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New Mexico Board of Pharmacy News

Published to promote compliance of pharmacy and drug law

5500 San Antonio Dr NE, Suite C • Albuquerque, NM 87109 • Tel: 505/222-9830 • Fax: 505/222-9845
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Prescription Monitoring Program

New PMP Regulations for Pharmacist Clinicians

New Mexico Board of Pharmacy regulations requiring prescription monitoring program (PMP) utilization by a pharmacist clinician (PhC) became effective last fall. The change in regulation was in part based on Senate Bill 263, Opioid Prescription Monitoring, which went into effect on January 1, 2017. A PhC exercising prescriptive authority in the prescribing of a controlled substance (CS) must utilize the PMP under many circumstances, including **before** prescribing a CS to a patient for the first time if the prescription is greater than a four-day supply, or if there is a gap in prescribing the CS for 30 days or more. If prescribing for a chronic condition, the PMP must be checked at least every three months during continuous prescribing of an opioid, benzodiazepine, or carisoprodol. The PMP must be checked at least every six months during continuous prescribing of a CS in Schedule II-IV that is not an opioid, benzodiazepine, or carisoprodol. The PhC must also review and document any indication of multiple situations involving a patient's use of CS. Please review 16.19.4.17(F) NMAC at *http://164.64.110.239/nmac/parts/title16/16.019.0004.htm* to be sure you are following the regulation.

Where Is NAR$_X$CHECK?

Some of you may have noticed that NAR$_X$CHECK is no longer available in PMP AWAR$_X$E. During the PMP transition to Appriss, Inc, the NAR$_X$CHECK piece was delayed and will be replaced with an upgraded version later this year.

PMP Reminders

- **Do** be sure you are entering and submitting all Drug Enforcement Administration (DEA) suffixes. This means all University of New Mexico DEA numbers should include the B-1111 number.
- **Do** use the partial spelling box when not finding a patient.
- **Do** check the PMP as required by Board regulations (16.19.4.16(E) NMAC).
- **Do not** add extra information in the name fields – only the name should be there. Searching for Jane Doe becomes impossible when she is entered as "Jane Doe (Snap Caps)" or "Jane Doe bottles only."
- **Do not** give patients a copy of their report. Refer them to the PMP staff at the Board to request a history.

Disciplinary Actions

Maria Arellano, PT – License PT-9903. Default order. Pharmacist technician license revoked by default.

Sherriece DeVargas, PT – License PT-10692. Default order. Pharmacist technician license revoked by default.

Mahmood Hurab, RPh – License RP-5289. Default order. Pharmacist license, PhC license, and CS license revoked. May not apply for reinstatement for a period of 10 years.

Amanda Mendoza, PT – License PT-5067. Default order. Pharmacist technician license revoked by default.

Armin Quedzuweit, RPh – License RP-7774. Order reinstating pharmacist license. Subject to the stipulation that respondent completes all continuing education. Must complete 120 hours of a pharmacy internship. Must successfully take and pass the Multistate Pharmacy Jurisprudence Examination® (MPJE®). Must pay all fines and fees. Respondent shall remain on probation and shall fully participate in and finish the full duration of the Monitored Treatment Program (MTP).

Ready Pharmacy – License PH-2001. Default order. Pharmacy license and CS license revoked. May not apply for reinstatement for a period of 10 years.

Regulation Update

With assistance from the New Mexico Poison & Drug Information Center, the Board has updated the Controlled Substances Regulation. Many identified substances showing abuse potential have been added as Schedule I CS. Eluxadoline, a product recently added to the market, was added as a Schedule IV CS to match federal regulations.

Also revised in the Controlled Substances Regulation is an allowance that a prescription for a CS in Schedule II may be partially filled if the total quantity dispensed in all partial fillings does not exceed the total quantity prescribed. Remaining portions shall be filled no later than 30 days after the date on which the prescription is written.

