft technology-specific or business model-specific rules. This will allow new models to emerge without needing express permission from our regulatory board as long as minimum public safety standards are met. While cutting red tape, the Board has maintained, and in some cases strengthened, its proposed rules related to controlled substances and compounding given their well-known public health implications.

What other key issues has the Board been focusing on?

We have focused considerable effort on prescription drug abuse. We have taken steps to refine and enhance the state’s prescription monitoring program (PMP). We are one of the states participating in NABP PMP Interconnect® and utilizing the integration of PMP Gateway. We have received a federal grant to help facilitate uptake of PMP Gateway by both prescribers and dispensers. We have also received state grant money to facilitate uptake of drug take-back programs at community pharmacies. We continue to better leverage our PMP data to identify potential instances of abuse, and we have pursued disciplinary cases accordingly. We will also be launching Prescriber Report Cards to provide objective information directly to prescribers.

What insights do you have for other states that may be facing similar challenges?

With respect to PI, our Board spent time learning about the medical model of health professional regulation, specifically regulating according to a community “standard of care” versus trying to regulate every conceivable worst-case scenario or “what if.” Learning from our colleagues in medicine was instrumental in shaping the approach toward PI. Once the Board agreed with the philosophical approach, we realized that a complete repeal and replace of the existing rulebook was necessary in order to fully execute the vision. The Mercatus Center has some resources available that were helpful in sharpening our approach, specifically measuring the current regulatory burden so that we were able to focus on specific priority areas.

Pharmacy is a small profession and discussions about what the Board is working on can spread quickly. To ensure accuracy of message, we have prioritized hosting town hall sessions across the state in order to describe what we are doing and why we are doing it. Interfacing directly with the regulated community has yielded very beneficial feedback and has created a shared understanding of what we are trying to accomplish. Transparency, accessibility to stakeholders, and evidence-based decision-making has been key to our success.

Newly Accredited VIPPS Facilities

The following internet pharmacies were accredited through the NABP Verified Internet Pharmacy Practice Sites® (VIPPS®) program:

Noble Health Services, Inc  
www.noblehealthservices.com

Solera Specialty Pharmacy, LLC  
www.solerarx.com

A full listing of the accredited VIPPS pharmacy sites representing more than 12,000 pharmacies is available on the NABP website at www.nabp.pharmacy.
With Ongoing Rollout of DSCSA Provisions, NABP Provides Members Guidance for Regulation of Wholesale Distributors

Food and Drug Administration (FDA) continues to roll out guidance to assist industry and state and local governments in understanding the provisions of the Drug Supply Chain Security Act (DSCSA) as these entities, including the boards of pharmacy, interpret and promulgate regulations to implement the law. With 41 boards of pharmacy responsible for regulating wholesale distributors, NABP membership has a high stake in ensuring appropriate regulations are implemented for drug supply chain safety.

NABP continues to support the boards by providing information gained from its wholesale distributor accreditation programs and by creating forums for boards of pharmacy to discuss the regulation of wholesale distributors.

Wholesaler Standards and Practices

In October 2017, board of pharmacy executive officers gathered at NABP Headquarters for the NABP Interactive Executive Officer Forum, which included a session providing an overview of the challenges many boards are already facing or likely to face with the implementation of DSCSA. One current challenge for state boards involves confusion over interpretation of what the law says as it relates to wholesaler standards.

For example, the law does not seem to clearly address the regulation of third-party logistics providers (3PLs). Since the enactment of DSCSA, more wholesalers have started using 3PLs for distribution of their products and some wholesale distributors claim that they do not need a license to sell into a state because their 3PL has a license. This claim is inaccurate; wholesalers must have a license if they sell a product. Under DSCSA, 3PLs are not required to pass on transaction information, making it very difficult to know a product’s origin. Therefore, it seems some gaps remain in the law. However, boards of pharmacy have been preempted from developing regulations stricter than those of the DSCSA.

Bypassing Drug Safety

During the presentation, NABP staff shared examples of scenarios that are prohibited under the new law, but continue to occur. For instance, some outsourcing facilities are engaging in wholesale distribution by drop shipping drug products to hospitals and billing them through their wholesaler. Such distribution is prohibited under DSCSA.

In addition, some manufacturers are being converted to 503B outsourcing facilities, so they can bypass the drug approval process and market and distribute unapproved drugs directly to hospitals and physicians. Unapproved drugs, including compounding kits, are also being sold to pharmacies. These drugs have National Drug Code numbers and resemble drugs approved by FDA, making it difficult to detect.

In addition to using 3PLs, more wholesalers are now co-locating with a closed-door or long-term care pharmacy. The pharmacy can purchase drugs at special prices under a Group Purchasing Organization agreement, which it then sells through the wholesaler. This practice is a major source of drug diversion and leads to record falsification.

Effective regulation of reverse distributors also continues to be a challenge for boards of pharmacy. Recent guidance from FDA indicates that under DSCSA reverse distributors are closely related to 3PLs because they do not take ownership of a product. The potential for diversion and the release of protected health information of a patient then becomes a concern as hospital pharmacies box up their drugs and ship them to reverse distributors.

Some people view DSCSA as a panacea for drug safety because they believe its mandates for serial number traceability and the electronic transfer of information will eliminate product diversion and counterfeiting; however, entities are already finding ways to circumvent traceability requirements. In addition, because many transactions are paper-based transactions, falsified transaction histories have been encountered.

