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New Mexico Board of Pharmacy News

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Significant Adverse Drug Events

1. A 62-year-old female patient diagnosed with insomnia and depression was prescribed Ambien® 10 mg to be taken nightly. The pharmacy instead dispensed Abilify® 10 mg. After taking the medication for four days, the patient reported insomnia as well as feelings of agitation and fatigue. The pharmacist attributes the error to a break in protocol – filling and performing the final check on the prescription instead of allowing the technician to fill. The pharmacist recommends calling the prescriber on all poorly legible prescriptions, even those that the pharmacist believes he or she can interpret correctly, and only allowing the technician to fill so that the pharmacist can focus on the final check.
2. A 44-year-old female patient with a history of migraines and a codeine allergy attempted to pick up a renewal prescription for butalbital/APAP/caffeine. The pharmacy mistakenly dispensed butalbital/APAP/caffeine/codeine. After taking the medication for an unspecified amount of time, the patient experienced nausea, broke out in a rash, and fainted. The pharmacy attributes the error to understaffing and lean payroll hours, and a break in protocol. A "floater" or fill-in pharmacist bypassed the barcode scanning technology/scale and proceeded to type, fill, and perform the final check on the prescription. The pharmacy recommends adhering to protocol for the filling of prescriptions.
3. A two-year-old female patient was prescribed amoxicillin suspension for an infection. The pharmacy instead dispensed generic Augmentin® (amoxicillin-clavulanate). The patient's mother reported that the patient threw up after taking the medication for an unspecified amount of time. The pharmacist attributes the error to poor staffing/busy pharmacy and a break in filling protocol. The pharmacist both filled and performed the final check on the prescription, which is against normal protocol. The pharmacist recommends following protocol by having the technician fill prescriptions instead of the pharmacist.
4. A 68-year-old male patient with an enlarged prostate attempted to pick up a refill of his dutasteride 0.5 mg prescription. The pharmacy dispensed to the patient both dutasteride 0.5 mg and duloxetine 60 mg bottles from its stock and labeled them both dutasteride 0.5 mg. After taking the duloxetine 60 mg for an unspecified amount of time, the patient missed work and experienced the following: racing thoughts, cardiac arrhythmias, shortness of breath, insomnia, dry mouth, urinary retention, tremors, sweating, and nightmares. The pharmacist attributes the error to a break in filling protocol. Typically, all bottles dispensed are scanned through barcode/scale technology, but in this situation, one bottle was scanned multiple times. The pharmacist recommends following operating procedures in relation to filling prescriptions by scanning all bottles being dispensed to the patient.
5. A 72-year-old male patient attempted to pick up a refill prescription for levothyroxine 50 mcg. The pharmacy placed a prescription for glipizide ER 10 mg into the patient's bag instead of levothyroxine. The glipizide was labeled for another patient. After taking the medication for an undisclosed period of time, the patient reported feeling unwell to his oncology physician, who in turn identified the misfill. The pharmacist attributes the error to multitasking and attempting to verify multiple prescriptions at once to save time. The pharmacy manager recommended retraining staff to follow procedures and verify only one prescription at a time.

Disclaimer: These suggestions are made by the pharmacist submitting the Significant Adverse Drug Event Report. The New Mexico Board of Pharmacy may not necessarily agree with these suggestions.

National Pharmacy Compliance News

June 2020

NABPF
National Association of Boards of Pharmacy Foundation

The applicability of articles in the *National Pharmacy Compliance News* to a particular state or jurisdiction can only be ascertained by examining the law of such state or jurisdiction.

President Trump Signs Legislation Extending Schedule I Status for Fentanyl Analogues

A law to extend the Schedule I status of fentanyl analogues for another 15 months was signed into law by President Donald J. Trump on February 6, 2020. Synthetic fentanyl analogues, often illegally manufactured, are widely believed to be fueling the "third wave" of the opioid crisis, as detailed in the October 2019 issue of *Innovations*® (pages 8-11), which can be accessed through the Publications section of the National Association of Boards of Pharmacy®'s website.

