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New Mexico Board of Pharmacy News

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Significant Adverse Drug Events

1. An 80-year-old male patient with hypothyroidism was given a new prescription for levothyroxine 125 mcg but was dispensed 175 mcg at the pharmacy. After taking the medication for approximately 30 days, the error was discovered when the patient attempted to refill the medication. As a result of the error, the patient had to have their thyroid levels reevaluated. The patient did not report any untoward effects as a result of taking the increased dose. The pharmacist-in-charge (PIC) attributes the error to a break in the filling process. The filling pharmacist confirmed the product selection via the typed label and not the original (electronic) prescription. The PIC recommends freeing up an unused computer terminal for the sole purpose of verifying prescriptions from the original scans/electronic information.
2. A 28-year-old female patient requested a refill for her birth control over the phone but instead the pharmacy filled estradiol 1 mg tablets from her profile. As a result of taking the incorrect medication for approximately one month, the patient had to have blood work and be reevaluated because she was scheduled to be artificially inseminated three months after the error occurred. According to the PIC, the technician taking the phone call did not verify the name of the medication, Pirmella™ 1/35. Instead, the technician was told to refill "birth control" and chose the wrong medication from the patient profile. The PIC recommends retraining all technicians to verify the name and strength of all medications being called in for refill verbally.
3. An 85-year-old female patient with hypertension was given a new prescription for metoprolol succinate ER 25 mg capsules, which was instead filled with metoprolol succinate ER 50 mg tablets. The patient took the medication for approximately 90 days before the error was discovered. As a result of taking the incorrect strength, the patient had to schedule a follow-up with the prescriber. The PIC attributes the error to a break in process as a result of short-staffing. Only one technician, who was an out-of-state floating technician, was working due to coronavirus disease 2019 (COVID-19) staffing limitations. The PIC recommends triple-checking the prescription as required by internal policy.
4. A 62-year-old male patient was prescribed gabapentin 300 mg but was dispensed gabapentin 100 mg at the point of sale. The error was discovered after the patient took three doses. As a result of taking the incorrect strength, the patient had to schedule a follow-up with the prescriber who reported no additional harm to the pharmacy. The PIC attributes the error to a break in process. The filling pharmacist entered, filled, verified, and sold the prescriptions. Normally, a technician handles most of these steps, according to policy. The PIC issued a written warning to the filling pharmacist and recommends retraining to follow written policies.

Disclaimer: These suggestions are made by the pharmacist submitting the Significant Adverse Drug Event Report. *Newsletter* publications of recommendations are not an indication of endorsement by the New Mexico Board of Pharmacy.

Changes to EPCS

The Board has received calls related to the new electronic prescriptions for controlled substances (EPCS) requirement. Please note that while regulation 16.19.20.42(B)(1) of the New Mexico Administrative Code went into effect on April 1, 2021, the Board recognizes that some practitioners are actively implementing EPCS capability. An Emergency Dispensing Declaration has been issued by the Board from April 1, 2021, through June 30, 2021. During this time period, the Board does not intend to take action against a pharmacist who fills a nonelectronic controlled substance (CS) prescription that is not otherwise subject to an exception for required EPCS. Please note:

- The pharmacist is to communicate directly with the prescriber as appropriate to establish the current circumstance.
- The duties and responsibilities of the pharmacist are otherwise unchanged, including corresponding responsibility.
- Pharmacists are to exercise sound professional judgment when determining whether a CS prescription is legitimate.

Additional information regarding the Emergency Dispensing Declaration can be found on the Board's website.

Scam Calls Targeting Pharmacists

The Board has received reports from pharmacists about calls from someone who claimed to be an undercover agent with the Board. The caller provided a fake badge number and told the pharmacists that they were under investigation by the Board, Drug Enforcement Administration, and/or the Federal Bureau of Investigation. The caller quoted "1985 Drug Trafficking Law" and the "Privacy Act," and made threats of license suspension and that a sheriff would be going to their house if they did not answer his questions. Calls may be routed to appear on caller ID as being from the Board office at 505/841-9102 and 505/222-9830. The Board does not make calls like those described above. If you receive such a call, please report it to one of the Board investigators.

National Pharmacy Compliance News

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NABPF
National Association of Boards of Pharmacy Foundation

Guidelines, Materials Available to Health Care Providers for Safely Administering COVID-19 Vaccines

Guidelines and materials are available to support health care providers with safely administering the coronavirus disease 2019 (COVID-19) vaccine, including safe practice recommendations from the Institute for Safe Medication Practices (ISMP) and a United States Pharmacopeia (USP) toolkit.

After numerous reports of errors or hazards associated with the administration of COVID-19 vaccines, ISMP is sharing safe practice recommendations.