Regulation 16.19.2 NMAC was also revised. This regulation is regarding examinations. A candidate taking the North American Pharmacist Licensure Examination® (NAPLEX®) may attempt the exam no more than five consecutive times without passing. Also, the candidate must wait at least 45 days before retaking the examination. For reinstatement of the pharmacist license, the Board may require an applicant to make a passing score on any combination

continued on page 4

National Pharmacy

The applicability of articles in the *National Pharmacy Compliance*
by examining the law of

FDA Issues Final Rule Amending List of Drug Products That May Not Be Compounded

Food and Drug Administration (FDA) issued a final rule amending FDA's list of drug products that may not be compounded under certain sections of the Federal Food, Drug, and Cosmetic Act (FD&C Act) that allow the marketing of unapproved compounded drugs. Drug products on the list may not be compounded because the drug products have been withdrawn or removed from the market for safety or effectiveness reasons, indicates FDA. The list may be found in the Code of Federal Regulations at Title 21, Section 216.24, at *www.ecfr.gov.*

The final rule adds 24 types of drugs to the withdrawn or removed list; modifies the withdrawn or removed list to allow one type of drug product to be compounded under certain circumstances; and clarifies that the withdrawn or removed list applies to sections 503A and 503B of the FD&C Act. The final rule is available at *www.gpo.gov/fdsys/pkg/FR-2016-10-07/pdf/2016-24333.pdf.* FDA provides more information online at *www.fda.gov/Drugs/DrugSafety/ucm524320.htm.*

Selected Medication Risks to Manage in 2017

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.*

Some medication safety risks are painfully apparent in an organization, while many others lie dormant in the system until an error or adverse event draws attention to them. ISMP thought it would be useful to describe selected medication safety risks for organizations to manage in 2017 that might otherwise fall off the radar screen.

Environmental Factors, Workflow, and Staffing Patterns – Poor Quality Lighting

Lighting is a crucial aspect of the physical environment that has been linked to medication safety.[1] Poor quality lighting has often impaired the highly visual tasks associated with medication use, thus leading to medication errors. Examples include tubing misconnections due to low lighting in a patient's room, infusion pumps that have been misprogrammed because of dim backlighting on the screens, and product selection errors in the pharmacy and patient care units caused by low lighting under a pharmacy hood or shadows around an automated dispensing cabinet (ADC).

Despite existing guidelines for lighting in health care, it has been a challenge to implement optimal lighting conditions for prescribing, dispensing, and administering medications. Recent literature reviews found that little system-wide action has been taken to increase staff awareness of the problem or improve the lighting.[1,2] This is largely because the tasks associated with medication use are varied and carried out under diverse physical conditions and in differing locations, and because there are differences in an individual's light requirements based on visual acuity and age. With an ever-increasing population of older health care providers, eye fatigue from computer work and task complexity, small font sizes on medication labels, poor background contrast, and glare or shadows have taken their toll on visual accuracy.[1,2]

Proper illumination improves both the accuracy and efficiency of medication-related tasks. Fluorescent cool white lamps or compact fluorescent lamps should be used in areas where critical tasks are performed, including on mobile medication carts, near ADCs, and in patients' rooms for nighttime administration of medications.[3,4] Administration of medications at night under low lighting to avoid disturbing the patient is an unsafe practice and should be avoided. Adjustable 50-watt high-intensity task lights are recommended when difficult-to-read prescriptions and product labels are encountered.[4] Illumination levels for computer order entry areas should be at least 75 foot-candles (fc), while 100-150 fc are needed when interpreting handwritten orders.[4] Medication preparation areas, medication verification areas, and patient counseling areas should have illumination levels between 90-150 fc.[4] Medication rooms should provide illumination at 100 fc.[4] Lighting levels should be increased if the workforce has an average age above 45 years. A magnifying glass and task light together can also significantly improve accuracy[3] and should be used on mobile medication carts (including those used with bar code medication verification systems)[4] and near ADCs.

References:

1. Chaudhury H, Mahmood A, Valente M. The effect of environmental design on reducing nursing errors and increasing efficiency in acute care settings: a review and analysis of the literature. *Environ Behav.* 2009;41(6):755-786.
2. Graves K. *Nurses' Decision Making Processes About Lighting During Medication Administration* [dissertation]. Denton: Texas Woman's University College of Nursing; 2014.
3. Grasha AF. Psychosocial factors, workload, and risk of medication errors. *US Pharm.* 2002;27(4):HS32-52.
4. United States Pharmacopeial Convention. Chapter <1066> Physical environments that promote safe medication use. *Revision Bulletin.* October 1, 2010;2-6. www.ismp.org/sc?id=1664.