In February 2018, Drug Enforcement Administration (DEA) issued a temporary order to establish fentanyl-related substances as Schedule I. The Temporary Reauthorization and Study of the Emergency Scheduling of Fentanyl Analogues Act extends the DEA order, which was set to expire on February 6, 2020. The bill requires the Government Accountability Office to produce a report within 12 months on the public health and safety effects of controlling fentanyl-related substances, according to *Homeland Preparedness News*.

Drug Overdose Deaths Related to Prescription Opioids Declined by 13% in 2018

Fatalities related to the use of prescription opioids declined by 13% in the United States during 2018, according to the 2019 National Drug Threat Assessment released by DEA. Despite this encouraging news, the report makes it clear that the opioid crisis continues at epidemic levels. Specifically, controlled prescription drugs remain a major factor in the record number of overdose deaths since 2017. Benzodiazepines and antidepressants were involved in an increasing number of overdose deaths.

Fentanyl and similar synthetic opioids also remain a major point of concern. Fentanyl maintained high availability through most of the US in 2018. Illegally manufactured versions of the powerful opioid continue to be smuggled into the US, primarily in the form of counterfeit pills made to look like prescription opioids and powder. Fentanyl remains the "primary driver" of the current opioid crisis, according to the report.

"Illicit drugs, and the criminal organizations that traffic them, continue to represent significant threats to public health, law enforcement, and national security in the United States," a DEA press release states. "As the National Drug Threat Assessment describes, the opioid threat continues at epidemic levels, affecting large portions of the United States."

Drug-Resistant Infections Are Increasing

A new report on antibiotic infections released by the Centers for Disease Control and Prevention (CDC) estimates more than 2.8 million antibiotic-resistant infections occur each year, and more than 35,000 Americans are dying annually as a result. While the report notes that prevention and infection control efforts in the US are working to reduce the number of infections and deaths caused by antibiotic-resistant germs, the number of people facing antibiotic resistance is still too high. "More action is needed to fully protect people," the report states.

The report lists 18 antibiotic-resistant bacteria and fungi and places them into three categories (urgent, serious, and concerning) based on clinical impact, economic impact, incidence, 10-year projection of incidence, transmissibility, availability of effective antibiotics, and barriers to prevention. It also highlights estimated infections and deaths since the last CDC report in 2013, aggressive actions taken, and gaps that are slowing progress.

The full report is available on the CDC website.

NASEM Report Recommends Framework for Opioid Prescribing Guidelines for Acute Pain

Contracted by Food and Drug Administration (FDA), a December 2019 report by the National Academies of Sciences, Engineering, and Medicine (NASEM) seeks to develop evidence-based clinical practice guidelines for prescribing opioids for acute pain. The report, *Framing Opioid Prescribing Guidelines for Acute Pain:*

Developing the Evidence, also develops a framework to evaluate existing guidelines, and recommends indications for which new evidence-based guidelines should be recommended.

As part of its work, NASEM examined existing opioid analgesic prescribing guidelines, identified where there were gaps in evidence, and outlined the type of research that will be needed to fill these gaps. NASEM also held a series of meetings and public workshops to engage a broad range of stakeholders who contributed expert knowledge on existing guidelines, and provided emerging evidence or identified specific policy issues related to the development and availability of opioid analgesic prescribing guidelines based on their specialties.

"We recognize the critical role that health care providers play in addressing the opioid crisis – both in reducing the rate of new addiction by decreasing unnecessary or inappropriate exposure to opioid analgesics, while still providing appropriate pain treatment to patients who have medical needs for these medicines," said Janet Woodcock, MD, director of FDA's Center for Drug Evaluation and Research in a statement. "However, there are still too many prescriptions written for opioid analgesics for durations of use longer than are appropriate for the medical need being addressed. The FDA's efforts to address the opioid crisis must focus on encouraging 'right size' prescribing of opioid pain medication as well as reducing the number of people unnecessarily exposed to opioids, while ensuring appropriate access to address the medical needs of patients experiencing pain severe enough to warrant treatment with opioids."

FDA will next consider the recommendations included in the report as part of the agency's efforts to implement the SUPPORT Act provision requiring the development of evidence-based opioid analgesic prescribing guidelines.

The report can be downloaded for free on the NASEM website.

