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Arizona State Board of Pharmacy News

Published to promote compliance of pharmacy and drug law

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Board Members

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 Seat Open

The Board would like to thank Bill Francis for his service to the Board and the residents of Arizona. Bill served as a member of the Board from January 2012 to March 2016. He has over 35 years of pharmacy practice experience including 23 years within managed care settings. He earned his pharmacy degree from the University of Arizona in 1979 and later completed a graduate degree in business administration from the same institution. Prior to returning to MedImpact Healthcare Systems as vice president of pharmacy management services, Bill was head of clinical outcome improvement – Medicare at Aetna, director of pharmacy services at the University of Arizona Health Plans, and director of business development for 11 years at MedImpact, where he worked with government-funded health care programs including behavioral health and managed Medicaid and Medicare plans. Currently, Bill holds an appointment as assistant professor of clinical pharmacy practice at the University of Arizona College of Pharmacy.

House/Senate Bill Update: Signed by Governor

House Bill (HB) 2109: Licensure. Removes the requirement that a pharmacist licensed in another jurisdiction hold the license in good standing for at least one year before being eligible to receive a license in Arizona without a pharmacist licensure examination. Requires an applicant for initial licensure apply for a fingerprint clearance card instead of submitting fingerprints for a criminal background check.

Senate Bill (SB) 1112: Pharmacists; scope of practice. Expands the immunizations or vaccines that a licensed pharmacist may administer.

HB 2265: Epinephrine auto-injectors. Permits an **authorized entity** to obtain and store epinephrine auto-injectors, as prescribed by a medical practitioner, and outlines training requirements for employees responsible for the oversight and emergency provision or administration of epinephrine auto-injectors.

HB 2355: Opioid antagonists; prescription; dispensing; administration. Allows a pharmacist to dispense naloxone hydrochloride (naloxone) without a prescription to a person at risk of experiencing an opioid-related overdose, a family member, or a community member in a position to assist that person. Allows a physician, licensed nurse practitioner, or any other health professional who has prescribing authority to prescribe and dispense naloxone to a person at risk, a family member in a position to assist a person at risk, a community organization that provides services to persons at risk, or to any other person who is in a position to assist persons at risk.

SB 1283: Controlled substances prescription monitoring program. Beginning October 1, 2017, or 60 days after the statewide health information exchange has integrated the Controlled Substances Prescription Monitoring Program (CSPMP), requires a medical practitioner to obtain a patient utilization report from the CSPMP's central database tracking system before prescribing an opioid analgesic or benzodiazepine controlled substance listed in Schedules II, III, or IV. There are exceptions built in.

For detailed information on the bills, visit *www.azleg.gov.*

Direct and Indirect Advertising

Over the years there has been a lot of discussion around online prescription order forms. See Arizona Administrative Code language below.

R4-23-404. Unethical Practices

B. Prescription order-blank advertising prohibited. A pharmacist or pharmacy permittee shall not:
   1. Directly or indirectly furnish to a medical practitioner a prescription order-blank that refers to a specific pharmacist or pharmacy in any manner; or
   2. Actively or passively participate in any arrangement or agreement where a prescription order-blank is prepared, written, or issued in a manner that refers to a specific pharmacist or pharmacy.

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FDA Calls for Review of Opioids Policy, Announces Action Plan

As part of a broad national campaign to address opioid abuse, dependence, and overdose, Food and Drug Administration (FDA) Deputy Commissioner for Medical Products and Tobacco, Dr Robert Califf, along with other FDA leaders, developed a comprehensive action plan to reassess the agency's approach to opioid medications. The objective of the plan is to "focus on policies aimed at reversing the epidemic, while providing patients in pain access to effective relief," indicates the FDA news release. FDA's plan is to:

- Re-examine the risk-benefit paradigm for opioids and ensure that the agency considers their wider public health effects;
- Convene an expert advisory committee before approving any new drug application for an opioid that does not have abuse-deterrent properties;
- Assemble and consult with the Pediatric Advisory Committee regarding a framework for pediatric opioid labeling before any new labeling is approved;
- Develop changes to immediate-release (IR) opioid labeling, including additional warnings and safety information that incorporate elements similar to the extended-release/long-acting (ER/LA) opioid analgesics labeling that is currently required;
- Update Risk Evaluation and Mitigation Strategy requirements for opioids after considering advisory committee recommendations and review of existing requirements;
- Expand access to, and encourage the development of, abuse-deterrent formulations of opioid products;
- Improve access to naloxone and medication-assisted treatment options for patients with opioid use disorders; and
- Support better pain management options, including alternative treatments.