DEA to Decrease Manufacturing Amount of Opioid Controlled Substances in 2017

Drug Enforcement Administration (DEA) is reducing the amount of almost every Schedule II opiate and opioid medication that may be manufactured in 2017 by 25% or more. Other medicines were reduced by more, such as hydrocodone, which will be 66% of last year's level, indicates the DEA news release. DEA notes that demand for these opioid medicines has declined based on sales data from IMS Health, a company that provides insurance companies with data on prescriptions written and prescription medications sold in the United States.

The aggregate production quota (APQ) established by the final order is the total amount of a controlled substance (CS) necessary to meet the estimated medical, scientific, research, industrial, and export needs for the year and for the maintenance

of reserve stocks. The 2017 APQ has been reduced for oxycodone, hydrocodone, fentanyl, hydromorphone, morphine, and other such medications. Much of this reduction is attributed to the elimination of a 25% buffer that was added to the APQ annually in 2013 through 2016 to guard against shortages. The purpose of quotas is to provide an adequate and uninterrupted supply for legitimate medical need of the types of Schedule I and II CS that have a potential for abuse, while limiting the amounts available to prevent diversion.

Additional details may be found in the DEA news release available at *www.dea.gov/divisions/hq/2016/hq100416.shtml* and in the final order available at *https://www.gpo.gov/fdsys/pkg/FR-2016-10-05/pdf/2016-23988.pdf*.

New CDC Brochure Offers Pharmacists Tips for Addressing Prescription Opioid Abuse and Overdose

Centers for Disease Control and Prevention (CDC) released a brochure encouraging pharmacists, who are an essential part of the health care team, to help prevent opioid abuse and overdose. The brochure, "Pharmacists: On the Front Lines," offers tips for communicating with patients who are receiving opioid therapy. In addition, the brochure offers tips on how to identify forged prescriptions and urges pharmacists to maintain collaborative working relationships with prescribers to improve patient outcomes. The brochure is available at *www.cdc.gov/drugoverdose/pdf/pharmacists_brochure-a.pdf*.

FDA Requires Boxed Warnings and Patient-Focused Medication Guides Indicating Serious Risks Related to Combined Use of Certain Opioid Medications and Benzodiazepines

FDA is requiring class-wide drug labeling changes to inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and benzodiazepines. Specifically, after an extensive review of the latest scientific evidence, FDA is requiring boxed warnings and patient-focused Medication Guides for prescription opioid analgesics, opioid-containing cough products, and benzodiazepines that provide information about the serious risks associated with using these medications at the same time. Risks include extreme sleepiness, respiratory depression, coma, and death.

FDA's news release indicates the changes are part of the agency's Opioids Action Plan, which focuses on policies aimed at reversing the prescription opioid abuse epidemic while providing patients in pain with access to effective and appropriate pain management. The public health crisis is evident through the significant rise of preventable overdose and death associated with the concurrent use of two drug classes, indicates FDA Commissioner Robert Califf, MD, in the press release, available at *www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm518697.htm*.

FDA's Division of Drug Information Offers CE Webinars for Students and Clinicians

FDA's Center for Drug Evaluation and Research (CDER), Office of Communications, Division of Drug Information presents a series of continuing education (CE) 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. Previous webinar topics have included an overview of drug shortages and prescription drug promotion. The webinars and presentation slides can be accessed on FDA's website at *www.fda.gov/DDIWebinars*.

FDA Approves Labeling Changes for All Prescription Testosterone Products

In October 2016, FDA approved class-wide labeling changes for all prescription testosterone products regarding the risks associated with abuse and dependence of the drug. The changes include adding a new warning as well as updating the Abuse and Dependence section to include new safety information from published literature and case reports regarding the risks associated with abuse and dependence of testosterone and other anabolic androgenic steroids (AAS). The Anabolic Steroids Control Act of 1990 placed AAS, including testosterone, in Schedule III of the Controlled Substances Act.