Moving forward, boards will need to consider how to address these problems.

Boards, NABP Find Solutions

As FDA moves toward fully implementing DSCSA, state boards of pharmacy may see more resistance to licensing from certain segments of the industry. Some manufacturers and repackagers may begin asserting

More Than 20 States Recognize VAWD Accreditation

The Verified-Accredited Wholesale Distributors® (VAWD®) accreditation plays a pivotal role in preventing contaminated, diverted, or counterfeited drugs from entering the United States drug supply. According to the 2017 Survey of Pharmacy Law, 41 boards are responsible for licensing wholesale distributors, 23 states recognize VAWD accreditation, and two states require VAWD accreditation for 503B outsourcing facilities.

continued on page 10
Executive Officers Convene to Discuss Current Challenges During Interactive Forum

Thirty-five board of pharmacy executive officers gathered for the annual NABP Interactive Executive Officer Forum, held October 3-4, 2017, at NABP Headquarters. Themed “Connect & Protect: Educating, Sharing, and Leading,” the event offered attendees an opportunity to collaborate and discuss common challenges faced by the state boards, as well as reinforced the partnership between the boards of pharmacy and NABP and their shared mission to protect the public health. The meeting format featured two days of sessions designed to provide executive officers an opportunity to discuss specific topics as well as issues of special interest provided by invitees via a pre-meeting topics survey. 

(Above) The session “Regulatory Oversight: #What Happens Next?” focused on two issues that boards are facing in a changing regulatory environment: the impact of the Federal Trade Commission vs North Carolina Dental Board Supreme Court ruling and the importance of asserting board of pharmacy relevancy through education and action. Panelists shared examples and insights from their boards, followed by an open discussion among attendees. Pictured are (left to right) Hal Wand, MBA, RPh, NABP chairperson; Virginia “Giny” Herold, MS, executive officer, California State Board of Pharmacy; Josh Bolin, associate executive director, NABP; session moderator Jeanne D. Waggener, RPh, DPh, NABP president; Steve Hart, RPh, executive director, Kentucky Board of Pharmacy; and Ray Joubert, BSP, registrar, Saskatchewan College of Pharmacy Professionals.

(Above) During the session “The Last Thin Line,” panelists shared insight on the various aspects of drug importation and the Drug Supply Chain Security Act. Panelists pictured are (from left to right) Gregg Jones, RPh, CPh, compliance senior manager, NABP; Caroline D. Juran, RPh, DPh, member, NABP Executive Committee; Jill Hardy, BScPharm, MSc, deputy registrar, College of Pharmacists of Manitoba; and session moderator Jack W. “Jay” Campbell IV, JD, RPh, NABP treasurer.
(Above) During the session “Resolving to Lead in Protecting the Public Health,” members of three NABP task forces – the Task Force on Best Practices for Veterinary Compounding, the Task Force on Long-Term Care Pharmacy Rules, and the Task Force on the Definition of a Patient-Pharmacist Relationship – provided updates on their task force’s efforts. Pictured are (left to right) session moderator Reginald “Reggie” Dilliard, DPh, member, NABP Executive Committee; Malcolm J. Broussard, RPh, executive director, Louisiana Board of Pharmacy; Kari Shanard-Koenders, RPh, executive director, South Dakota State Board of Pharmacy; Steve Saxe, RPh, FACHE, executive director, Washington State Pharmacy Quality Assurance Commission; Deena Speights-Napata, MA, executive director, Maryland Board of Pharmacy; Mark Hardy, PharmD, RPh, executive director, North Dakota State Board of Pharmacy; and Sam Lanctin, BScPharm, MBA, registrar, New Brunswick College of Pharmacists.

(Above) The session “Connecting: Is Your Network Working?” discussed the importance of interprofessional networking and connecting with colleagues. Panelists pictured are (from left to right) session moderator Richard B. Mazzoni, RPh, member, NABP Executive Committee; Steven Schierholt, Esq, executive director, State of Ohio Board of Pharmacy; Bob Nakagawa, RPh, registrar, College of Pharmacists of British Columbia; and Shauna White, PharmD, MS, RPh, executive director, District of Columbia Board of Pharmacy.
DSCSA Update
continued from page 7

that they are exempt from wholesale
distribution and, therefore, do not
need a wholesale license in states.

NABP invites state boards of
pharmacy to work with the
Association to develop solutions to
address challenges that arise from
the implementation of DSCSA. NABP
gathers crucial information about all
aspects of drug distribution and the
issues facing states through surveys
and on-site inspections and shares
this information with member boards.

Additionally, NABP continues to offer
accreditation through its Verified-
Accredited Wholesale Distributors®
(VAWD®) program as a solution for
the boards to ensure wholesale
distributors, 3PLs, and other affected
entities doing business in their state
meet the continually evolving DSCSA
regulations. States that require
VAWD can trust that they and their
accredited facilities conform with
the law’s requirements as NABP
continuously reviews and updates its
VAWD criteria to ensure it aligns with
DSCSA provisions.

Furthermore, through the Verified-
Accredited Device Integrity Program®
(VDIP®), NABP offers accreditation
for business entities that distribute
diagnostic over-the-counter medical
devices that may be dispensed
pursuant to a prescription. The
Association also continues to review
and update its VDIP criteria.

