Boards Investigate Regulating Pharmacies for Patient Care Outcomes to Ensure Quality

Twelve years ago, David Brushwood, RPh, JD, a professor at the University of Florida College of Pharmacy, advised that the state boards of pharmacy should adjust their policies to begin regulating pharmacies for patient care outcomes. Some in pharmacy regulation also recognized the importance of such an approach. Charles R. “Chuck” Young, RPh, CFE, during his tenure as executive director of the Massachusetts Board of Registration in Pharmacy from 1996 to 2006, initiated several efforts, including creating a board staff position that focused on continuous quality improvement (CQI), the first of its kind in the nation.

Today, boards are refocusing on CQI programs and are working to improve or implement their own plans. In the push for CQI programs in the community pharmacy setting, boards are looking at methods to evaluate the success of these programs and, subsequently, to establish uniform standards to facilitate uniform success.

NABP and stakeholders from all areas of pharmacy practice and regulation emphasize the importance of looking for the root of “quality-related events” in pharmacy structure and process, or systems, and adjusting those systems as necessary to support CQI programs and prevent the recurrence of medication errors. A necessary part of the process involves measuring changes that actually result from the adjustments to pharmacy systems.

According to CQI reports, health care “outcomes” refer to “changes in a patient’s health status that result from the provision of health care.” They state, however, “[o]ther important outcomes are disability, discomfort, and dissatisfaction,” and, “[e]xamples in pharmacy of directly measured outcomes would be adverse drug reactions, patient dissatisfaction, and diminished quality of life. Proxy outcomes measures would include the rate of medication-related emergency room visits or blood pressure readings of hypertensive patients.”

Brushwood emphasized that measuring such outcomes is the only way (continued on page 138)
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Regulating for Outcomes

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to reliably determine the relevance and success of system changes. “The importance of outcomes,” he said in the August 1996 issue of the NABP Newsletter, “is that they can be linked to particular aspects of structure and process, which can be altered to produce improved outcomes. Correspondingly, the importance of structure and process is that they can be linked with outcomes.” This cyclical approach is fundamental to effective change.

According to a 2004 article, “Framework for Pharmacy Services Quality Improvement – A Bridge to Cross the Quality Chasm. Part I. The Opportunity and the Tool,” in the Journal of Managed Care pharmacy, “[q]uality improvement in health care services in the United States will be made in incremental changes that rely on a structure-process-outcome model. . . . Incremental changes in structure and process will result in the desirable outcome of meeting customer needs for more effective drug therapy and disease management.”

Based on this model, pharmacy CQI programs should include looking at the number of errors and, once systems have been modified to reduce the incidence of errors, checking to see if that reduction has actually occurred. Ensuring that appropriate changes are being implemented and leading to a reduction in quality-related events should be part of inspecting pharmacies for CQI.

By 2001, the momentum was building steam, as noted in the article, “Regulating for Outcomes as a Systems Response to the Problem of Drug-Related Morbidity,” in the Journal of the American Pharmaceutical Association. “Health care accreditation agencies are moving toward regulation for outcomes,” the article states. “Such regulations would clarify pharmacy’s role in support of safe and effective pharmacotherapy and would constitute a commitment to pharmaceutical care as public service. A widely adopted system of measuring and improving the quality of medication use and outcomes could eventually lead to quality benchmarks in the community pharmacy setting, which would more firmly establish the value of the pharmacist in pharmacotherapy.”

Today, focusing on quality and regulating for outcomes in patient care are consistent with the recommendations of the NABP 2007-2008 Task Force on Continuous Quality Improvement, Peer Review, and Inspecting for Patient Safety (CQI task force). This philosophy is an important aspect of the proposed pharmacy accreditation program that the CQI task force outlines.

To assist the boards with inspecting pharmacies to ensure that CQI practices are in place and operating successfully, the CQI task force recommends that NABP explore the possibility of developing and implementing a pharmacy accreditation program, in conjunction with the boards, that will ensure pharmacies are operating in a manner consistent with CQI standards, decreasing the occurrence of quality-related events and ultimately increasing patient safety.

With many boards facing budget strains and lacking the resources to increase the frequency and complexity of pharmacy inspections, NABP is currently exploring a community pharmacy accreditation program to address this need and to assist those boards in implementing or upholding pharmacy CQI standards in their jurisdictions.

NABP President Rich Palombo, RPh, remarked at the NABP 104th Annual Meeting in May 2008 that “the purpose and desire to develop such a program is to assist the boards and move patient safety forward. . . . Such a program will provide invaluable data to the boards about the pharmacies in their states and across the country.” This information would provide useful evidence on which to base future systems and standards. “If we are successful in assisting pharmacists to effectively implement a meaningful definition of patient safety to their practices,” President Palombo says, “we will have achieved something that is momentous and that will impact patient care and safety for generations.”

To establish a foundation for pharmacy CQI program (continued on page 142)
In April of this year, the Pharmacy Curriculum Outcomes Assessment® (PCOA®) was administered for the first time to 3,652 P1 through P4 students from 24 schools and colleges of pharmacy across the nation. A comprehensive assessment tool, the PCOA was developed by NABP and key stakeholders in response to the need expressed by the United States schools and colleges of pharmacy for assistance with curriculum development and measurement of student performance and growth.

The assessment was administered on a date chosen by each school, within the two-week period of April 7-18, 2008, and the results of the administration were sent to the participants in early July. The reports included an individual student score report, a cumulative score report, and a school summary report, and contained individual student performance information and overall school performance as it compares to national data.

Overall, the results from the first administration demonstrated a significant increase in scores from year to year. These results demonstrate the PCOA’s assessment of the pharmacy curriculum from year to year and ability to measure student performance and growth over all four professional years.

As a follow up to the 2008 administration, NABP surveyed the participating schools to determine if further improvements were needed to the administration process. Of the schools that responded, all stated that the overall testing experience was positive. In addition, 94% said they would recommend that their university participate in the PCOA next year.

Some schools requested additional flexibility for multiple testing dates within the two-week time period rather than testing all students in one day. NABP is considering the feasibility of implementing this.

Through the NABP Foundation, the educational arm of the Association, NABP was able to provide the 2008 PCOA administration to participating schools and colleges of pharmacy at no charge; however, beginning with the 2009 administration, the PCOA will be administered at a cost of $75 per student.

