



# Arizona State Board of Pharmacy

*Published to promote compliance of pharmacy and drug law*

1616 W Adams St, Suite 120 • Phoenix, AZ 85007 • Website: <https://pharmacy.az.gov>  
Email: [chunter@azpharmacy.gov](mailto:chunter@azpharmacy.gov)

### Board Members

- Darren Kennedy, RPh.....President
- Thomas Van Hassel, RPh.....Vice President
- Michael Blaire, RPh.....Member
- Kevin Dang, PharmD.....Member
- William Francis, MBA, RPh.....Member
- Kyra Locnikar.....Member (Public)
- Dennis McAllister, RPh.....Member
- Reuben Minkus.....Member (Public)
- Kristen Snair, CPhT.....Member (Technician)

### Board Mission

The Arizona State Board of Pharmacy protects the health, safety, and welfare of the citizens of Arizona by regulating the practice of pharmacy and the distribution, sale, and storage of prescription medications and devices and nonprescription medications.

The Board accomplishes its mission by:

- ◆ Issuing licenses to pharmacists, pharmacy interns, and pharmacy technicians;
- ◆ Issuing permits to pharmacies, manufacturers, wholesalers, and distributors;
- ◆ Conducting compliance inspections of permitted facilities;
- ◆ Investigating complaints and adjudicating violations of applicable state and federal laws and rules; and
- ◆ Promulgating and reviewing state rules and regulations.

### Board Member Reappointment



Dennis K. McAllister, RPh, FASHP, has been a Board member since 1996 and Board president from 2004-2005 and 2015-2016. Dennis also served as the 2005-2006 National Association of Boards of Pharmacy® president.

Other honors Mr McAllister has received include the American Association of Colleges of Pharmacy Innovations in Teaching Award in 2002; the Arizona Pharmacy Association

Faculty Excellence in Pharmacy Administration Award in 2000; and Preceptor of the Year from the University of Arizona College of Pharmacy in 1997. He was also designated a fellow of the American Society of Health-System Pharmacists. Mr McAllister received a bachelor of science in pharmacy degree from the University of Minnesota.

Congratulations, Dennis, on your reappointment!

### Board Meeting Schedule

Board meetings play an important role in the regulation of pharmacy practice in Arizona. Attending these meetings is a great learning opportunity, especially for new pharmacists just entering the profession. The Board extends an open invitation to all pharmacists, pharmacy interns, technicians, and interested parties to attend. Your feedback and engagement can help ensure that public health and safety are optimized.

All of the following meetings start at 9 AM and will be held at 1616 W Adams St, Suite 120, Phoenix, AZ 85007 (in the Land Department Building).

- ◆ May 11-12
- ◆ June 8-9
- ◆ August 24-25
- ◆ November 16-17

### Interns in Pharmacies

In order to work as an intern in a pharmacy located in Arizona and to obtain the experience needed for licensure as a pharmacist, you need to maintain an active pharmacy intern license.

#### R4-23-301. Intern Licensure

G. Verification of license. A pharmacy permittee or pharmacist-in-charge shall not permit a person to practice as a pharmacy or graduate intern until the pharmacy permittee or pharmacist-in-charge verifies that the person is currently licensed by the Board as a pharmacy or graduate intern.



## **FDA Approves Naloxone Nasal Spray to Prevent Opioid Overdose Deaths**

Food and Drug Administration (FDA) has approved Narcan® Nasal Spray (also known as naloxone), a life-saving medication that can stop or reverse the effects of an opioid overdose. Prior to this approval, naloxone was only approved in injectable forms, most commonly delivered by syringe or auto-injector, explains FDA in a news release.

Narcan Nasal Spray does not require assembly and delivers a consistent, measured dose when used as directed. This prescription product can be used on adults or children and is easily administered by anyone, even those without medical training. The drug is sprayed into one nostril while the patient is lying on his or her back, which can be repeated if necessary. However, it is important to note that it is not a substitute for immediate medical care, and the person administering Narcan Nasal Spray should seek further immediate medical attention on the patient's behalf. The use of Narcan Nasal Spray in patients who are opioid dependent may result in severe opioid withdrawal characterized by body aches, diarrhea, increased heart rate (tachycardia), fever, runny nose, sneezing, goose bumps (piloerection), sweating, yawning, nausea or vomiting, nervousness, restlessness or irritability, shivering or trembling, abdominal cramps, weakness, and increased blood pressure. Narcan Nasal Spray is distributed by Adapt Pharma, Inc, of Radnor, PA. The FDA news release is available at [www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm473505.htm](http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm473505.htm).