FDA will also seek guidance from outside experts in the fields of pain management and drug abuse. The National Academies of Sciences, Engineering, and Medicine has been asked by FDA to help develop a framework for opioid review, approval, and monitoring that balances individual need for pain control with considerations of the broader public health consequences of opioid misuse and abuse. The news release is available on FDA's website at *www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm484765.htm.*

More 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. *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. *Email: ismpinfo@ismp.org.*

Manufacturer Drug Labeling, Packaging, Nomenclature – Per Liter Electrolyte Content on Various Sizes of Manufacturers' IV Bags

The way electrolyte concentrations are expressed on intravenous (IV) bags in volumes less than or greater than one liter has tripped up many practitioners over the years. Concentrations are listed per liter, not per container volume. For example, a 250 mL 0.9% sodium chloride injection container label lists the sodium chloride content as 154 mEq/1,000 mL, rather than 38.5 mEq/250 mL. Commercially available parenteral nutrition products available in containers greater than one liter also express the electrolyte ingredients "per liter."

An error occurred while a pharmacist was preparing a bag of 3% sodium chloride after the pharmacy unexpectedly ran out of the commercially available bags. The pharmacist mistakenly set the proportion up as 154 mEq/0.9% = x/3% and calculated that he needed 513 mEq of sodium chloride, when he actually only needed 256-257 mEq of sodium chloride for a 500 mL bag (77 mEq/0.9% = x/3%).

For single- and multiple-dose injectables, the United States Pharmacopeial Convention (USP) requires the strength per total volume as the primary, prominent display on the label, followed in close proximity by the strength per mL enclosed in parentheses. This should apply to large volume parenterals as well. Until it does, pharmacists who calculate electrolyte quantities should seek out an independent double check. Sufficient quantities of commercially available products should be used whenever possible. For products that routinely require admixture, an instruction sheet should be available to guide the process.

Patient Education – Discharging Patients Who Do Not Understand Their Discharge Medications

Despite the importance of teaching patients about the medications to take after discharge, studies suggest health care providers are not successfully preparing patients for the transition home. Between 30% and 70% of patients make a medication error in the immediate weeks following hospitalization,[1-5] and the Centers for Medicare & Medicaid Services reports an average national hospital readmission rate of 17.5% to 19.5%.[6] The discharge process is often rushed and interrupted, making it difficult to ensure patients know what medications to take, the correct doses, and how to take them after discharge. Immediately prior to discharge is not an ideal time for education either, as patients may be overwhelmed with the amount of information being provided at once.

Medication errors that occur during the first few weeks after discharge from the hospital can cause significant harm. In fact, one study showed that almost a quarter of all post-discharge errors were considered serious or life-threatening, and that

most of these errors happened within the first 14 days after discharge.[5] The highest predictors of post-discharge errors included low health literacy and low subjective numeracy (self-reported measure of the ability to perform mathematical tasks and the preference for numerical versus prose information (ie, ordinary words)).[4]

Perhaps this risk is best addressed with a redesigned discharge process that facilitates the most effective means of teaching patients about their medications, initiating education earlier in the hospital stay, and providing post-discharge support.

References

1. Coleman EA, Smith JD, Raha D, Min SJ. Posthospital medication discrepancies: prevalence and contributing factors. *Arch Intern Med.* 2005;165(16):1842-1847.
2. Mesteig M, Helbostad JL, Sletvold O, Røsstad T, Saltvedt I. Unwanted incidents during transition of geriatric patients from hospital to home: a prospective observational study. *BMC Health Serv Res.* 2010;10:1.
3. Lalonde L, Lampron AM, Vanier MC, Levasseur P, Khaddag R, Chaar N. Effectiveness of a medication discharge plan for transitions of care from hospital to outpatient settings. *Am J Health Syst Pharm.* 2008;65(15):1451-1457.
4. Mixon AS, Myers AP, Leak CL, et al. Characteristics associated with postdischarge medication errors. *Mayo Clin Proc.* 2014;89(8):1042-1051.
5. Kanaan AO, Donovan JL, Duchin NP, et al. Adverse drug events after hospital discharge in older adults: types, severity, and involvement of Beers criteria medications. *J Am Geriatr Soc.* 2013;61(11):1894-1899.
6. American Hospital Association. Rethinking the hospital readmissions reduction program. *TrendWatch.* March 2015.