By working with NABP and each
other, state boards of pharmacy will
find solutions they need to deal with
wholesale distributors and other
segments of the drug industry now
and in the coming years.
New .Pharmacy Program Consumer Campaign Launches, Features Animated PSAs to Raise Awareness of Rogue Sites

Consumers increasingly turn to the internet for medicines traditionally bought from a brick-and-mortar drugstore, and risk falling prey to illegal drug outlets distributing substandard medications at low prices. Following the success of the 2015 and 2016 consumer campaigns, the .Pharmacy Verified Websites Program launched another multi-faceted campaign to inform consumers about the dangers of buying medicine online from these illegal drug outlets. Launched in fall 2017, the new campaign promotes .pharmacy verified websites through television and radio public service announcements (PSAs), animated PSAs, digital banner advertisements on websites, and “out-of-home” (OOH) advertisements, with the goal of driving consumers to .pharmacy websites in the Buying Safely section at www.safe.pharmacy.

A new, animated PSA was developed for the 2017 campaign. The PSA educates consumers about rogue sites and elucidates the difference between .com and .pharmacy web addresses. Available in 15-, 30-, and 60-second versions, the PSAs may be viewed on www.safe.pharmacy by going to the Buying Safely section and clicking on .Pharmacy on Your TV.

Growing Canadian Presence

With the assistance of the National Association of Pharmacy Regulatory Authorities, which now assists NABP in the evaluation of .Pharmacy Program applications for pharmacies located or doing business in Canada, the .Pharmacy Program has seen growth in the number of online Canadian pharmacies seeking interest in registering .pharmacy domain names. Therefore, the 2017 consumer campaign was also released in Canada in an effort to educate more Canadian consumers about the risks of rogue pharmacy sites and how .pharmacy verified websites are safe sources for buying medication online.

In Canada, the campaign components were released in both English and French. Consumers in this country may see television PSAs, digital banner ads targeting key audiences, and Outbrain ads, a form of digital content marketing that displays an image and headline on top websites such as CNN, ESPN, and USA Today, among others. Those who click on the link will be brought to the list of verified websites on safe .pharmacy. Outbrain ads running in French publications, or in French-speaking areas, will be brought to the French language PSA.

In the United States, the TV PSAs, Outbrain ads, and digital banner ads are only running in English. In addition, radio PSAs are being run in the US. Finally, NABP is again utilizing its 2016 OOH ads throughout the US, which will be displayed on buses, trains, transit shelters, and shopping mall kiosks. Examples of the OOH ads can be found on page 17 of the October 2016 issue of Innovations.

For more information about the .Pharmacy Program, visit www.safe.pharmacy.

The 2017 .Pharmacy Verified Websites Program campaign features animated public service announcements (PSAs). The images shown are from the PSA, which feature information about rogue sites and elucidate the difference between .com and .pharmacy web addresses.
NABP and Member Boards Partner on Data Sharing Initiatives, Prepare for Future Enhancements to e-Profile Connect

The NABP e-Profile Connect platform currently connects member boards of pharmacy with a plethora of unique licensee data, and the Association is partnering with the member boards on efforts that will build an even more robust data set to support licensure decision-making and other board processes. Key to the success of this partnership is the NABP e-Profile ID, the unique identifier attached to the NABP e-Profiles of pharmacists, technicians, students/interns, and facilities.

Currently boards can utilize NABP e-Profile Connect to access data attached to individual e-Profile IDs and they can work with NABP to have customized reports built that compile data in specified parameters. Boards also access and report Clearinghouse data, process examination eligibility, access candidate examination scores, verify Foreign Pharmacy Graduate Examination Committee™ certification, and access and upload facility inspection reports.

NABP is working with the boards toward the goal of adding more data and more reporting features to e-Profile Connect. This article, the first of a three-part series, explains how these enhancements will help boards further automate and streamline their licensing processes, as well as support board efforts to ensure licensees are maintaining professional and public safety standards.

Data Quality and Security Imperative

NABP continually ensures the quality and security of data stored in the e-Profile Connect system. Data quality efforts include working with the boards to ensure license numbers are correctly recorded and reaching out to e-Profile holders to correct data as needed. Such data quality efforts result in efficient processing for the boards. For example, accurate license number information means that board Clearinghouse data uploaded to the system will be associated with the correct e-Profile IDs. With security as a priority, the NABP e-Profile ID also eliminates the necessity of exchanging sensitive data with the boards to identify a licensee such as social security numbers or dates of birth. (More information on NABP data security initiatives is in
the article “NABP Cyber Security Initiatives Protect Data” on page 19.)

**e-Profile Connect Supports CPE Audits**

With the success of the CPE Monitor® service, boards now have the option of requesting customized reports on continuing pharmacy education (CPE) activity in order to conduct audits or complete other processes, such as requesting more information on CPE activity specific to an individual licensee. Again, the e-Profile ID is key in these processes as it is the unique identifier licensees use to obtain credit from Accreditation Council for Pharmacy Education (ACPE)-accredited CPE providers, and that allows ACPE to verify the credits for recording CPE activities in the CPE Monitor system.

In previous years, boards of pharmacy relied on paper-based auditing processes. Now, customized reports can be generated for the boards of pharmacy using any data contained within the e-Profile system. In addition, with the launch of the CPE Monitor subscription and NABP mobile application in early 2018, pharmacists will have the ability to upload non-ACPE continuing education (CE) activities. This service will also provide the boards with an even more complete set of CPE data for automated audits.