## **Selected Medication Safety Risks to Manage in 2016**



*This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting [www.ismp.org](http://www.ismp.org). ISMP provides legal protection and confidentiality for submitted patient safety data and error reports. Help others by reporting actual and potential medication errors to the ISMP National Medication Errors Reporting Program Report online at [www.ismp.org](http://www.ismp.org). Email: [ismpinfo@ismp.org](mailto:ismpinfo@ismp.org).*

It is a nearly impossible task to list all the risks associated with medication use that could lead to harmful medication

errors. So where do health care professionals start to improve medication safety? Most people frequently resort to playing “whack-a-mole,” addressing risks only after they pop up and become visible after an adverse event.

Listed below are two serious medication safety risks that might fall off the radar screen unless an adverse event happens to draw attention to them. Additional serious risks will be published in future issues of the National Association of Boards of Pharmacy® *National Pharmacy Compliance News*.  
**Patient Information – Placing Orders on the Wrong Patient's Electronic Health Record**

A potentially hidden vulnerability that can lead to serious errors is placing orders on the wrong patient's electronic health record. A recent study published in the *Journal of the American Medical Informatics Association* identified and quantified close calls that would have resulted in wrong-patient errors. According to this study, about 14 wrong-patient electronic orders are placed every day in a large hospital system with approximately 1,500 beds, or about 68 wrong-patient errors per 100,000 medication orders. By this measure, one in 37 hospitalized patients will have an order placed for them that was intended for another patient.<sup>1</sup>

These errors are sometimes due to juxtaposition but more often caused by interruptions and having more than one patient's electronic health record open.

Multiple studies have demonstrated ways to reduce these events. Requiring verification of the patient's identity has reduced errors by 16% to 30%, and requiring re-entry of the patient's identification has reduced errors by 41%.<sup>1,2</sup> Prompting clinicians for an indication when certain medications are ordered without an indication on the patient's problem list has intercepted errors at a rate of 0.25 per 1,000 alerts.<sup>3</sup> In one study, most emergency department (ED) staff (81%) felt a room number watermark on the patient's electronic health record would eliminate most wrong-patient orders in the ED.<sup>4</sup>

## **Communication About Drug Therapy – Confusing the Available Concentration as the Patient's Dose on Electronic Records**

Another risk deals with how home medications appear on computer screens. For example, a physician accidentally ordered 100 units of Lantus® (insulin glargine) instead of the correct dose of six units because the list of medications used at home displayed the concentration right next to the drug name on the first line, and the patient's dose below it on the second line: “Insulin glargine (Lantus) 100 units/mL,” followed on the next line with “6 units subcutaneous daily every evening.”

Now that insulin is available in 100 units/mL, 200 units/mL, 300 units/mL, and 500 units/mL concentrations, the risk



of receiving an overdose of insulin is high if the presentation of the order lists the product's concentration before the patient's dose. ISMP's recommendation is to list the drug name, patient-specific dose, and directions for use on the first line of the electronic medication administration record and patient medication lists, and the available concentration and any directions on how to measure the patient's dose below it.

#### References

1. Adelman JS, Kalkut GE, Schechter CB, et al. Understanding and preventing wrong-patient electronic orders: a randomized controlled trial. *J Am Med Inform Assoc.* 2013; 20(2):305-310.
2. Green RA, Hripcsak G, Salmasian H, et al. Intercepting wrong-patient orders in computerized provider order entry system. *Ann Emerg Med.* 2015; 65(6):679-686.
3. Galanter W, Falck S, Burns M, Laragh M, Lambert BL. Indication-based prescribing prevents wrong-patient medication errors in computerized provider order entry (CPOE). *J Am Med Inform Assoc.* 2013; 20(3):477-481.
4. Yamamoto LG. Reducing emergency department charting and ordering errors with a room number watermark on the electronic medical record display. *Hawaii J Med Public Health.* 2014; 73(10):322-328.