USP Publishes Chapter on Handling Hazardous Drugs in Health Care Settings

A new general chapter, <800> *Hazardous Drugs—Handling in Healthcare Settings,* has been published as part of a suite of health care quality standards included in the *United States Pharmacopeia – National Formulary (USP–NF)* by USP to help prevent and/or limit hazardous drug exposures in health care. The standard applies to all health care personnel, such as physicians, nurses, veterinarians, pharmacists, and technicians, and all health care facilities where hazardous drugs are handled or manipulated, including their storage and distribution. Health care facilities have more than two years to conform to the new requirements and have until July 1, 2018, to implement the new standard, indicates a USP press release, which is available at *www.usp.org* in the News section. General Chapter <800> is available in both the First Supplement to *USP 39–NF 34* and the *USP Compounding Compendium.*

FDA Provides Training Video on Keeping Medications Safe in Emergency Situations

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 February 2016 Drug Info Rounds video, "Emergency Preparedness – Keeping Medications Safe," pharmacists discuss educating patients about having a plan in place for emergency medication and medical supplies and the resources available for pharmacists to use when advising their patients. Drug Info Rounds is developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research, 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.*

FDA Requires Class-Wide Labeling Changes for IR Opioid Analgesics

FDA is requiring class-wide safety labeling changes for IR opioid pain medications, which will include a new boxed warning about the serious risks of misuse, abuse, addiction, overdose, and death. The announcement is part of the agency's effort to educate prescribers and patients about the potential risks related to opioid use. FDA is also requiring several safety labeling changes across all prescription opioid products to include additional information on the risk of these medications. The new requirements are part of a plan to reassess the agency's approach to opioid medications. The plan is focused on reversing the epidemic of abuse and overdose while still providing patients in pain access to effective relief, indicates the FDA news release at *www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm491739.htm?source=govdelivery&utm_medium=email&utm_source=govdelivery.*

Further, FDA is requiring updated labeling for all opioids (both IR and ER/LA products) to include safety information about potentially harmful drug interactions with other medicines that can result in a serious central nervous system condition called serotonin syndrome. In addition, updated labeling will include information about opioid effects on the endocrine system, including a rare but serious disorder of the adrenal glands (adrenal insufficiency) and decreased sex hormone levels (androgen deficiency). More information about these risks is available in FDA's Drug Safety Communication announcement, available at *www.fda.gov/Drugs/DrugSafety/ucm489676.htm.*

FDA Issues Alert Regarding All Unexpired Sterile Drug Products Produced by Medaus Pharmacy

On April 1, 2016, FDA alerted health care providers and patients not to use products marketed as sterile from Medaus Pharmacy in Birmingham, AL. Insanitary conditions, including poor sterile production practices, were identified by FDA investigators during a recent inspection at Medaus' facility. The affected products were distributed nationwide and internationally. The alert applies to all unexpired drug products that are intended to be sterile. Health care providers should check their medical supplies, quarantine any drug products marketed as sterile from Medaus, and not administer them, indicates the FDA Safety Alert, available at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsForHumanMedicalProducts/ucm493871.htm.*

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It is the decision of the Board to treat an online website as a store. It is also the decision of the Board to allow prescribers to print an order form from those websites as long as the pharmacist or pharmacy name is not referenced in any way on the printout.

Help Your Colleague by Making a Confidential Referral

If you are concerned about a fellow pharmacist or technician whom you feel has a problem with alcohol or other drugs or a mental illness, you can get assistance by asking the Board and Pharmacists Assisting Pharmacists of Arizona (PAPA) to intervene.