Prescription testosterone products are FDA-approved as hormone replacement therapy for men who have low testosterone due to certain medical conditions. However, testosterone and other AAS are abused by adults and adolescents, including athletes and body builders, notes FDA. FDA indicates the new warning will "alert prescribers to the abuse potential of testosterone and the serious adverse outcomes, especially those related to heart and mental health that have been reported in association with testosterone/AAS abuse." In addition, new labeling information in the Warning and Precautions section advises prescribers of the importance of measuring serum testosterone concentration if abuse is suspected.

FDA explains that abuse of testosterone, usually at doses higher than those typically prescribed and usually in conjunction with other AAS, is associated with serious safety risks affecting the heart, brain, liver, mental health, and endocrine system. Reported serious adverse outcomes include heart attack, heart failure, stroke, depression, hostility, aggression, liver toxicity, and male infertility. Individuals abusing high doses of testosterone have also reported withdrawal symptoms, such as depression, fatigue, irritability, loss of appetite, decreased libido, and insomnia. The FDA announcement is available at *www.fda.gov/Drugs/DrugSafety/ucm526206.htm*.

Latest FDA Drug Info Rounds Training Videos Available

Drug Info Rounds, a series of online videos by FDA, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better decisions. In the latest Drug Info Rounds video, "Extortion Scam," pharmacists discuss steps a potential victim could take if they receive a call from individuals posing as FDA and DEA agents. Drug Info Rounds is developed with contributions from pharmacists in FDA's 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*.

continued from page 1

of either the NAPLEX, MPJE, or the Pharmacist Assessment for Remediation Evaluation®.

Reminders

- An impaired licensee must be reported to the impaired pharmacist program or referred to the Board. The Board-approved program is MTP. Failure to report an impaired pharmacist or refer to MTP is considered unprofessional or dishonorable conduct.
- United States Pharmacopeia Chapter <800> will become effective and enforceable in July 2018. If you compound sterile and nonsterile products using hazardous drugs, you must be in compliance. To determine if you are in compliance, visit *http://800gaptool.com.*
- Information regarding naloxone is available in the Forms and Applications section of the Board's website at *www.rld.state.nm.us/boards/Pharmacy.aspx.* This will provide you with the standing order prescription you need to dispense naloxone to a New Mexico citizen.
- Is your pharmacy taking back unused medications for destruction? If so, Board Regulation 16.19.6.15 NMAC states, "Patient dispensed legend and [over-the-counter] medications that are unwanted or expired may be returned to an authorized pharmacy for destruction. The pharmacy must submit a protocol or subsequent changes to the board or the [board's] agent, for approval. Once approved the pharmacy is authorized to collect pharmaceuticals for destruction. A protocol is to be submitted to the board of pharmacy for staff approval." This is a great service for the public. Please ensure that your pharmacy has an approval letter if accepting drugs for destruction.
- A pharmacy may not refuse to transfer original prescription information to another pharmacy that is acting on behalf of a patient. The transfer of original prescription information must be done in a timely manner.
- The next Board meeting is scheduled for April 20-21, 2017. The agenda must be posted at least 72 hours prior to the beginning of the meeting. Meetings are open to the public.