New Research Shows Pharmacists Positively Impact Hospital Care Transitions

Patients who received focused attention from pharmacists during hospital stays expressed higher satisfaction, according to research presented at the American Society of Health-System Pharmacists Midyear Clinical Meeting and Exhibition. The study centered on the effect of pharmacists educating patients about medications as they transitioned out of hospital care. During the study, pharmacists reconciled patients' medications before discharge, talked with patients about the medications they were taking, and contacted them by phone after discharge to discuss their care.

Of the 1,728 patients included in the study, 414 received the full transition-of-care education protocol, including a follow-up pharmacist phone call. Those patients showed a 14.7% increase in the overall average mean score, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems survey, which assesses patients' perceptions of their care after discharge. A post hoc analysis also showed that 30-day readmission rates dropped from 17.3% to 12.4% when a post-discharge phone call was made to patients as a part of the study.

"Pharmacists play a multitude of vital roles for patients during a hospital stay, including comprehensive medication management and ensuring medication safety. Now, they can feel increasingly confident about their role in helping patients when transitioning from different levels of care. Our findings add to growing literature demonstrating that pharmacist involvement in hospital discharge improves outcomes and safety," said Katherine L. March, PharmD, BCPS, clinical pharmacy specialist at Methodist University Hospital in Memphis, TN, in a press release.

Disciplinary Actions

Douglas Chan – RP00006764. Probation. During its January 2020 meeting, the Board ordered probation for a period of 10 years. During this time, the licensee may not own or operate a pharmacy in New Mexico or be designated to perform duties as a pharmacist-in-charge. The licensee must also take and pass the Multistate Pharmacy Jurisprudence Examination® within six months and pay fines, investigative costs, and cost of hearing in the amount of $2,540.86.

Cheyenne Ntiforo – License IN00004239, PT00009979. Probation. During its January 2020 meeting, the Board ordered probation for a period of three years. During this time, the licensee must meet with and (if recommended) enroll in the Monitored Treatment Program (MTP) and fully comply with terms and conditions required by MTP. The licensee must also meet with the Board's executive director prior to each renewal of her intern license.

Reminders

- Upcoming pharmacy law lecture dates are as follows:
  - **Friday, June 12, 2020**
    Remote event
  - **Tuesday, June 16, 2020**
    Remote event
  - **Friday, July 10, 2020**
    Albuquerque
  - **Friday, August 7, 2020**
    Albuquerque, NM
  - **Friday, September 4, 2020**
    Albuquerque
  - **Friday, October 2, 2020**
    Albuquerque
  - **Friday, November 6, 2020**
    Albuquerque
  - **Tuesday, November 17, 2020**
    Carlsbad Medical Center
    Carlsbad, NM
  - **Tuesday, December 1, 2020**
    MountainView Regional Medical Center
    Las Cruces, NM
  - **Wednesday, December 2, 2020**
    Memorial Medical Center
    Las Cruces
  - **Friday, December 4, 2020**
    Albuquerque
- Because of the coronavirus disease 2019 (COVID-19) restrictions, some of the law update reviews have been given in webinar format. The most up-to-date information on review format and a full list of law updates can be found on the Board's website.
- The Board has compiled a list of resources and information regarding COVID-19. Such resources include, but are not limited to, emergency dispensing provisions, consultant pharmacist visitation requirements, and garbing/personal protective equipment information. This information is available on the Board's website under the FAQ section.
- Be sure to submit Adverse Drug Event reports to the Board within **15 days of discovery.** This is required by regulation, and noncompliance could potentially result in disciplinary action. This report **must** include an appropriate root cause analysis with recommendation(s) for improvement.
- Pharmacists, be sure that you are completing the required continuing education (CE) prior to relicensure. The Board conducts audits on a monthly basis. Some things to keep in mind when completing your CE:
  - The patient safety and safe/appropriate use of opioid requirements can be combined if CE is appropriate to cover both topics.
  - Your New Mexico law CE credits do not count toward your 10-hour live CE requirement.
  - CE credits required to maintain pharmacist prescriptive authority do not count toward your 30-hour CE requirement.

Failure to comply with all requirements may result in a fine of up to $1,000 and disciplinary action against your license.

The *New Mexico Board of Pharmacy News* is published by the New Mexico Board of Pharmacy and the National Association of Boards of Pharmacy Foundation® (NABPF®) to promote compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of NABPF or the Board unless expressly so stated.

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