Additional information regarding the PCOA is available in the Assessment Programs section of the NABP Web site at www.nabp.net.
Definition sections of statutes and regulations are essential to set forth the parameters of the regulatory schemes enforced by boards of pharmacy. Equally on the forefront of board of pharmacy activities is the issue of compounding and the enforcement rights and responsibilities of the boards. Some boards are empowered to determine through rulemaking what constitutes a prescription, subject to dispensing only upon a valid script. Consider the following:

A licensed pharmacist and owner of a licensed pharmacy consulted with a patient regarding her nasal irritation. After offering to provide a product to the patient to ease her discomfort, the pharmacist compounded a nasal spray containing a mixture of 2-deoxy-d-glucose, dyclonine, miconazole, methylcellulose, sodium chloride, and distilled water. Each such substance was, by itself, a nonprescription drug, and the pharmacist sold the patient the compounded product in a bottle that was not labeled with a prescription number, the prescriber’s name, or a pharmacist’s initial on the label. The patient used the nose drops once and experienced increased nasal irritation and filed a complaint with the Iowa Board of Pharmacy.

The complaint was assigned to an investigator with the Board. During the investigation, the pharmacist admitted he compounded the nasal spray for the patient without a prescription based upon previous compounding experiences with similar substances. During the investigation related to the compounding complaint, the investigator found several additional violations of pharmacy regulations that had been noted on previous inspections. These violations included the inability to produce forms required to record transactions involving narcotics, a log for permanent and nonpermanent employees, compounding productions records, and a log book containing the initials of pharmacists who provided customers with certain cough syrups containing codeine.

The Board filed two charges against the pharmacist alleging repeated violations of Board rules regarding pharmacy operations and records and unlawful manufacturing and dispensing of a compounded drug without a prescriber’s authorization. Following a hearing, the Board found the pharmacist committed the alleged violations and placed him on probation for three years with several conditions. Specifically, the Board ordered the pharmacist to refrain from compounding of any kind without authorization from a prescriber.

The pharmacist appealed the matter to the district court alleging that the compounding regulations were unconstitutional, that the Board lacked the authority to promulgate such regulations, and that the disciplinary action was not supported by substantial evidence. The pharmacist’s petition was denied by the district court and the pharmacist appealed the matter to the Iowa Supreme Court.

The Supreme Court outlined the scope of review as a determination of errors at law. It noted the crucial question is “whether the interpretation of the statute has been clearly vested by a provision of law in the agency’s discretion.” If vested, the court will defer to the agency’s interpretation unless such is irrational, illogical, or wholly unjustifiable.

In the current matter, the court held that the legislature has delegated broad authority to the Board regarding the regulation of the practice of pharmacy. Specifically, the enabling statute conferred
on the Board the authority to adopt all necessary and proper rules to implement and interpret the practice act. Following previous case law, the court held that such language clearly vested in the Board the authority to interpret a statute.

Addressing the merits of the pharmacist’s arguments, the court examined the Board’s authority to define prescription drugs. In addition to defining prescription drugs as those defined by federal or state law, Iowa law designates a drug or device that is required by any applicable federal or state law or regulation to be dispensed by prescription only. Under this grant of authority, the Board promulgated a regulation (rule 20.2) requiring that certain drugs be dispensed by prescription only. Specifically, rule 20.2 prohibits a pharmacist from dispensing compounds consisting of exclusively nonprescription components without a prescription from a practitioner. Thus, rule 20.2 brings a compound made from exclusively nonprescription components within the definition of a “prescription drug.” The court held that the enabling statute did not vest in the Board the authority to designate compounded substances made from nonprescription drugs as a prescription drug.

The court held that the practice act clearly evidenced legislative intent to authorize the Board to determine through rule those substances that may be dispensed by pharmacists only if prescribed by a practitioner. It also noted that no other state agency is assigned the regulatory responsibilities over prescription drugs or controlled substances. The court determined that recognizing this authority in the Board was not irrational, illogical, or wholly unjustified. In its ruling, the court rejected the pharmacist’s argument that the role of the Board is to recommend to the general assembly the appropriate classification of drugs.

The court noted the relevance and importance of distinguishing between controlled substances and prescription drugs. Prescription drugs are defined as either a drug or device, and a drug is defined as:

a. a substance recognized as a drug in the current official United States Pharmacopoeia – National Formulary, official Homeopathic Pharmacopoeia, or other drug compendium or any supplement to any of them.

b. a substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals.

c. a substance, other than food, intended to affect the structure or any function of the body of humans or other animals.

d. a substance intended for use as a component of any substance specified in paragraph a, b, or c.

e. a controlled substance.

While certain chapters of Iowa statutes limit the definitions of controlled substances, no such limitation defined the parameters of prescription drugs. Thus, the court held that although limited authority has been granted to the Board to recommend to the general assembly those substances to be designated as controlled substances, no such limitation appears related to prescription drugs.

Turning its attention to the rule 20.2, the court also held that its validity would be sustained unless such rule was irrational, illogical, or wholly unjustifiable. The pharmacist contended that the rule was irrational because it forbids trained pharmacists from combining and distributing compounds composed exclusively of substances available without a prescription, while allowing non-pharmacists to do so.

The court disagreed and held that the rule was within the bounds of the Board authority and a rational and logical connection existed between the rule and the Board’s duties under the practice act to promote, preserve, and protect the public health. The Board argued that the rule was intended to draw a bright line between the practice of medicine and the practice of pharmacy. As stated by the court:

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standards, the task force developed a form for use by each pharmacy in conducting a quality self-audit at least quarterly, as well as upon a change of pharmacist-in-charge. The goals of the quality self-audit are to monitor changes in the number of quality-related events over time, as well as to evaluate compliance with CQI procedures, and to develop a plan for improved adherence with the CQI program. This mechanism for measuring outcomes provides pharmacies with a quantifiable means of assessing, initially, whether system adjustments are needed, and subsequently, whether they have improved patient care outcomes.

The task force used as a basis for its recommendations several aspects of CQI programs established over the past decade by the Massachusetts Board of Registration in Pharmacy. As mentioned earlier, the Board, under the direction of Young, who served as an ex officio member of the task force, initiated several efforts, including the establishment of the “continuous quality improvement coordinator” position. The coordinator position was created to review on-site CQI procedures established by licensed pharmacies based on “Best Practice Recommendations” implemented by the Board. These efforts assisted the Board in moving forward in its attempt to proactively regulate for outcomes and move away from a reactive, strict disciplinary approach to regulation.