**Boards’ Use of e-Profile ID to Support Access to Enhanced Licensee Data**

Recognizing the power of the NABP e-Profile ID in reporting and accessing licensure data, several boards of pharmacy have begun to require that pharmacists provide their NABP e-Profile ID during the licensure application and renewal process. In doing so, these boards open the door to access a candidate’s examination information, current and previous licenses, disciplinary history, license status, and CE through the NABP e-Profile Connect system. When boards are able to utilize the e-Profile ID in their own data systems, they will be able to further streamline the licensure process and expedite reporting to NABP, thus reducing the boards’ administrative burden and enhancing the ability to make informed licensing decisions.

Utilizing the e-Profile ID in board data also prepares the board to participate in future planned data exchanges with NABP. The data exchanges will offer the possibility to automate additional processes and enhance access to more robust data for all boards. The Association is currently working with five state boards to design and pilot data-syncing processes.

To date, 10 state boards of pharmacy require licensees to provide their NABP e-Profile ID during the CPE Monitor application process, including: Indiana, Iowa, Kansas, Louisiana, Mississippi, New Jersey, North Carolina, North Dakota, Ohio, and Virginia. For example, per Board Rule 1615, the North Carolina Board of Pharmacy now requires all pharmacists, pharmacy technicians, pharmacies, and durable medical equipment (DME) facilities to obtain and report an e-Profile ID to assist the Board in accessing and tracking CPE compliance, pharmacy and DME facility inspections, and out-of-state disciplinary actions. NABP is recommending all boards of pharmacy require the e-Profile ID on initial and renewal licensure applications to ensure licensees are synced with NABP profiles. By doing so, the e-Profile requirement will guarantee the board is receiving real-time notification when discipline occurs from other state boards of pharmacy on a shared licensee.

NABP will continue to inform and reach out to the boards regarding implementation of the e-Profile ID in their systems, and the planned data exchanges, and more information on these efforts will also be provided in future issues of Innovations.

For more information about NABP e-Profile Connect and how boards can leverage the e-Profile ID to assist in their licensing processes contact NABP Member Relations and Government Affairs staff at GovernmentAffairs@nabp.org.

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**What data is in a pharmacist e-Profile and where does it come from?**

<table>
<thead>
<tr>
<th>Applicant</th>
<th>NABP</th>
<th>State Board</th>
<th>ACPE</th>
<th>Schools</th>
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<td>• Examination information</td>
<td>• Disciplinary history</td>
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<td>Transcripts</td>
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November/December 2017 innovations | 13
To obtain licensure, a student/candidate will use their NABP e-Profile to register for the NAPLEX and MPJE, check exam scores, and place score transfer requests. Additionally, they can purchase and take the Pre-NAPLEX practice exam, using e-Profile.

For more information on NABP’s e-Profile, visit www.nabp.pharmacy or for e-Profile support contact NABP customer service at help@nabp.pharmacy.
To obtain licensure, a student/candidate will use their NABP e-Profile to register for the NAPLEX and MPJE, check exam scores, and place score transfer requests. Additionally, they can purchase and take the Pre-NAPLEX practice exam, using e-Profile.

Pharmacists use their NABP e-Profile to access CPE Monitor and record/review ACPE-accredited CPE activities. Submitted CPE will be recorded for all licenses the pharmacist has added to their profile. The NABP e-Profile supports obtaining licensure in multiple states. In April 2018, the entire e-LTP process will be paperless. Once the application is submitted, the pharmacist can monitor the status.

For more information on NABP's e-Profile, visit www.nabp.pharmacy or for e-Profile support contact NABP customer service at help@nabp.pharmacy.

Pharmacist

Pharmacist Transferring Licenses
The Future Is Now: Medical Apps for Health Care Providers

Smartphones, with their on-the-go computing power, internet connectivity, and native mobile applications, or apps, have touched every industry within the last decade, and the health care sector is no exception. They have played a prominent role in the development and growth of mobile health (also referred to as mHealth), and smartphones equipped with medical apps have become vital tools used on a daily basis by health care practitioners.

Health care providers can and do often use features on their smartphones that are not specific to the health care industry but nonetheless assist them in their jobs, such as built-in calendars and reminders that help them manage their time, track appointments, and other administrative tasks; emailing and texting capabilities that facilitate (non-Health Insurance Portability and Accountability Act [of 1996]-restricted [HIPAA]) communication; camera functions that allow for additional sharing of images or documents; and internet connectivity that brings a world of information in response to a search request. But native mobile apps – software programs designed to run on a mobile device to accomplish a specific purpose – designed for use by health care providers and patients have also become ubiquitous. More than 250,000 apps related to mHealth are available in major app stores. According to one industry observer, more than 100,000 health-related apps have been added to the market just since 2015. While quality varies widely and most of these apps are designed for and used by the patient (or consumer), thousands of apps are intended for use by health care providers.

As an example, a 2013-2017 Mobile Health Market Report indicates that 80% of physicians use medical apps on their smartphones, and of those physicians, 72% access drug information (e.g., dosage calculators, side effects, interactions, and so on). Another 63% use their tablets to access medical research and 44% use their smartphones to communicate with nurses and other staff.

Further, physicians spent 38% of their phone time searching professional apps. Continuing medical education activities were the most frequently viewed content, according to a 2012 study.