### **FDA Provides Training Videos on MedWatch Resources and Breakthrough Therapy**

FDA Drug Info Rounds, a series of online videos, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better decisions. In the January 2016 Drug Info Rounds video, "MedWatch Tips and Tools," pharmacists discuss reporting adverse events to FDA's MedWatch Safety Information and Adverse Event Reporting Program and the resources available for health care professionals to report safety information. In the December 2015 Drug Info Rounds video, "Breakthrough Therapy," pharmacists discuss the breakthrough therapy designation program, which is intended to expedite the development and review of drugs for serious or life-threatening conditions. Drug Info Rounds is developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research (CDER), Office of Communications, Division of Drug Information. All Drug Info Rounds videos can be viewed on the FDA website at [www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm](http://www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm).

### **Reading Medicine Labels Helps Reduce Acetaminophen Overdoses**

The Acetaminophen Awareness Coalition (AAC) reminds pharmacists and other health care providers to encourage patients to properly read medicine labels to avoid unintentional acetaminophen overdoses. The coalition also encourages pharmacists and other health care providers to talk to their patients about medicine safety and acetaminophen use.

AAC's "Know Your Dose" campaign reminds patients to take these four steps to avoid acetaminophen overdose:

- (1) Always read and follow the medicine label.
- (2) Know if their medicines contain acetaminophen.
- (3) Take only one medicine at a time that contains acetaminophen.
- (4) Ask their health care provider about any questions.

Additionally, pharmacists may download or order free educational materials, including posters, flyers, and talking points, to give their patients on the Know Your Dose website at [www.knowyourdose.org](http://www.knowyourdose.org).

### **Over-the-Counter Children's Medicine Recalled Due to Incorrect Dose Markings**

In January 2016, Perrigo Company voluntarily recalled two lots of children's guaifenesin grape liquid cough medicine (100 mg/5 mL) and three lots of children's guaifenesin DM cherry liquid cough medicine (100 mg guaifenesin and 5 mg dextromethorphan HBr/5 mL) sold in 4 oz bottles. The recall was initiated because some packages contain an oral dosing cup with incorrect dose markings. The affected products were sold by distributors nationwide and distributed through retail stores. The recalled lots and store brands are available in the Perrigo press release posted on the company's website, [www.perrigo.com](http://www.perrigo.com), under "Investors." To date, the company has not received reports of overdose. Distributors and retailers that have the affected lots should stop distribution and return the product using the information provided in the press release.

Adverse reactions or quality problems may be reported to FDA's MedWatch Safety Information and Adverse Event Reporting Program at [www.fda.gov/MedWatch](http://www.fda.gov/MedWatch).

### **FDA Offers Webinars on Online Drug Information Resources for Students and Clinicians**

FDA's Division of Drug Information, CDER, presents a series of continuing education webinars targeted toward students and health care providers who wish to learn more about FDA and drug regulation. The webinars are presented by FDA staff and allow participants to interact with staff. Past topics have included "Introduction to FDA's MedWatch Adverse Reporting Program" and "An Overview of the FDA's Breakthrough Therapy Designation Program." Upcoming webinars, previous webinars, and presentation slides can be accessed on FDA's website at [www.fda.gov/AboutFDA/WorkingatFDA/FellowshipInternshipGraduateFacultyPrograms/PharmacyStudentExperientialProgramCDER/ucm228391.htm](http://www.fda.gov/AboutFDA/WorkingatFDA/FellowshipInternshipGraduateFacultyPrograms/PharmacyStudentExperientialProgramCDER/ucm228391.htm).



## How Many Licenses/Permits Does the Board Manage?

### Licenses

|                     |        |
|---------------------|--------|
| Pharmacists         | 10,778 |
| Interns             | 1,621  |
| Technicians (PTCB)  | 10,746 |
| Technician Trainees | 8,244  |

**Total: 31,389**

### Permits

|  |       |
|--|-------|
| Pharmacy                                 | 2,209 |
| Medical Gas/Durable<br>Medical Equipment | 558   |
| Manufacturer                             | 331   |
| Nonprescription                          | 4,549 |
| Wholesaler                               | 1,000 |