The cyclical approach to outcomes assessment, systems modification, and subsequent outcomes assessment follows the basic philosophy of evidence-based medicine, which has become increasingly pertinent in medical practice. The objective is to make patient care decisions, both on an individual patient and a pharmacy systems level, based on past experience with and documentation of those systems that have proven successful. Once this assessment process begins and data is collected from multiple pharmacies, the boards may glean information on the most effective systems that lead to the best patient care outcomes, and they may anticipate problems based on previous poor outcomes.

The accumulation of such data will allow the boards to develop and implement uniform quality standards to improve outcomes nationally and, ultimately, enhance patient safety.

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Generally speaking, the practice of medicine involves the intake of patients, diagnosis of illnesses, and prescription of treatment, while the practice of pharmacy primarily consists of preparing and dispensing medications. By requiring the “prescriber/patient/pharmacist” relationship as a prerequisite to the dispensing of compounded drugs by pharmacists, the Board has exercised administrative discretion to prohibit pharmacists from diagnosing illnesses and prescribing treatment for their customers – functions traditionally undertaken by doctors. The Board could rationally and logically have concluded this exercise of discretion clearly separating the pharmacist function from that of the prescriber advances the health, safety, and welfare of pharmacists’ customers.

In addition and providing further confidence in its findings, the court noted that there is no significant market for compounding services of non-pharmacists in that non-pharmacists are not licensed to dispense drugs and do not hold themselves out as experts in compounding substances.

While agreeing with the licensee that pharmacists are not prohibited by statute or rule from recommending nonprescription drugs to their patients who describe symptoms and seek advice, the court disagreed that such activities blur the line between medicine and pharmacy in that pharmacists who do so are arguably diagnosing and prescribing. The court held that such an argument does not make this otherwise rational rule irrational, illogical, or wholly unjustifiable. Further, the court quickly disposed of the constitutional arguments of the pharmacist finding that as a pharmacist, the licensee is not similarly situated to non-pharmacists and therefore differential treatment is sustainable.

Finally, the court held that the additional violations found by the Board related to records and documentation were supported by substantial evidence and not subject to reversal. Regarding the sanctions imposed, the court deferred to the Board and found no justification to second guess the probationary period.

This case presents an interesting assessment of the authority of a board of pharmacy to implement a rule related to compounding of drugs, comprised solely of nonprescription ingredients. A careful reading of the relevant laws and definitions of controlled substances and prescription drugs revealed a legislative intent to authorize the Board to promulgate a rule defining prescription drugs. Such a judicial opinion highlights the importance of language in the enabling legislation. Boards of pharmacy are encouraged to examine applicable laws in this regard.

Houck v Iowa Board of Pharmacy Examiners, 2008 WL 2553275 (IA 2008)
Updated Model Act Incorporates Amendments Recommended by NABP Committee, Task Forces on Diversion, CQI

NABP recently amended the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy (Model Act)* to incorporate the changes that were recommended by the 2007-2008 Task Force on Prescription Drug Diversion from Common Carriers; the Task Force on Continuous Quality Improvement, Peer Review, and Inspecting for Patient Safety; and the Committee on Law Enforcement/Legislation. The emphasis of the amendments was to further protect the public in the distribution of prescription drugs and, more importantly, to improve quality and safety in patient care.

Amendments resulting from recommendations of the Task Force on Prescription Drug Diversion from Common Carriers include several new definitions and provisions that increase reporting requirements and security for prescription drug distribution.

For instance, new definitions were added for *common carrier* and *significant loss*. *Common carrier* “means any person or entity who undertakes, whether directly or by any other arrangement, to transport property including Prescription drugs, for compensation.”

*Significant loss* “means any loss of a Prescription Drug that exceeds a reasonable level established by like persons, which requires the loss to be reported to the Board or as required by [Drug Enforcement Administration (DEA)] or other state and/or federal agencies for Prescription drugs and Controlled Substances.”

These definitions were further clarified by newly added comments that specifically exclude wholesale distributors from the definition of common carriers, as they are separately defined. A comment also provides factors to consider when determining what constitutes a significant loss. Such factors include:

- the actual quantity of prescription drugs or controlled substances lost in relation to the type of business;
- the specific prescription drugs or controlled substances lost;
- whether the loss can be associated with access by specific individuals or attributed to unique activities;
- a pattern of losses over a specific time period, whether the losses appear to be random, and the results of efforts taken to resolve the losses;
- whether the specific prescription drugs or controlled substances are likely candidates for diversion;
- local trends and other indicators of the diversion potential of the missing prescription drugs or controlled substance; and
- if it is determined that the loss is not significant, a record of the occurrence should be kept for future reference.

The revised *Model Act* also includes new reporting requirements for significant losses of prescription drugs and controlled substances.

For instance, a new provision was added to the Model Rules for the Practice of Pharmacy that gives the pharmacist-in-charge the additional responsibility of “reporting any theft, suspected theft, diversion, or other Significant Loss of any Prescription Drug within one business day of discovery to the Board of Pharmacy or as required by DEA or other state or federal agencies for Prescription drugs and Controlled Substances.”

Additional information on these updates is contained in the accompanying article and a current version of the *Model Act* is available for download in the Publications section of the NABP Web site at www.nabp.net.

- Due diligence – a wholesale distributor must provide “a list of all secured common carriers approved by the Wholesale Distributor” and the distributing or acquiring wholesale distributor must “require
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BTC Drug Class: Exploring a Third Tier in Continued Protection of Public Health

Whether referred to as transitional, third, counseling, pharmacist-managed, or behind-the-counter (BTC), the primary purpose behind the development of an additional drug class is the same – to sustain patient safety while providing increased access to certain vital medications. As debates continue on whether a three-tiered drug system should be implemented in the United States, a BTC drug class may be on the horizon. Establishment of a BTC drug class would allow patients access to medications that were previously available by prescription only, while preventing possible medication misuse through patient counseling and monitoring provided by pharmacists. The demand for this intermediary class of drugs comes at a time when patients’ interests in their own health care and their desire for empowerment expands worldwide.

Many proponents of this BTC class have suggested that the class would likely include vaccines, oral contraceptives, antimigraine medications, epinephrine auto injectors, antivirals, smoking-cessation products, and statins such as Merck & Co’s Mevacor®, which was recently denied over-the-counter (OTC) status by Food and Drug Administration (FDA). The key characteristics of these medications is that they treat conditions that can be detected easily and accurately, do not require complex monitoring, have favorable benefit-to-risk ratios, have few adverse effects, and have a low potential for abuse. Ultimately, the classification of these medications would be FDA’s decision.