As a general rule, medical-specific mobile apps for providers fit into five broad categories: reference, clinical decision-making, communication, professional development, and patient self-care. At the same time, the lines between these categories blur, and many apps include functions that fall within several

“Drug information is among that most frequently accessed by a smartphone app, by both physicians and pharmacists.”
and provide medication information for mystery pills and capsules. Health care professionals also increasingly use their mobile devices to access a wealth of medical literature published in journals and textbooks, as well as to keep up on current health care news. Some apps are source-specific, like NEJM This Week, which gives access to articles and information specifically from the New England Journal of Medicine; others, like Read by QxMD or BrowZine, act more like portals that allow users to access journal articles and other information from multiple sources. Medscape MedPulse does the same for breaking news.

**Clinical Care**

Many health care providers also use apps that assist them in their clinical decision-making. As mentioned above, many of the same apps that provide reference material also contain medical calculators, guidelines, best practices, predictive indices, and more. In addition, numerous organizations and the federal government have put out apps to walk health care providers through screening and management guidelines for particular medical topics and conditions, from antibiotic use (from the United States Centers for Disease Control and Prevention) and vaccine guidelines (from the Society of Teachers of Family Medicine) to cardiovascular disease (from the American College of Cardiology) and cervical cancer (from the American Society for Colposcopy and Cervical Pathology). Lab test apps help providers order appropriate tests or more accurately interpret results; calculator apps can help providers complete such tasks as computing risk factors for medical conditions or figuring medication dosages to assist them in appropriate diagnosis and treatment.

One of the more popular apps among physicians that combines reference and clinical support functions (other than Epocrates) is UpToDate, with a huge database of consistently updated, evidence-based medical information.

**Communication**

Not all apps useful to health care professionals are specific to the medical field. Apps like Google Translate, for

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**NABP Mobile Trends**

As smartphones and other mobile devices have become nearly universal accessories, individuals are increasingly connected to news and information while on the go. The following highlights mobile device trends among users accessing NABP publications and websites:

**NABP e-News**

- 57% of subscribers use mobile devices or tablets to access these weekly messages.
- 43% of subscribers use desktops.

**NABP Website**

- 32% of site visitors use mobile devices or tablets.
- 68% of site visitors use desktops.

**NABP 2017 Annual Meeting Website**

- 75% of on-site attendees used mobile devices to access information.
- 24% used mobile devices to access meeting information prior to the meeting.

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continued on page 18
Mobile Apps  
continued from page 17

example, can help providers who interact with non-English-speaking patients. In addition, the basic texting or messaging apps that come part and parcel with smartphones make intra-professional communications easy, and may be used for numerous purposes, whether administrative coordination or seeking a professional opinion. However, since these built-in functions do not protect patient privacy, some more specialized apps tailored to the health care field allow providers to communicate with each other and with patients in a more HIPAA-compliant format. The Doximity network app is one of the most popular of these – its makers claim that 60% of US clinicians belong to the professional network – and allows HIPAA-compliant communication, including faxing, among other functions.

Other apps allow health care providers to connect with others specifically in their field. The ASHP Connect app (from the American Society of Health-System Pharmacists), for example, allows ASHP members to communicate with each other via member discussion groups, or by using the app’s membership directory.

Professional Development

Health care providers also use mobile apps in their professional development, including such activities as networking, attending meetings, and completing and tracking their continuing education (CE). Some aspects of these activities, including virtual networking and staying abreast of current medical developments, overlap with the communications and reference/clinical support categories discussed above. Indeed, some apps that allow providers to review medical literature, including UpToDate and Doximity, will grant them CE credits for doing so and allow them to generate a printable record of CE completed in this manner. Less common are apps that allow health care professionals to input and track their CE, and search for CE courses.

While not all professional associations have produced apps like ASHP Connect, many do offer apps that allow members to optimize their experience at major meetings. The American Pharmacists Association, the National Association of Chain Drug Stores, the National Pharmacists Association, and the ASHP are among those associations that offer their members meeting apps.

Patient Empowerment

The majority of mHealth apps are aimed at patients, and industry observers have lauded the potential of mHealth to empower patients and enable them to take a more active role in their health care. Indeed, health care providers and organizations may recommend particular apps or categories of apps to their patients, to assist them, for example, in making healthy lifestyle choices (such as diet and fitness trackers), managing a chronic disease (such as diabetes or heart disease management tools), or increasing treatment adherence (such as pill reminder programs). A number of pharmacy chains like Rite Aid and Duane Reade have rolled out apps that allow patients to do tasks like set pill and refill reminders, and refill prescriptions within the app; the Walgreens Connect app syncs with certain Walgreens-sold medical devices to enable users to monitor their blood pressure or blood glucose levels and receive rewards for doing so.

MHealth advocates point to apps’ potential to allow patients to perform such functions as making appointments, contacting their health care providers, accessing insurance information, maintaining copies of their electronic health records, tracking their state of health, and transmitting monitored information to their health care providers. At the moment, however, not all functions allowed by apps are possible in all practice sites or settings, and the vision of seamless, streamlined mHealth remains largely theoretical.