**Total: 8,647**

## Help Is Available for Impaired Pharmacists, Pharmacy Interns, and Technicians

The Board subsidizes Pharmacists Assisting Pharmacists of Arizona (PAPA) to assist pharmacists, pharmacy interns, and technicians. PAPA is a recovery program that specializes in alcohol and/or chemical dependency. If you or someone you know is looking for more information, you can contact **Deborah Marcum, PAPA director, at the Arizona Pharmacy Association office at 480/207-7869 or via email at [papa@azpharmacy.org](mailto:papa@azpharmacy.org).**

### Pharmacist Prescribing

The Board office has been receiving numerous calls regarding out-of-state pharmacist prescribing. Many states across the country have expanded the role of pharmacists to prescribe. Arizona, being a snowbird state, is seeing those prescriptions being introduced at its pharmacies. It is the Board's decision to treat these prescribing pharmacists as mid-level practitioners.

### Overprescribing of Controlled Substances

The United States contains 4.6% of the world's population, yet it consumes 80% of the world's supply of opioids and 99% of the world's supply of hydrocodone. In the US, health care providers in 2012 wrote 259 million prescriptions for opioid painkillers, with activity varying from state to state. In 2015, Arizona had the 10<sup>th</sup> highest rate of drug overdose deaths in the US, with 17.8 per 100,000 residents.

Results showed that in Florida, after statewide legislative and enforcement actions in 2010 and 2011, the death rate from prescription drug overdose decreased 23%.

"Prescription drug overdose is epidemic in the United States. All too often, and in far too many communities, the treatment is becoming the problem," said Centers for Disease Control and Prevention Director Tom Frieden, MD, MPH. "Overdose rates are higher where these drugs are prescribed more frequently. States and practices where prescribing rates

are highest need to take a particularly hard look at ways to reduce the inappropriate prescription of these dangerous drugs."

Knowing the gravity of the situation, health agencies have discussed this matter in detail. Executive directors from the other health boards have expressed their appreciation of how pharmacy plays a key role by contacting the appropriate board/agency when necessary. Below is a quick reference contact list for the health boards. They look forward to discussing your concerns regarding questionable prescribing.

### Arizona Board of Osteopathic Examiners in Medicine and Surgery

Jenna Jones, Executive Director

602/771-2522

[jenna.jones@azdo.gov](mailto:jenna.jones@azdo.gov)

### Arizona Medical Board

Patricia McSorley, Executive Director

480/551-2720

[pmsorley@azmd.gov](mailto:pmsorley@azmd.gov)

### Arizona State Board of Dental Examiners

Elaine Hugunin, Executive Director

602/542-4493

[elaine.hugunin@azdentalboard.us](mailto:elaine.hugunin@azdentalboard.us)

### Arizona State Board of Nursing

Janeen Dahn, PhD, FNP-C, Associate Director

602/771-7814

[jdahn@azbn.gov](mailto:jdahn@azbn.gov)

## Disciplinary Actions and Updates

### Pharmacists

**Battle (Egwu), Eberenna (S016791)** – Probation terminated. Effective January 27, 2016.

**Breese, Steven (S014427)** – Probation terminated. Effective January 27, 2016.

**Cluff, Gregg (S010248)** – Probation terminated. Effective January 27, 2016.

**Goodwillie, Robert (S011971)** – Consent agreement offered with the following terms: suspension for six months, probation for three years upon termination of suspension, retake and pass the North American Pharmacist Licensure Examination® (NAPLEX®) and Multistate Pharmacy Jurisprudence Examination® (MPJE®) exams, and complete additional continuing education courses. Effective January 28, 2016.

**Pitts, Jami (S016776)** – Probation terminated. Effective January 27, 2016.

### Intern

**Gerber, Colin (I011780)** – Consent agreement offered suspending his intern license for one year.

## Disciplinary Actions and Updates – Other Health Boards

### Arizona Medical Board

**James Jeffrey Chien, MD #40347** – *Interim Consent Agreement for Practice Restriction*. Respondent is prohibited from engaging in the practice of medicine in the state of Arizona until he applies to the executive director and receives permission to do so as stated in the interim

*Continued on page 5*

consent agreement for practice restriction. Respondent may not request release from or modification of this interim consent agreement for practice restriction until he has completed a Physician Health Program (PHP) assessment and any required evaluations or treatment that arise from assessment recommendations. Effective December 7, 2015.