FDA, NABP, Others Discuss BTC

Though the subject of a third drug class has been discussed by regulators and others in the practice of pharmacy for many years, FDA recently took a more active approach in investigating the concept, holding a public meeting late last year. The meeting was held to discuss the development of a BTC drug class and explore its possible benefits to patients. Calling on health care organizations, professionals, experts, and consultants; OTC drug makers; retail pharmacies; pharmacy schools; and other interested stakeholders to share their knowledge and insight on the subject, the meeting addressed mixed views of the proposed BTC drug class. (A transcript of the November 14, 2007 FDA public meeting is available at www.fda.gov/oc/op/btc/transcripts11_14_07.html.)

During the meeting, FDA Commissioner on Public Policy Randall W. Lutter commented on FDA’s reasoning and timing for revisiting the subject. “There’s been a collection of changes over the years,” he stated, “and I think most recently they’re really driven by an increased trend toward consumer involvement and consumer and patient empowerment in their own decisions and responsibilities that they take for health care.” Additionally, Lutter mentions that with the Internet leading to increased consumer and patient awareness, the time seems appropriate to improve public health.
through increased access, and explore whether that access can be accomplished through the implementation of a BTC drug class.

With several participants present to share their views on a new drug class, FDA was pleased with the outcome of its November public meeting, stating that the agency’s next steps will be to evaluate how the BTC system will work and to examine the statutory authority FDA currently holds to determine whether additional legislation will be necessary.

Several organizations openly advocated the development of the BTC drug class and commended FDA for taking further initiative to explore the idea. Along with enthusiastic support, many provided their own suggestions and thoughts regarding a BTC drug class. Though not taking a position for or against a BTC drug class, the National Association of Chain Drug Stores declared its belief that the class should be used as a clinical service, not as an enforcement method, stating that if a medication contained a clear clinical profile requiring pharmacist intervention it should be available BTC. The BTC drug class should not be used as a means of enforcing age, placing quantity-based limits, or otherwise restricting patient access. Unlike the requirement that products containing pseudoephedrine be moved behind the counter, which was implemented to reduce diversion, FDA intends for a BTC class of drugs to provide opportunities for increased informative interaction between pharmacists and patients, rather than act as a barrier between patients and their medications.

In response to some organizations questioning pharmacists’ knowledge and skills related to managing a BTC drug class, the American Pharmacists Association (APhA) reported that pharmacists have demonstrated their abilities to deliver vital clinical care, stating in its extensive comments to FDA that in 44 states pharmacists successfully take part in screening, evaluating, and administering vaccines, and are adapting nationwide to the sales restrictions on nicotine replacement therapy products, unique requirements of levonorgestrel (Plan B®), and the congressionally mandated controls on pseudoephedrine products.

APhA voiced its support for the development of a BTC drug class based upon four key principles: that pharmacist-patient clinical intervention is essential; that FDA base its BTC categorization decisions on science; that the processes for drug availability without a prescription be uniform; and that pharmacists are compensated for the clinical services provided.

In addition, the issue of pharmacist liability and whether it would increase significantly with the responsibility of managing a BTC drug class was raised at the meeting. Though liability would be an obvious concern, as it is for all those practicing health care, pharmacists are already expected to interact with patients and, therefore, liability should not increase as clinical intervention services are within the scope of pharmacy practice. Rather, liability for pharmacists may in fact decrease with the implementation of the BTC drug class as collaboration within the pharmacist-patient-practitioner triad is expected to increase, thereby collapsing existing communication barriers and resulting in improved patient care.

NABP was also an active participant during the FDA open meeting in November. The Association testified that “a transitional class of drugs would provide significant benefits to patients without decreasing access to such medications, . . . would allow FDA and manufacturers to collect additional data on drugs similar to phase four clinical trials, and provide valuable data about the side effects and safety of the drug, what the long-term risks and benefits are, and how well the drug works when it’s used more widely than at clinical trials.” This monitored middle-tier drug

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class would allow FDA to collect additional data to more accurately determine if medications in that class can be safely transitioned to OTC status.

NABP Advocates BTC Drug Class

A long-time proponent for the development of a BTC drug class, NABP has continually stressed that moving certain drugs directly from prescription only to OTC places patients at potential risk, especially when those medications have serious side effects and require special monitoring. NABP believes a BTC drug class will promote patient counseling where necessary, providing an additional component to ensuring patient safety.

During its 104th Annual Meeting in Baltimore, MD, NABP passed Resolution No. 104-6-08 Behind-the-Counter Class of Drugs, which directs NABP to “collaborate with FDA and interested stakeholders to develop the statutory authority and other necessary legislative language to establish a behind-the-counter class of drugs that would be available without a prescription but only after intervention by a pharmacist.” This was the third resolution passed addressing NABP’s support of the establishment of a transition class of drugs. In her report as incoming president, regarding patients who might receive BTC drugs from their pharmacists, Vandever stated, “[I]f first counseled by a pharmacist, such patients would be prepared for possible side effects, more likely to relate them to the drug, and more apt to seek advice from their pharmacist or physician.”

According to Vandever, putting certain medications in a BTC class rather than moving them straight to OTC would assist in reducing errors related to these medications, and correct patients’ improper use of these products once access to these drugs would not be available unless the patients were first counseled.

During this same time period in 1995, Michigan Congressman John D. Dingell requested that the Government Accountability Office (GAO) investigate the benefits of a BTC drug class. Like NABP, Dingell was a long-time advocate for an expanded role of pharmacists in educating patients about their own drug therapy. In its investigation, GAO compared 18 European systems with a pharmacist or pharmacy-controlled system and evaluating the overall degree and quality of patient counseling in the US at present. GAO investigators also examined results of the Florida Pharmacist Self-Care Consultant Law. In its report, “Nonprescription drugs: Value of a Pharmacist-Controlled Class Have Yet to Be Demonstrated” the GAO concluded that “little evidence supports the establishment of a pharmacy or pharmacist class of drugs in the US at this time, as either a fixed or transition class.”

Despite this assessment, hopes remained high among NABP and the state boards of pharmacy and in November 1995, the NABP Executive Committee approved language to be proposed as an amendment to Title 21, Section 353 of the Federal Food, Drug, and Cosmetic Act. Once again, however, the Association met resistance when the proposed amendment was introduced to legislators. Subsequently, little activity occurred regarding the BTC drug class.