A Rapidly Evolving Field

Every day, new health care and wellness apps are added to the market; every day, other apps become obsolete. Much-used resources of a year ago become outdated and difficult to use; advances in mobile technology and cyber security allow completely new functions. MHealth has become big business, and with interest by large technology companies like Google or Apple, and investments by venture capitalists, the pace seems unlikely to slow in the near future. Issues and concerns remain, including privacy and security protections, app quality, and regulation, among others. What appears certain, however, is that mobile apps will continue to permeate and shape the provision and practice of health care, and will only become more integral a part of patients’ and providers’ personal and professional lives.”
NABP Cyber Security Initiatives Protect Data

As part of the Association’s ongoing efforts to maintain security of its private networks, computer systems, and web applications, NABP successfully completed a series of routine cyber security tests in September 2017. These routine inspections of the Association’s infrastructure, referred to as “penetration testing,” simulate cyber attacks using several scenarios that a hacker or malicious user could take to gain access to sensitive information.

Testing the Security of Networks

NABP enlists the help of a third-party organization to conduct these penetration tests on its external, internal, and wireless networks. Penetration testing is an attempt to breach the security of a network or system. External network penetration testing is performed remotely by a pseudo-attacker to identify vulnerabilities on servers accessible from the internet, such as an email server.

Similarly, wireless penetration testing is an attempt to gain access to a private wireless cloud and intercept data that is secured with a weak encryption. Internal network penetration testing is performed from the perspective of an insider, such as an employee or visitor who has access to an organization’s secure network.

Penetration tests aim to identify weaknesses in security with the intent of gaining access to the environment, and follow practices used by hackers to take advantage of weak security systems; thus, providing insight on how to improve a system’s security.

Outcomes of Penetration Tests

NABP gained valuable insight as a result of the penetration tests attempted on its external, internal, and wireless networks. As technology advances, so does the sophistication of skilled hackers and other cybercriminals who target computer networks and businesses. Analysis of penetration testing results is one initiative used by the Association to stay abreast of industry best practices for protecting data and preventing hackers from breaching its systems.

For more information about the penetration testing performed, contact NABP’s Information Services department at help@nabp.pharmacy.

“As technology advances, so does the sophistication of skilled hackers and other cybercriminals who target computer networks and businesses.”
Proposed Amendments to the NABP Constitution and Bylaws Due in March

To be considered during the 114th Annual Meeting, proposed amendments to the NABP Constitution and Bylaws:

• must be submitted between Monday, February 5, 2018, and Thursday, March 22, 2018. (Proposed amendments may be accepted no earlier than 90 days and no later than 45 days before the First Business Session of the Annual Meeting.)

• may be proposed by any active member board of pharmacy, the NABP Executive Committee, or the Committee on Constitution and Bylaws.

• must be submitted in writing to NABP Executive Director/Secretary Carmen A. Catizone at NABP Headquarters, 1600 Feehanville Dr, Mount Prospect, IL 60056, or via email at ExecOffice@nabp.pharmacy.

Save the Date for the NABP 114th Annual Meeting!

May 5-8, 2018
Hyatt Regency Denver at Colorado Convention Center

Join us in Denver, CO, for the NABP 114th Annual Meeting! The event offers attendees the opportunity to assist in shaping the future direction of NABP by participating in important business sessions, during which officers and members of the NABP Executive Committee are elected and resolutions are voted upon. The meeting also provides Accreditation Council for Pharmacy Education-accredited continuing pharmacy education programs and networking opportunities. More information will be available in future issues of Innovations as well as on the NABP Annual Meeting website.
Around the Association

Executive Officer Changes

- Kerry Ryan Przybylo, JD, has been named manager of the Boards and Committees Section, Bureau of Professional Licensing, Michigan Department of Licensing and Regulatory Affairs, replacing Cheryl Pezon. Previously, Przybylo was department analyst of the Boards and Committees Section. Przybylo is also an attorney and adjunct professor at Western Michigan University Thomas M. Cooley Law School, where she received her juris doctor degree in 1996.

Board Member Appointments

- Robert “Bob” Prentice, MD, has been appointed a member of the Wyoming State Board of Pharmacy. Prentice’s appointment will expire March 1, 2023.
- Timothy “Tim” Seeley, RPh, has been appointed a member of the Wyoming State Board of Pharmacy. Seeley’s appointment will expire March 1, 2021.

2018 Survey of Pharmacy Law Available in December

Serving as a convenient reference source for individuals seeking an overview of the laws and regulations that govern pharmacy practice in 53 jurisdictions, the 2018 Survey of Pharmacy Law will be available in late December. Interested individuals may now get a head start on their purchase by pre-ordering a copy through their NABP e-Profile.

The Survey, which is produced as a digital pdf, consists of four chapters: a state-by-state overview of organizational law, licensing law, drug law, and census data. The 2018 Survey includes 17 new questions addressing:

- state tech-check-tech requirements;
- state requirements for the Verified Pharmacy Program® and pharmacy licensure;
- ordering of lab tests;
- telepharmacy;
- United States Pharmacopeia (USP) Chapters <795>, <797>, and <800> compliance and USP Chapters <795>, <797>, and <800> incorporation into board statutes/regulations;
- manufacturer licensure requirements;
- device wholesale distributor licensure requirements;
- census data for outsourcing facilities, sterile compounding, device manufacturers and dispensers; and
- NABP e-Profile ID data collection.

In addition, several sections have been reorganized and revised to better address pharmacy practice topics. Section 17 has been renamed Wholesale Prescription Drug Distributor Licensure Requirements to make it easier to find, and new sections were created dedicated to manufacturer licensure requirements and device wholesale distributor licensure requirements.