**Kenny Chuu, MD #50684** – *Interim Consent Agreement for Practice Restriction*. Respondent is prohibited from engaging in the practice of medicine in the state of Arizona until he applies to the executive director and receives permission to do so as stated in the interim consent agreement for practice restriction. Respondent may not request release from or modification of this interim consent agreement for practice restriction until he has completed any and all recommended components of the PHP assessment and any required evaluations or treatment that arise from assessment recommendations. Effective December 7, 2015.

**Erick A. Falconer, MD #45505** – *Findings of Fact, Conclusions of Law and Order*. Based on the foregoing, it is ordered that on the effective date of the Board's final order in this matter, the Board revoke license number 45505 for the practice of allopathic medicine in Arizona previously issued to Respondent Erick A. Falconer, MD. It is further ordered assessing Erick A. Falconer the cost of the formal hearing. Effective December 3, 2015.

**Govind S. Gill, MD #22277** – *Order for Probation and Consent to the Same*. Respondent is placed on probation for a period of 10 years with the following terms and conditions: respondent shall not engage in the practice of medicine in the state of Arizona for a period of 10 years. Effective December 3, 2015.

**Kevin S. Lewis, MD #17850** – *Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License*. Respondent's license to practice allopathic medicine in the state of Arizona, license number 17850, is summarily suspended. Respondent is prohibited from practicing medicine in the state of Arizona and is prohibited from prescribing any form of treatment including prescription medications or injections of any kind until receiving permission from the Board to do so. Effective December 29, 2015.

**Christiana M. Lietzke, MD #48554** – *Interim Consent Agreement for Practice Limitation*. Respondent is prohibited from engaging in the practice of medicine in the state of Arizona until she applies to the Board and receives its affirmative permission to do so. Respondent is responsible for all expenses relating to the assessment and any subsequent recommended evaluation and/or treatment. Respondent is also required to pay a minimum fee, which is due and payable at the time of the assessment. Effective December 28, 2015.

**Michael Mahl, MD #12868** – *Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License*. Respondent's license to practice allopathic medicine in the state of Arizona, license number 12868, is summarily suspended. Respondent is prohibited from practicing medicine in the state of Arizona and is prohibited from prescribing any form of treatment including

prescription medications or injections of any kind until receiving permission from the Board to do so. Effective December 29, 2015.

**Frank Pallares, MD #41363** – *Interim Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation*. Respondent is issued a letter of reprimand. Respondent's license is placed on probation for two years with the following terms and conditions: respondent's practice is immediately restricted for up to nine months in that he shall not practice medicine in the state of Arizona and he is prohibited from prescribing any form of treatment including prescription medications until respondent completes a competency evaluation offered by the Center for Personalized Education for Physicians. Effective February 5, 2016.

**Edward Jack Sayegh, MD #40787** – The Arizona Medical Board was informed that, on or about August 3, 2015, the Maricopa County Superior Court ordered Edward Sayegh, MD, to surrender his Arizona medical license following his plea agreement in case number CR2014-005809-001DT. The Board implemented the court's order, and the Board's record along with Dr Sayegh's public profile has been updated to reflect the license status of surrendered. Effective October 15, 2015.

**Laura Kathryn Sherman, MD #34716** – *Interim Consent Agreement for Practice Restriction*. Respondent is prohibited from engaging in the practice of medicine in the state of Arizona until she applies to the executive director and receives permission to do so. Respondent may not request release from or modification of this interim consent agreement for practice restriction until she has resumed compliance with PHP monitoring. Effective January 28, 2016.

**Issada Thongtrangan, MD #45920** – *Interim Consent Agreement for Practice Restriction*. Respondent shall not practice medicine in the state of Arizona until he has implemented the practice recommendations from Pine Grove Behavioral Health as issued in its final report. Effective February 3, 2016.

## **Arizona Board of Osteopathic Examiners**

**Christine Walker, DO #006029** – *Interim Consent Agreement Findings of Fact, Conclusions of Law, and Stipulated Order for Suspension and Evaluations*. It is hereby ordered that Christine Walker, DO, osteopathic medical license number 006029, is placed on **suspension** for a minimum period of six months from the effective date of this order. Respondent shall not practice osteopathic medicine of any kind or in any manner, including medicine involving direct or indirect patient care. Effective December 11, 2015.