By 2004, however, prescription-only to OTC medication switches were again on the rise. FDA reported that the agency’s goal was to increase prescription-to-OTC switches by 50% for its 2004 fiscal year budget. With this increase, the need and timeliness of a BTC drug class became apparent and activity in this area resurfaced.

In August 2006, the emergency contraceptive, Plan B, was approved for OTC use by women 18 years and older. Because it remained a prescription-only drug for women 17 and younger, FDA required it to be kept behind the pharmacy counter. With its unique classification, Plan B raised many logistical and administrative challenges; however, the switch renewed the demand for a third class of drugs. (See the November-December 2006 NABP Newsletter “Plan B Availability OTC Raises Logistical and Administrative Challenges.”)

What’s Next?

Even with many issues addressed, a plethora of questions remain. In a January 16, 2008 letter to the GAO, Congressman Dingell and Congressman Bart Stupak requested that GAO update its 1995 study by examining any new available data. The letter stated, “it is imperative that more data be provided to assess accurately the true benefits, if any, of a BTC class of drugs.”

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The NABP 2008 Symposium, to be held December 4-5, 2008, at the JW Marriott Starr Pass Hotel in Tucson, AZ, offers attendees the opportunity to collaborate with peers on solutions in the fight against counterfeit drugs and to share insight on the logistics for establishing uniform requirements for a behind-the-counter (BTC) drug class. The one-and-a-half day Symposium welcomes board of pharmacy executive officers, members, and compliance officers to hear from experts from the pharmacy profession, and gives these attendees the opportunity to discuss these issues with state and federal regulators and stakeholders in the practice of pharmacy. All attendees can earn up to 12 hours (1.2 CEUs) of Accreditation Council for Pharmacy Education-approved continuing pharmacy education credit.

### Educational Programming

**Thursday, December 4**

**8 AM - noon**

**Counterfeit Drugs: Serious Threat or Ploy?**

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**Noon - 1:15 PM**

**Luncheon**

**1:30 - 5 PM**

**Joint CPE Programming**

**What Are We Going to Do to Counter Counterfeiting?**

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**6 - 6:30 PM**

**Meet and Greet . . . a networking opportunity**

(Cash bar will be available.)

### State and federal pharmacy regulators, as well as law enforcement agencies, continue to gauge anti-counterfeiting efforts and seek to gain as much information as possible – but are counterfeit drugs a true concern? If so, can these concerns be substantiated? Why do some people, including legislators and patients, continue to ignore the warnings? This session will provide an overview of the problem of drug counterfeiting and what can be expected in the future. Attendees will earn four contact hours (0.4 CEUs) of continuing pharmacy education credit as they hear from experts on the following topics:

- The Hard Evidence of Counterfeit Drugs
- A Global Look at Counterfeiting
- Illegal Importation: Point-Counterpoint
- Prevalence of Counterfeit Drugs from Manufacturer to Patient
- Diversion through Secondary Wholesalers

### Friday, December 5, 2008

**6:30 AM - 7:15 AM**

**Qigong Class**

**7:15 AM - 8:30 AM**

**Continental Breakfast**

**8:30 AM - 1 PM**

**Joint CPE Programming**

**Behind-the-Counter Class of Drugs: Is the Time Right?**

ACPE Program #205-000-08-010-L03-P

(0.45 CEUs – 4.5 contact hours)

Note: The NABP 2008 Symposium schedule is subject to change.

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**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.
Recently, the Indiana Board of Pharmacy and North Dakota State Board of Pharmacy began recognizing and accepting surety bonds payable to other states provided the wholesale distributors are accredited through the Verified-Accredited Wholesale Distributors® (VAWD®) program. Both Indiana and North Dakota passed legislation to require VAWD accreditation; however, in addition to the VAWD requirements, they initially required that all wholesale distributors wishing to be licensed in either of their states obtain a surety bond with Indiana or North Dakota named as the beneficiary, respectively. By recognizing surety bonds payable to other states, Indiana and North Dakota are now providing wholesale distributors with an opportunity to apply for VAWD accreditation within their states without the obligation to obtain additional surety bonds.

Prior to the change, a distributor that wished to obtain licensure in Indiana or North Dakota and was licensed in a different state was required to obtain a separate surety bond, specifically payable to Indiana or North Dakota in the amount of $100,000. As such, the surety bond requirements for Indiana and North Dakota were in addition to bonds mandated by other states in which the wholesale distributor was licensed. NABP worked closely with the Indiana and North Dakota boards of pharmacy to ensure that recognizing surety bonds payable to other states remains in the best interest of the boards.

According to the Model Rules for the Licensure of Wholesale Distributors section of the Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy, all wholesale distributors are required to provide “a surety bond of not less than $100,000, or other equivalent means of security acceptable to the Board or a third party recognized by the Board.” In addition, the Model Rules also provide for a waiver of the surety bond requirement for publicly traded companies and in instances where the wholesaler has a bond payable to another state. The VAWD criteria also states that “the wholesale distributor maintains sufficient liability insurance coverage and secured monetary funds to ensure payment in the event damages, fines, costs, and the like are assessed against the wholesale distributor.” Though a surety bond in the amount of $100,000 is required, the VAWD program does not specify a beneficiary.

Several state boards of pharmacy require that wholesale distributors obtain a surety bond in order to be licensed in their state and may have additional requirements pertaining to these bonds separate from the requirements of the VAWD program. NABP recommends that wholesale distributors contact individual state boards of pharmacy directly to confirm licensure requirements and accreditation recognition.

Currently, 21 states recognize VAWD or some form of wholesale distributor accreditation, and a total of approximately 275 facilities across the United States have obtained VAWD accreditation. For additional information on the VAWD program, visit the Accreditation section of the NABP Web site at www.nabp.net.
NABP Revisits TOEFL iBT Standards for FPGEC Certification, Convenes Task Force to Assess Findings

Recently, NABP again reviewed the expectations and standards set for the Foreign Pharmacy Graduate Examination Committee™ (FPGEC®) Certification Program in order to ensure that these requirements continue to uphold pharmacy practice standards while remaining realistically attainable for qualified FPGEC applicants. In addition, this review was a response to inquiries regarding the fairness of the passing standards NABP set for the Test of English as a Foreign Language™ Internet-based Test (TOEFL® iBT). The test is being phased in worldwide to replace the TOEFL and Test of Spoken English™ (TSE®).