Updates for the 2018 Survey were graciously provided by the state boards of pharmacy. In addition to the boards’ support, NABP requested data from relevant health care associations for the Survey’s prescribing authority and dispensing authority laws in Sections 25 and 26 and laws pertaining to the possession of non-controlled legend drugs and possession of controlled substances in Sections 27 and 28.

The Survey, which is provided as a pdf on a USB drive, can be purchased online for $195 by visiting the Publications and Reports section of the NABP website at [www.nabp.pharmacy](http://www.nabp.pharmacy). NABP will mail pre-ordered copies of the Survey in late December.

All final-year pharmacy students receive the Survey free of charge. In addition, board of pharmacy executive directors will receive a complimentary copy for board use.

For more information on the Survey, please contact Customer Service via phone at 847/391-4406 or via email at help@nabp.pharmacy.
Illinois Adopts New Patient Counseling Rules

The Illinois Department of Financial and Professional Regulation (IDFPR), Division of Professional Regulation adopted new rules related to patient counseling, which went into effect on August 18, 2017. Pharmacists are required to provide verbal counseling prior to dispensing:

• a prescription to a new patient;
• a new medication to an existing patient; and
• any medications where the dose, strength, route of administration, or directions for use has changed.

Under the new rules, an offer to provide counseling must still be made on all other prescriptions where counseling is not mandated. The previous rule required that a patient merely be offered counseling. The adopted rules also require pharmacies serving patients at physical locations to post an 8½ x 11-inch color sign notifying patients of their right to counseling. Where oral counseling and display of signage is not practicable, such as a mail-order pharmacy set-up, a pharmacist must use alternate forms of patient information and must advise the patient in writing that the pharmacist may be contacted for consultation. A copy of the IDFPR-provided patient notification sign must be included within any mailed prescriptions. Additional information, as well as the required sign, can be found in the IDFPR news release at www.idfpr.com/News/2017/0818.

Oregon Passes New Dextromethorphan Regulation

Effective on January 1, 2018, Senate Bill (SB) 743 prohibits the sale or delivery of any dextromethorphan-containing product to an individual younger than 18 years of age unless he or she has a valid prescription in Oregon. SB 743 will be enforced by law enforcement agencies in similar fashion to the current processes for tobacco and alcohol sales. The bill only imposes a requirement that a retailer manually obtain and verify proof of age as a condition of the sale of a dextromethorphan-containing product.

The Oregon State Board of Pharmacy anticipates that this will impact pharmacies in two ways. The first will require the implementation of internal processes for checking the age of anyone purchasing dextromethorphan, and the second will be a possible increase in dextromethorphan prescriptions for individuals under the age of 18. The bill is available at https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/SB743?profiled.

Massachusetts Requires Gabapentin Reporting to MassPAT

Massachusetts requires that gabapentin be reported to the Massachusetts Prescription Awareness Tool (MassPAT) as of August 1, 2017. MassPAT is an online tool utilized by authorized providers that supports safe prescribing and dispensing of Schedule II-V controlled substances (CS). It is part of the Massachusetts Prescription Monitoring Program and requires pharmacies to report prescribing and dispensing information for all drugs in Schedules II-V and those drugs in Schedule VI that have been designated as "additional drugs." This information is then used to provide more complete information to prescribers, dispensers, and regulatory agencies in order to identify prescribing and dispensing trends, detect drug abuse and diversion, and facilitate communication between health care providers based on a patient’s prescription fill history. More information about MassPAT and its use may be found at www.mass.gov/dph/dcp/pmp.

South Carolina Introduces New Laws for Pharmacists and Pharmacy Technicians

The bill H. 3824 was signed by South Carolina Governor Henry McMaster on May 19, 2017, and includes the following amendments impacting pharmacy practice.

The bill requires each licensed pharmacist, as a condition of an active status license renewal, to complete 15 hours (1.5 CEUs) of Accreditation Council for Pharmacy Education-accredited continuing pharmacy education or continuing medical education, Category I, or both, each license year. Of the 15 hours, a minimum of six hours must be obtained through attendance at lectures, seminars, or workshops. At least 50% of the total number of hours required must be in drug therapy or patient management and at least one hour must be related to approved procedures for monitoring CS listed in Schedules II, III, and IV of the schedules provided for in Sections 44-53-210, 44-53-230, and 44-53-250.

In addition, the bill allows a supervising pharmacist to authorize a certified pharmacy technician to perform any of the following actions including, but not limited to: receiving and initiating verbal telephone orders; conducting one-time prescription transfers; checking a technician’s refill of medications if the medication is to be administered by a licensed health care professional in an institutional setting; and checking a technician’s repackaging of medications from bulk to unit dose in an institutional setting. However, a certified technician is prohibited from checking another technician’s fill, refill, or repackaging of medications for delivery to a patient in an outpatient setting. Further, pharmacy technicians are exempt from continuing education requirements for the first renewal period following initial registration.

Additional details about this bill can be found in the August 2017 South Carolina Department of Labor, Licensing, & Regulation – Board of Pharmacy Newsletter, available on the board’s contact page in the Boards of Pharmacy section of the NABP website.