Significant Adverse Drug Events

1. A 70-year-old patient received tramadol 50 mg tablets, which were intended for another patient. The patient did not state how many doses of the medication were taken, but the patient did not experience an adverse reaction. The pharmacist reported that the medication was typed under the wrong patient name and the patient did not receive counseling. The pharmacist attributes the error to a busy workweek in the beginning of the year, relying too much on work staff, and rushing the process of filling the prescription. No recommendations for improvement were provided.
2. A 50-year-old female patient received oxycodone/acetaminophen 5-325 mg tablets, which were intended for another patient with a similar name. The medication was delivered to the patient with her other medications; she took one dose with no adverse reaction to report and contacted the pharmacy for clarification on the prescription. The pharmacy immediately picked up the incorrectly delivered medication and identified the prescription as incorrectly bagged. The pharmacist attributes the error to an IOU being incorrectly placed in a delivery box and failure of double-checking patient information by the delivery person. The pharmacist recommends that pharmacists double-check all deliveries, the delivery staff be retrained, delivery personnel double-check all patient information with the patient prior to delivery, and delivery staff contact the pharmacist if there is a question.
3. A nine-year-old male patient received trazodone 50 mg tablets, which were intended for another patient with the same name and similar contact information. After taking the medication for 19 days, the patient reported difficulty waking in the morning, grogginess, and daytime fatigue. The error was attributed to a technician being called to assist when the pharmacy needed additional assistance. This person sold the medication without properly verifying the patient's address and telephone number. The patient had noticed a discrepancy in the contact information. This was overlooked by the technician. The pharmacist attributed the error to the pharmacy technician not following proper out-window procedures. The pharmacist recommends the technician follow the company procedures when selling medication.
4. A 50-year-old female patient was newly prescribed sucralfate 1 gram tablets but received guanfacine 1 mg tablets. The patient took nine doses of the medication over a two-day period and experienced drowsiness and severe dry mouth. The patient contacted her doctor about the side effects, which were then brought to the pharmacy's attention by the charge nurse. The pharmacy attributed the error to handling multiple prescriptions at once, look-alike drug names, and the doctor's writing, which was difficult to read. The pharmacist recommends that two different people review prescriptions – the technician will type and the pharmacist will review.
5. A 32-year-old patient requested a refill for labetalol 200 mg tablets but received lamotrigine 200 mg tablets. The patient took the prescription as prescribed for approximately 12 days and experienced an itchy rash on the throat, upper chest, and upper back. The patient contacted the pharmacist-in-charge to report the side effects and was advised to discontinue the medication and see her practitioner. The practitioner prescribed corticosteroids, which resulted in the rash resolving. It was identified that the medication was labeled and placed for verification in the stock bottle. This label placed on the stock bottle covered the barcode, National Drug Code, and part of the drug name. The pharmacist recommends implementing a policy of not covering up the barcode when dispensing a stock bottle, or if the barcode is covered, the label should be easily removable for verification of the medication being dispensed.
6. A 52-year-old female patient was prescribed liothyronine 12.5 mcg capsules but received porcine 90 mg capsules. The patient was prescribed both of these compounded medications. The patient experienced stomach pain and renal issues, which resulted in an emergency room (ER) visit. The patient noticed the capsules had a different color and contacted the pharmacy to inform of her ER visit and question a change in formulation. The pharmacist requested that the patient read the corresponding lot numbers and discovered the prescription was filled incorrectly by the pharmacy technician and the lot number had not been verified by the pharmacist. The pharmacist instructed the patient to stop taking the medication, inform her provider of the error, and ask for consultation on treatment. The pharmacist attributed the error to the technician incorrectly filling the medication and the pharmacist not verifying the lot number against the computer-generated number on the prescription. The pharmacist recommends policies and procedures for compounded prescriptions to verify the lot number and expiration date before dispensing to a patient.
7. A 16-year-old female patient was prescribed Wellbutrin XL® 150 mg tablets but received bupropion XL 300 mg tablets. The

continued on page 5

continued from page 4

patient did not experience an adverse event after about a week's use of the medication. The medication for the prescription was incorrectly pulled and filled by the technician and sent to verification. The pharmacist stated that the verification process had been interrupted by phone calls and the error was missed. The patient denied counseling by the pharmacist and was dispensed the medication. No recommendations for improvement were provided.