The TOEFL iBT, which is a requirement for achieving FPGEC certification, is an English language proficiency test based on four components: reading, listening, speaking, and writing and is provided by the Educational Testing Service (ETS). Currently, the FPGEC requires all applicants to score a minimum of 21 on the reading component, 18 on the listening component, 26 on the speaking component, and 24 on the writing component in order to qualify for FPGEC certification.

In anticipation of the TOEFL iBT phase in, a standard-setting meeting was held in May 2005 in which representatives from NABP participated, along with representatives from five other health care organizations including the National Council of State Boards of Nursing, Educational Commission for Foreign Veterinary Graduates, Commission on Graduates of Foreign Nursing Schools (CGFNS International), the National Board for Certification in Occupational Therapy, and the Federation of State Boards of Physical Therapy. The meeting was hosted by ETS and provided participants with the opportunity to discuss the existing TOEFL and TSE standards in order to develop consistent and appropriate standards for the TOEFL iBT. The outcome was a recommended baseline of passing standards necessary for health care professionals to carry out their responsibilities.

Subsequent to the standard-setting meeting, NABP reviewed these recommended passing standards with the intent to maintain the integrity of the practice of pharmacy while also considering the command of the English language necessary for foreign pharmacy graduates to safely practice in the United States.

The command of the English language necessary for foreign pharmacy graduates to safely practice in the United States.

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The International Commission on Healthcare Professionals', a division of CGFNS International, minimum passing score was found to differ slightly from NABP, requiring a score of 25. During the mean score comparison it was also found that in order to be licensed as a dentist in the US, graduates must have obtained their degrees within the US.

NABP’s required speaking component score of 26 for the TOEFL iBT was also found to be equivalent to a score of 50 on the TSE, the minimum passing requirement for FPGEC certification.

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NABP Symposium
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and Closed Door Pharmacies: An Update
• Malware Ties to Online Drug Distributors and Organized Crime: What are the Implications?
• Pedigrees: From Tomatoes to Jalapeños to Pharmaceuticals
• California Pedigree Law Update

Thursday, December 4
1:30 - 5 PM
What Are We Going to Do to Counter Counterfeiting?
Looking to the future, this session presents information on the need for the industry and regulators to share information obtained in their efforts to protect products and cooperate for effective outcomes as well as provides information on current and potential future efforts by NABP to curb counterfeiting, avert illegally operating rogue Internet drug outlets, and protect the public health. In addition, this session, which provides three-and-a-half contact hours (0.35 CEUs) of continuing pharmacy education credit, offers participants the opportunity to participate in roundtable discussions on the following topics:
• The “Haves” and the “Have Nots” of Pedigrees
• Educating about Internet Drug Safety – Strategies for Informing and Educating Patients
• The Dream Team: A Strategy for Combating Counterfeit Drugs

Friday, December 5
8:30 AM - 1 PM
Behind the Counter Class of Drugs: Is the Time Right?
In the final session of the Symposium participants will hear from Food and Drug Administration about the ins and outs of establishing a BTC class of drugs and how this will affect board of pharmacy rulemaking and the practice of pharmacy, as well as how the Federal Food, Drug, and Cosmetic Act will have to be amended to allow for a BTC class of drugs and how state pharmacy practice laws and regulations may affect the dispensing of BTC medications. A representative from the National Association of Pharmacy Regulatory Authorities will also be on hand to describe the association’s experiences with a BTC class of drugs. Finally, a stimulating point-counterpoint discussion will present participants with proponents’ and opponents’ viewpoints and debate from various entities about the benefits and risks of creating a third, BTC class of drugs. Participation in this session will enable attendees to earn four-and-a-half contact hours (0.45 CEUs) of continuing pharmacy education credit.

Additional information about the NABP 2008 Symposium and registration forms for the meeting are available in the Meetings section on the NABP Web site at www.nabp.net.
Fast, easy, and available at a low cost, NABP LAW® Online continues to provide state boards of pharmacy and other researchers a complete and accurate online database of state pharmacy laws and regulations for 51 jurisdictions (all 50 states and the District of Columbia).

Established in 1993 with its data first distributed on floppy disks, NABP LAW has grown to an online format with many benefits, servicing a diverse group of subscribers. NABP can aid state boards of pharmacy with research for writing statutes and regulations as the database provides comprehensive answers to queries of the laws and regulations implemented and amended by other states. This streamlined research process allows comparisons of findings for multiple states.

In addition to the state boards of pharmacy, the database is utilized by law firms, chain drug stores, pharmaceutical manufacturers, health care organizations, Internet pharmacy practice sites, pharmacy associations, colleges and universities, as well as students needing research assistance.

In 2005, the NABP LAW database was upgraded to improve usability, and since then NABP has received many compliments regarding NABP LAW’s ease-of-use compared to other services. One reason that subscribers may find NABP LAW more accessible than other database research tools is NABP LAW’s straightforward layout and design. NABP LAW Online narrows the search field strictly to the state pharmacy laws and regulations of each state – subscribers do not have to wade through huge amounts of regulatory information pertaining to other professions. The database’s powerful capabilities also allow users to research subjects one state at a time or pull information from multiple states all at once.

Along with a simple, clutter-free navigation system, NABP LAW provides subscribers with knowledgeable NABP staff members who continually update the database to ensure the most updated and accurate information is available, and to assist with any questions on how to perform a search. In addition, those interested in subscribing can try the online demonstration free of charge, allowing them to see if the research tool is right for them before making the commitment to subscribe. (Go to www.nabp.net and click on NABP LAW.)

NABP LAW provides a variety of subscription options. Subscriptions are available on a daily, weekly, monthly, or annual basis. Special pricing is offered to the state boards of pharmacy and schools and colleges of pharmacy.

Annual first-year subscribers who renew their NABP LAW subscriptions are rewarded with a $300 discount to continue in the second year and will continue to receive this discount in all subsequent years they renew their subscriptions.

Future enhancements are on the way for NABP LAW, including 24/7 online subscribing.

To subscribe to NABP LAW Online, visit the NABP Web site at www.nabp.net, or call Customer Service at 847/391-4406 and ask to speak with the NABP LAW coordinator.

Subscriptions can be ordered by filling out the subscription form and mailing it to NABP with a check or money order. Credit card payments may be made over the phone. The subscription form can be printed from www.nabp.net.