Pharmacists are required by law and professional ethics to report a colleague to the Board who is impaired or has a behavioral problem that may adversely affect his or her patients or practice of pharmacy. If done early and before there is any adverse patient outcomes or legal involvement, it is often possible for the person to receive assessment, treatment, and monitoring in a confidential manner (officially "unknown" to the Board and the public). PAPA provides support and monitoring for impaired pharmacists to ensure health and safety of both the pharmacist and the public.

Your referral may save a pharmacist's or technician's life and can help ensure that the public is being protected. Calls are confidential. You can call Kam Gandhi, PharmD, Board executive director, at 602/771-2740. To report in writing, send your referral to PO Box 18520, Phoenix, AZ 85005, or 1616 W Adams St, Suite 120, Phoenix, AZ 85007. The PAPA program is located at 1845 E Southern Ave, Tempe, AZ 85282. Its phone number is 480/207-7869, and its fax number is 480/838-3357. You can remain anonymous if you desire.

Guidelines for Board Complaint Resolution

The Board has adopted this substantive policy statement to provide the licensees and the public with general guidelines used by the Board during the complaint resolution process. The Board is not limited by these guidelines and may select any combination of resolutions found in the chart.

Level	Errors or Violations of Law/Rule and/or Community Standards of Care
I	Errors are not of sufficient seriousness to merit direct action against the licensee. Examples may include prescription dispensing errors that did not cause harm, failure to provide counseling, insignificant record-keeping deficiencies, or failing to report to the Board a change of home address, employer, or residency status. **Resolutions:** ♦ Advisory letter ♦ Order for continuing education (CE) (non-disciplinary)
II	Violations of law or community standard of pharmaceutical practice have occurred that do not warrant revocation or suspension of a license. Examples may include ethical violations; violation of any federal or state law/rules relating to the practice of pharmacy; engaging in activities that are unprofessional by current standards of practice; records violations; dispensing error resulting in potential harm; unintentional misrepresentation; providing rebates; or entering into an agreement for the payment of rebates to a medical practitioner or any other person in the health care field. **Resolutions:** ♦ Letter of reprimand ♦ Order for CE ♦ Censure ♦ Civil penalty ♦ Probation ♦ Order for rehabilitation ♦ Operation evaluation
	♦ Assessment of RPh competence (North American Pharmacist Licensure Examination® (NAPLEX®), Multistate Pharmacy Jurisprudence Examination® (MPJE®), and/or Pharmacist Assessment for Remediation Evaluation® (PARE®)) ♦ Assessment of technician competence (approved technician certification exam) ♦ Restriction or limitation on practice/profession
III	Violations of law or community standard of pharmaceutical practice that warrant suspension or revocation; mentally or physically unable to safely engage in the practice of pharmacy. This level may include egregious acts of unprofessional conduct. Examples may include ethical violations; a dispensing error that results in potential harm or death; commission of a felony or misdemeanor involving moral turpitude; intentional and/or willful fraud, misrepresentation, or deception; intentional and/or willful violation of confidentiality; knowingly dispensing a drug without a valid prescription; violating a formal Board order, consent agreement, or term of probation; gross negligence; failing to comply with a Board-issued subpoena; refusing without just cause authorized Board agents to examine documents that are required to be maintained by law; or practicing pharmacy while impaired or incapacitated. **Resolutions:** ♦ Order for rehabilitation ♦ Probation with suspension ♦ Summary suspension ♦ Suspension/revocation ♦ Assessment of competence (NAPLEX, MPJE, and/or PARE) ♦ Assessment of technician competence (approved technician certification exam) ♦ Operation evaluation

Disciplinary Actions and Updates

Pharmacy Technician

Ashley Brooks (T012892) – Pharmacy technician license revoked.

Permits

Integrity Rx Specialty Pharmacy, LLC (Y005956) – Civil penalty of $22,200 for filling/compounding in violation of the deviation granted by the Board. Investigative fee of $175 and deviation granted in 2014 rescinded.

Vasco Rx (Y004706) – Civil penalty of $22,200 for filling/compounding in violation of the deviation granted by the Board. Investigative fee of $175 and deviation granted in 2014 rescinded.

Disciplinary Actions and Updates – Other Health Boards

Arizona Medical Board

Visit *https://www.azmd.gov/GLSPages/RecentActions.aspx* for additional details.