8. A 23-year-old female patient was prescribed Ortho Tri-Cyclen® Lo tablets but received Ortho Tri-Cyclen tablets. After taking the medication for a month, the patient reported feeling "moody" and having more cramps than usual. The pharmacist attributed the error to look-alike/soundalike drugs, handling multiple prescriptions, staffing, and high patient volume. The pharmacist recommends paying close attention when dealing with soundalike drugs.
9. A 30-year-old male patient was prescribed Latuda® 40 mg tablets but received ziprasidone 40 mg capsules. The patient took the medication for 14 days and reported delirium, cognitive impairment, withdrawal-like symptoms, and severe agitation. The pharmacist attributes the error to similarity of generic names, work overload, and distractions. The pharmacist recommended the prescription always be typed in as a brand name.
10. A 75-year-old female patient was prescribed anagrelide 0.5 mg capsules but received anagrelide 1 mg capsules. The patient did not report an adverse drug event, but the pharmacist verified the prescription had been filled and checked with the wrong dose. The pharmacist recommends to check and double-check prescriptions prior to and at dispensing.
11. A 72-year-old female patient was newly prescribed lorazepam 2 mg tablets but received lorazepam 1 mg tablets. The patient's sister reported that the patient suffered a mini-seizure, which resulted in an ER visit. The patient returned to the pharmacy for the correct prescription, and results of the ER visit were still unknown. The pharmacist recommends double-checking the typing before entering a prescription and the pharmacist to check data entry typing against the hard copy during verification to make sure the correct dose is dispensed.
12. A five-year-old male patient was prescribed Ritalin® 5 mg tablets but received methadone 10 mg tablets. The patient's school nurse contacted the pharmacy questioning why the patient was receiving methadone. The pharmacy then contacted the mother and contacted the physician to report the error. The patient went to the hospital. The error was caused when the strength changed from 5 mg (take one tablet) to 10 mg (take one-half tablet) for insurance payment. The insurance would not cover a lower dose of the medication. No recommendations have been made by the pharmacist.
13. A 48-year-old female patient was prescribed oxycodone 30 mg tablets but received oxycodone 15 mg tablets. The patient stated she experienced withdrawal symptoms, then contacted her prescriber. Prescriber instructed patient to double-up on the medication and wrote a new prescription. The pharmacist identified that the incorrect medication had been dispensed to the patient. The pharmacist recommends to verify when reviewing the patient's PMP if he or she identifies a change in strength. This may have prevented the error.
14. A measles, mumps, and rubella II live vaccine subcutaneous injection was given to a female patient who was pregnant or considering becoming pregnant. The patient was continuing to be monitored but should not have received the vaccine if pregnant or considering pregnancy. The pharmacist recommends verbally asking patient if she is pregnant or considering becoming pregnant before giving any immunization.
15. An 87-year-old female patient called in a prescription refill for hydralazine. The patient called with an old prescription number for hydralazine 100 mg, but instructed the technician that she wanted the 50 mg tablets. The old prescription was filled; the patient received hydralazine 100 mg tablets. The patient took the medication for two weeks and experienced shortness of breath and dizziness while exercising. The pharmacist recommends updating policies and procedures to include discontinuing older medications that have changed strength and/or dosing frequency.
16. A 63-year-old female patient received metformin 1,000 mg tablets, which was for another patient. The patient took one tablet and experienced flushing and itching. The pharmacist attributed the error to the cashier not verifying the patient's name and date of birth, or the cashier rushing. The pharmacist recommends to slow down and double-check the patient's name and date of birth.
17. An 82-year-old patient received escitalopram 10 mg tablets prescribed for another patient. The patient took one dose. The caregiver took him to urgent care. The patient reported no adverse effects. The pharmacist contributed the error to the medication being incorrectly bagged during the filling process. The pharmacist recommends staff working on one prescription/patient at a time going forward.
18. An 11-year-old male patient was prescribed topiramate suspension 6 mg/mL but received topiramate suspension 72 mg/5 mL. The error was discovered on refill. The pharmacist attributed the error to the label not being checked against the hard copy, the technician and pharmacist using one formula that they assumed was the correct concentration, and a check of the right dose/strength of the medication not occurring. No recommendations were made by the pharmacist.
19. A 46-year-old female patient transferred a prescription for vitamin D3 5,000 IU but received vitamin D2 50,000 IU. The patient contacted the pharmacy complaining of nausea and vomiting and was instructed to see her physician. The pharmacist recommends double-checking the data entry prior to completing the prescription.
20. A 48-year-old male patient was prescribed testosterone intramuscular (IM) injection but received cyanocobalamin IM injection. The prescription was then refilled in error. The pharmacist attributes the error to rushing and to busy workflow. The pharmacist recommends slowing the work process, technician matching the drug to hard copy, and internally examining workflow.

Disclaimer: The 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.

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Ben Kesner - State News Editor

Carmen A. Catizone, MS, RPh, DPh - National News Editor & Executive Editor

Amy Suhajda - Communications Manager