### NABP LAW Online Offers Variety of Subscription Options

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With several options to choose from, NABP LAW Online allows users to select a subscription to best meet their needs.
Medication Error Reporting Notice Required in Delaware Pharmacies

The Delaware State Board of Pharmacy reports in its June 2008 Newsletter that the Board is the contact agency for reporting unresolved medication errors in that state. Every Delaware pharmacy is required to provide a conspicuous notice to consumers informing them of this fact, as stated in 24 Del. C. §2528(a)(5). The following information should be posted in each pharmacy: Medication errors or violations of pharmacy law may be reported in writing to the Division of Professional Regulation at www.dpr.delaware.gov or via phone at 302/744-4500.

Kansas Board Recaps 2008 Legislative Changes

The Kansas legislature passed several important pharmacy-related bills during its 2008 session. Senate Bill (SB) 491 creates the prescription drug monitoring program (PMP) recommended by the Pre-monitoring program (PMP) during its 2008 session. The Senate Bill (SB) 491 requires pharmacies to report its findings to the Board within six months pursuant to a proviso from the Kansas 2007 legislative session. The bill requires the Kansas State Board of Pharmacy to establish and maintain a PMP for Schedule II through IV controlled substances. Each distributor of controlled substances is required to electronically submit to the Board each controlled substance prescription dispensed. The Board must develop and maintain a database, which will be confidential with limited access to only persons authorized by the Board to access the data. The Board may also require the Board to provide technical support to entities that wish to participate.

Additionally, House Bill (HB) 2578 creates the Utilization of Unused Medications Act, a voluntary program through which adult-care homes, mail-service pharmacies, and medical-care facilities may donate unused medications to indigent health care clinics, federally qualified health centers, or community mental health centers for distribution to medically indigent Kansas residents. The bill would establish criteria for which medications can be donated, including provisions that medications must come from a controlled storage unit of the donating entity, must be in either their original tamper-evident packages, and be nonexpired. Controlled substances cannot be donated. The Board will establish and implement the unused medication program and provide technical support to entities that wish to participate. The Board will promulgate rules and regulations for program implementation by December 1, 2008.

NEWLY ACCREDITED VAWD FACILITIES

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

**Priority Healthcare Distribution, Inc**

*dba CuraScript SD Specialty Distribution*

Groveport, OH

Accredited July 8, 2008

Priority Healthcare Distribution, Inc

dba CuraScript SD Specialty Distribution

Grove City, OH

Accredited July 8, 2008

A full listing of accredited VAWD facilities is available on the NABP Web site at www.nabp.net.
Updated Model Act
(continued from page 143)

that all Common Carriers contracted with or utilized by the Wholesale Distributor conduct criminal background checks of employees whose responsibilities include handling Prescription Drugs.”

1. Record keeping – a mandatory reporting requirement was revised to include “any theft, suspected theft, diversion, or other significant loss of any Prescription Drug or Device to the Board and [Food and Drug Administration (FDA)], and where applicable, to DEA.” A new comment was also added to include that this information should be reported to NABP if NABP becomes a data collection repository.

2. Policies and procedures – the addition of a procedure for wholesale distributors to verify the security provisions of common carriers.

Amendments recommended by the Task Force on Continuous Quality Improvement, Peer Review, and Inspecting for Patient Safety include two new definitions and several definition revisions. New definitions include peer review and peer review committee. Peer review establishes what should be involved for “a process that is part of an outcome-based, continuous quality improvement process” and specifies that it “should not be a punitive activity or a performance evaluation.” Peer review committee also includes a clarifying comment, which describes possible functions and who may be included as members.

The definition of the practice of pharmacy was revised to include the “effective use of emerging technologies and competency-based training.” Quality-related event (QRE) was revised for clarification and periodic self-audit was changed to quality self-audit and was also revised to “assess the effectiveness of the Continuous Quality Improvement (CQI) Program.”

The revised Model Act also includes a new provision pertaining to CQI programs, specifically in the protection from discovery language, which is aimed to increase the protection afforded to licensees when participating in CQI programs. In addition, the subsection was revised so that boards were not prevented from reviewing a pharmacy’s CQI program and related records, provided a subpoena was issued, “as necessary to protect the public health and safety.”

Additionally, the CQI program subsection was substantially revised to include specific components that, if followed, “may be considered by the Board as a mitigating factor in the investigation and evaluation of a QRE.” The subsection also provides that pharmacies conduct a quality self-audit at least quarterly to “determine whether the occurrence of QREs has decreased and whether there has been compliance with preventative procedures.”

The task force also recommended the development of standardized forms to assist pharmacies in developing and maintaining CQI programs. The newly revised and developed forms include the Community Pharmacy Quality-Related Event Data Collection Form, the Community Pharmacy Continuous Quality Improvement Program Inspection Form and the Community Pharmacy Quality Self-Audit, which can be found in Appendix F of the Model Act.

Amendments recommended by the Committee on Law Enforcement/Legislation include adding the definition of a valid patient-practitioner relationship and revising the definition of prescription drug order so that it includes the existence of a valid patient-practitioner relationship. A valid patient-practitioner relationship exists when the following have been established:

1. a face-to-face physical examination adequate to establish the medical complaint has been performed by the prescribing practitioner or in the instances of telemedicine through a telematic practice approved by the appropriate practitioner board; and

2. some logical connection exists between the medical complaint, the medical history, and the physical examination and the drug prescribed.

A newly added comment clarifies the definition and suggests that this relationship should be addressed in each jurisdiction’s medical practice act and consumer fraud protection act or their equivalents.

Along the same line, amendments also included a new provision in the pharmacy practice section of the Model Rules for the Practice of Pharmacy that prohibits a pharmacist from dispensing a prescription drug “if the Pharmacist knows or reasonably should know that the Prescription Drug Order was issued solely on the basis of an Internet-based questionnaire, an Internet-based consultation, or a telephonic consultation, all without a valid Patient-Practitioner Relationship.”