Licensee Name and Number	Description of Action and Effective Date
Mark Allan Abramovich, MD – 35225	Decree of censure with probation, effective April 7, 2016 View Full Document [PDF]
Lucio Arteaga, MD – 16150	Letter of reprimand with probation, effective April 7, 2016 View Full Document [PDF]

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Alaaeldin Ahmed Babiker, MD – 28043	Surrender, effective April 7, 2016 View Full Document [PDF]
Michael Stuart Biscoe, MD – 20915	Surrender, effective June 3, 2016 View Full Document [PDF]
Michael Conrad Bryan, MD – 37126	Letter of reprimand with probation, effective June 3, 2016 View Full Document [PDF]
Mohamed Ibrahim Elyan, MD – 44396	Letter of reprimand with probation, effective June 3, 2016 View Full Document [PDF]
Gabrielle Julie Goodrick, MD – 22811	Inactive with cause, effective June 3, 2016 View Full Document [PDF]
Susan Browning Greger, MD – 47822	Interim practice limitation – must be reviewed by executive director to evaluate restriction, effective June 2, 2016 View Full Document [PDF]
Tamera Beasley Jordan, MD – 34494	Letter of reprimand, effective April 7, 2016 View Full Document [PDF]
Timothy Wallace Jordan, MD – 26988	Letter of reprimand with probation, effective July 8, 2016 View Full Document [PDF]
Daniel Kunil Kim, MD – 18541	Letter of reprimand, effective May 6, 2016 View Full Document [PDF]
Kevin Scott Lewis, MD – 17850	Surrender, effective April 7, 2016 View Full Document [PDF]
Randal John Lewis, MD – 50616	Surrender, effective May 6, 2016 View Full Document [PDF]
Edgar Franklin Livingstone, MD – 31013	Letter of reprimand, effective May 6, 2016 View Full Document [PDF]
Elizabeth Victoria Mahour-Moyer, MD – 37282	Letter of reprimand, effective May 6, 2016 View Full Document [PDF]
Wendy J. Marshall, MD – 35482	Surrender, effective June 3, 2016 View Full Document [PDF]
Jonathan Bruce Murphy, MD – 44962	Letter of reprimand with probation, effective May 12, 2016 View Full Document [PDF]
Shaun Delaney Parson, MD – 27008	Probation, effective June 3, 2016 View Full Document [PDF]
Manish Jagdishchandra Patel, MD – 29685	Letter of reprimand with probation, effective April 7, 2016 View Full Document [PDF]
Joel Jesus Paulino, MD – 28843	Letter of reprimand, effective June 3, 2016 View Full Document [PDF]
Subhaschand Ramnarain Ramnauth, MD – 31498	Probation, effective April 11, 2016 View Full Document [PDF]
Howard Joel Rolins, MD – 24625	Letter of reprimand, effective May 6, 2016 View Full Document [PDF]
Ronald Mannon Salik, MD – 25392	Letter of reprimand, effective June 3, 2016 View Full Document [PDF]
Susan Dee Scarla, MD – 13951	Interim practice restriction must be reviewed by executive director to evaluate restriction, effective April 7, 2016 View Full Document [PDF]
Rachel Mindie Schacht, MD – 30018	Probation, effective June 3, 2016 View Full Document [PDF]
Allen Dorris Sloan, MD – 17481	Letter of reprimand, effective July 8, 2016 View Full Document [PDF]
Jose Antonio Sosa-Roche, MD – 18643	Interim practice restriction must be reviewed by executive director to evaluate restriction, effective June 7, 2016 View Full Document [PDF]
Issada Thongtrangan, MD – 45920	Decree of censure with probation, effective May 6, 2016 View Full Document [PDF]
Timothy Ellis Walker, MD – 11843	Surrender, effective June 3, 2016 View Full Document [PDF]
Helen Elizabeth Watt, MD – 22016	Letter of reprimand, effective May 12, 2016 View Full Document [PDF]
Mark Alan Wellek, MD – 6416	Surrender, effective April 7, 2016 View Full Document [PDF]
Duane Maurice Wooten, MD – 17126	Letter of reprimand, effective April 7, 2016 View Full Document [PDF]

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