November/December 2017 innovations | 22
New Study Shows Substantial Variation in the Availability of Pharmacies Across the Country

Despite the rising number of United States pharmacies from 2007 to 2015, the availability of pharmacies varied significantly across local areas, indicates a new study. The study, *The availability of pharmacies in the United States: 2007–2015*, found that the number of community pharmacies increased 6.3% from 63,752 to 67,753 from 2007 to 2015. Although the number of pharmacies per-capita remained at 2.11 per 10,000 individuals between 2007 and 2015, the researchers found substantial variation across counties. “Some counties have 13 pharmacies per capita, while others have none,” said Dina Qato, lead author of a new study and assistant professor of pharmacy systems, outcomes and policy, in a University of Illinois at Chicago (UIC) news release.

In 2015, counties in the highest quintile had nearly three-fold more pharmacies than those in the lowest quintile. Counties in the lowest quintile are located in the Pacific West, Southwest, and Great Lakes regions, while counties with the highest tend to be located in the Northeast, Southeast, Northern Appalachia, and Plains states. The researchers conclude that future programs and policies should address the availability of pharmacies and ensure pharmacy characteristics, including accommodations such as multilingual staffing and home delivery, align with local population needs.

To view the study, visit [https://doi.org/10.1371/journal.pone.0183172](https://doi.org/10.1371/journal.pone.0183172). The UIC news release is available at [https://today.uic.edu/access-to-pharmacies-limited-to-some-patients](https://today.uic.edu/access-to-pharmacies-limited-to-some-patients).

AMA Opioid Task Force Encourages Co-Prescribing Naloxone to At-Risk Patients

The American Medical Association (AMA) Opioid Task Force encourages physicians to consider co-prescribing naloxone when it is clinically appropriate to do so. The AMA Opioid Task Force offers several questions for determining whether to co-prescribe naloxone to a patient, or a patient’s family member or close friend, which may be found in the August 2017 document, “AMA Opioid Task Force naloxone recommendations,” available on the AMA opioid microsite at [www.end-opioid-epidemic.org](http://www.end-opioid-epidemic.org).

The Naloxone section of the AMA opioid microsite also offers physicians multiple resources on co-prescribing naloxone in their practice and community. To help end the opioid epidemic, the AMA Opioid Task Force made several recommendations for physicians, including registering and using state prescription drug monitoring programs, training and education on evidence-based treatment, and promoting safe storage and disposal of opioids and medications.

Consent Decree Entered Against Outsourcing Facility Isomeric Pharmacy Solutions

Under a consent decree of permanent injunction entered in August 2017, Isomeric Pharmacy Solutions of Salt Lake City, UT, its owners, and chief operating officer are prohibited from manufacturing, processing, packaging, holding, or distributing drugs until they comply with the Federal Food, Drug, and Cosmetic Act (FD&C Act) and its regulations, in addition to other requirements. Isomeric manufactured and distributed purportedly sterile drug products, including injectable and ophthalmic drugs, that were adulterated because the drugs were made under insanitary conditions and in violation of current good manufacturing practice requirements under the FD&C Act, according to the complaint for permanent injunction. The complaint also alleges that Isomeric manufactured and distributed unapproved drugs and drugs that were misbranded because their labeling did not bear adequate directions for use. Isomeric initially registered as an outsourcing facility in July 2015, and re-registered in December 2015 and January 2017. Additional information is available in a Food and Drug Administration (FDA) news release at [www.fda.gov/NewsEvents/Newsroom](http://www.fda.gov/NewsEvents/Newsroom).

FDA Issues Warning on Alcohol Pads or Benzalkonium Chloride Antiseptic Towelettes Made by Foshan

In September 2017, FDA alerted health care providers and patients to not use alcohol pads or benzalkonium chloride antiseptic towelettes made by Foshan Flying Medical Products Co, Ltd, located in China, due to the lack of sterility assurance and other quality issues. These products are distributed by Total Resources International, of Walnut, CA, and Simple Diagnostics, Inc, of Williston Park, NY. The use of these alcohol pads and antiseptic towelettes could cause infections.

FDA placed all drug products made by Foshan on import alert on May 23, 2017, to stop these products from entering the US. However, FDA is concerned these products might still be in distribution in the US. FDA also sent Foshan a warning letter on August 1, 2017, for violations of current good manufacturing practice regulations. FDA initially contacted Foshan regarding a recall on May 25, 2017, and had several follow-up meetings with the company. Foshan has not taken action to remove its alcohol pads or antiseptic towelettes from the market. The safety alert posted to FDA’s website may be found at [www.fda.gov/Safety/MedWatch/ucm574576.htm](http://www.fda.gov/Safety/MedWatch/ucm574576.htm).

Pharmacies and health care facilities that have alcohol pads and antiseptic towelettes labeled by Total Resource or Simple Diagnostics should immediately stop using them and discard the products. Adverse events or side effects related to the use of these products may be reported to FDA’s MedWatch Safety Information and Adverse Event Reporting Program at [www.fda.gov/MedWatch/report](http://www.fda.gov/MedWatch/report).
## UPCOMING EVENTS

**NABP Interactive Compliance Officer & Legal Counsel Forum**  
November 29-30, 2017  
NABP Headquarters

**PARE Administration**  
December 5-16, 2017

**Committee on Law Enforcement/Legislation**  
January 22-23, 2018  
NABP Headquarters

**Committee on Constitution and Bylaws**  
March 28, 2018  
NABP Headquarters

**FPGEE Administration**  
April 18, 2018

**NABP 114th Annual Meeting**  
May 5-8, 2018  
Denver, CO