The updated Model Act is available in the Publications section of the NABP Web site at www.nabp.net.
Switch to HFA-Propelled Albuterol Inhalers Advised Prior to CFC Ban

Food and Drug Administration (FDA) recently issued a public health advisory alerting patients, caregivers, and health care professionals to switch to hydrofluoroalkane (HFA)-propelled albuterol inhalers because chlorofluorocarbon (CFC)-propelled inhalers will not be available in the United States after 2008. CFC-propelled albuterol inhalers are being phased out to comply with the Clean Air Act and an international environmental treaty, the Montreal Protocol on Substances that Deplete the Ozone Layer. Under this treaty, the US has agreed to phase out production and importation of ozone-depleting substances including CFCs. No CFC-propelled albuterol inhalers may be produced, marketed, or sold in the US after December 31. Three HFA-propelled albuterol inhalers have been approved by FDA: Proair™ HFA Inhalation Aerosol, Proventil® HFA Inhalation Aerosol, and Ventolin® HFA Inhalation Aerosol. In addition, an HFA-propelled inhaler containing levallbuterol is available as Xopenex® HFA Inhalation Aerosol. More information is available on the FDA Web site at www.fda.gov/cder/mdt/albuterol.htm.

DEA Proposes Rule for e-Prescribing of Controlled Substances

On June 27, 2008, the US Drug Enforcement Administration (DEA) published a proposed rule that will provide practitioners with the option of writing prescriptions for controlled substances electronically and will allow pharmacists to receive, dispense, and archive the electronic prescriptions. DEA maintains that the proposed regulations will reduce paperwork for registrants and have the potential for decreasing prescription forgeries. Additionally, the proposed regulations could reduce prescription errors due to illegible handwriting or oral miscommunication, and will increase efficiency by allowing pharmacies and hospitals to integrate prescription and medical records. The agency is now accepting comments on the proposed regulations that must be postmarked, or electronically sent, on or before September 25, 2008. A detailed explanation of the regulations will be published in an upcoming issue of the NABP Newsletter. Additional information regarding the proposed rule is available at the Federal Register at http://frwebgate4.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=031933218375+0+1+0&WAISaction= retrieve.

NABP Past President Joseph J. Schwemin Passes

Joseph J. Schwemin, BS, passed away on July 13, 2008, at the age of 85. He was an active member of NABP, serving on the Executive Committee from 1970 to 1973, and as president of NABP from 1973 to 1974. He was also the executive director of the Oklahoma State Board of Pharmacy.

Schwemin served in the Marine Corps during World War II and attended the pharmacy program at Southwestern Oklahoma State University (SWOSU). In 1955, Schwemin and his father bought Vern Rexall Drug in Tulsa, OK, and operated in partnership until his father passed away in 1963. He is widely known among those in the profession for his many contributions made to the practice of pharmacy.

Schwemin was an active member of the Oklahoma Pharmaceutical Association, serving as president from 1961 to 1962. He chaired the Controlled Dangerous Substances Diversion Investigation Unit for the State of Oklahoma Policy Board and was a member of the Board of Directors of the Bureau of Narcotics and Dangerous Drugs, as well as several drug committees for the State Board of Health, Department of Mental Health, and Department of Public Safety. In addition, Schwemin served as president and was a member of the board of directors of the Oklahoma Pharmacy Heritage Foundation Inc.

In 1962, Schwemin received the Bowl of Hygeia Award, presented by the National Association of Retail Druggists. A scholarship was also established at SWOSU to honor him. In addition, Schwemin was inducted into the Oklahoma Pharmacy Hall of Fame by the Oklahoma Pharmacy Heritage Foundation board and is listed in the Who’s Who in America.

NABP is deeply saddened by Joseph Schwemin’s death and will miss him greatly. He continued to contribute to NABP as an active member of the Association after his presidency until he retired.

Schwemin is survived by his wife, Louise; six children; 12 grandchildren; 10 great grandchildren; and his sister.
NABP Continues to Report Not Recommended Internet Drug Outlets on Association Web Site

As part of its mission to educate patients about the potential dangers of purchasing medication online, NABP continues to identify Internet drug outlets that appear to be out of compliance with state and federal laws or NABP patient safety and pharmacy practice standards. Those Internet sites reviewed and identified as such thus far are posted on the NABP Web site and listed as Not Recommended.

As of September 5, 2008, 796 sites are listed as Not Recommended. Of these:

- 749 sites do not require a valid prescription
- 566 sites offer foreign or non-FDA-approved drugs
- 395 sites are located outside of the United States and selling drugs illegally to patients in the US
- One site is listed as a Reviewed Internet Pharmacy Practice Site™. This site appears to comply with state and federal laws and NABP patient safety and pharmacy practice standards based on a review of available public information.

NABP advises consumers to use Reviewed Internet Pharmacy Practice Sites with caution, as information to conclusively determine the legitimacy and legality of these sites may not have been available.

Fifteen sites are listed as Recommended. These sites are accredited through the NABP Verified Internet Pharmacy Practice Sites™ (VIPPS®) program.

NABP recommends that consumers use VIPPS-accredited Internet pharmacies. All VIPPS sites have completed the rigorous NABP accreditation process, which includes a thorough review of all policies and procedures regarding the practice of pharmacy and dispensing of medicine over the Internet, as well as an on-site survey of the facilities used by the site to receive, review, and dispense medicine.

Full listings of Recommended, Reviewed, and Not Recommended sites, along with program criteria and related patient information, are available in the Internet Pharmacies section of the NABP Web site, www.nabp.net.

Around the Association

Board Member Appointments

- Dale Carlson, MM, has been appointed a public member of the Michigan Board of Pharmacy. Carlson’s appointment will expire on June 30, 2010.
- Maria Olmo Diaz, RPh, has been appointed a member of the Puerto Rico Board of Pharmacy. Olmo’s appointment will expire on November 16, 2010.
- Migdalia Ruiz Vicente, BS, has been appointed a member of the Puerto Rico Board of Pharmacy. Vicente’s appointment will expire on December 10, 2011.
- Tomas Ramirez, RPh, has been appointed a member of the Puerto Rico Board of Pharmacy. Ramirez’s appointment will expire on August 13, 2011.
- Albert Hill, RPh, has been appointed a member of the Tennessee Board of Pharmacy. Hill’s appointment will expire on July 30, 2012.
- Brenda S. Warren, RPh, has been appointed a member of the Tennessee Board of Pharmacy. Warren’s appointment will expire on July 15, 2013.

Board Member Reappointments

- Gary Dewhirst, RPh, has been reappointed a member of the North Dakota State Board of Pharmacy. Dewhirst’s appointment will expire on May 8, 2013.

Board Officer Changes

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

- Cathryn J. Lew, RPh, President
- Lee Howard, Vice President

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

- Randolph A. Harrop, RPh, President
- Alison Kay McManus, RPh, Vice President
- Terry Carr, RPh, Secretary-Treasurer
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