A new USP toolkit is also available to facilitate operational efficiencies that can help accelerate delivery and support safe handling of COVID-19 vaccines while maintaining quality and ultimately the public's trust. Download the USP toolkit.

FDA Issues Guidance to Protect Consumers From Methanol Poisoning

Food and Drug Administration (FDA) has issued guidance for industry, *Policy for Testing of Alcohol (Ethanol) and Isopropyl Alcohol for Methanol, Including During the Public Health Emergency (COVID-19).* The guidance is intended to help pharmaceutical manufacturers and pharmacists who engage in drug compounding to avoid using pharmaceutical alcohol contaminated with or substituted with methanol in drug products. FDA noted that methanol is not an acceptable ingredient for any drug product and should not be used. The guidance is available on the FDA website.

Standardize Concentrations for Oral Liquid Preparations

ISMP Institute for Safe Medication Practices An ECRI Affiliate

This column was prepared by ISMP, an ECRI affiliate. Have you experienced a medication error or close call? Report such incidents in confidence to ISMP's National Medication Errors Reporting Program online at www.ismp.org *or by email to ismpinfo@ismp.org to activate an alert system that reaches manufacturers, the medical community, and FDA. To read more about the risk reduction strategies that you can put into practice today, subscribe to the ISMP Medication Safety Alert! newsletters at* www.ismp.org.

Few would disagree that standardizing the concentrations of drugs has enormous potential for increasing safety, especially in pediatric care. Standardization limits the risk of variation, especially when patients are transitioned from hospital to home or have prescriptions filled at different pharmacies. However, ISMP has learned of multiple instances in which unrecognized differences or changes in drug concentrations led to confusion and dosing errors.

In one example, a patient was prescribed hydroxyurea, an antineoplastic agent. The community pharmacy compounded a 50 mg/mL suspension for the patient with instructions to take 13 mL (650 mg) for each dose. When the patient was later admitted to the hospital, the inpatient pharmacy prepared their standard concentration of 100 mg/mL, but the same dose volume of 13 mL was ordered. As a result, the patient received doses of 1,300 mg for several days before the error was recognized. It is unclear why the community pharmacy prepared a 50 mg/mL concentration. Perhaps the prescriber ordered that concentration or that was the concentration with which the pharmacist was most familiar.

Similar concentration mix-ups have been reported in literature. In one case, the oral class 1c antiarrhythmic medication flecainide was involved. The parents of a nine-month-old infant were told to increase the child's dose volume of flecainide to 4 mL, assuming the concentration was 5 mg/mL as in the original prescription.[1] However, the parents refilled the prescription at a different pharmacy and received the drug in a 20 mg/mL concentration. The patient received 80 mg/4 mL, a fourfold overdose, resulting in wide complex tachycardia and QRS prolongation.

There have been efforts, including those by a collaborative led by the University of Michigan[2]and the American Society of Health-System Pharmacists (ASHP)[3], to publish lists of consensuses and literature-based standard concentrations. In fact, for the medications involved in the cases above, both the University of Michigan and ASHP standard recommendations are in alignment – hydroxyurea 100 mg/mL and flecainide 20 mg/mL. However, the outreach and communication of these standardization efforts do not appear to be reaching prescribers and pharmacists. Both inpatient and outpatient practitioners need to get on the same set of standard concentrations for compounded oral liquids. It is imperative that both medical and pharmacy professional organizations develop and implement effective strategies to reach and influence practitioners to use the published standard concentrations. ISMP urges prescribers and pharmacists to review the University of Michigan and

ASHP lists and consider adopting the proposed standard concentrations. Your efforts can help reduce the risk of medication errors.

It is also important for pharmacists to provide patients or caregivers with appropriately sized metric-only dosing devices (eg, oral syringes) to measure and administer doses. Label directions for patients and caregivers should include the dose in terms of mL (not teaspoonfuls), matching the dosing device. The community pharmacy label should also include the concentration next to the drug name. To be sure patients or caregivers are able to use the dosing device and measure the proper dose, use the teach-back method to demonstrate how to measure and administer prescribed amounts. This also gives pharmacists, patients, and caregivers an opportunity to catch an error.

References

1. Wang GS, Tham E, Maes J, et al. Flecainide toxicity in a pediatric patient due to differences in pharmacy compounding. Int J Cardiol. 2012;161(3):178-9.
2. *www.mipedscompounds.org/*
3. *www.ashp.org/-/media/assets/pharmacy-practice/s4s/docs/Compound-Oral-Liquid.ashx*

Opioid Use Disorder Educational Programs, Resources Available for Pharmacists

Through its Opioid Use Disorder (OUD) Education Program, the College of Psychiatric and Neurologic Pharmacists (CPNP) provides educational programs and resources that can help pharmacists during the ongoing opioid epidemic. These educational opportunities include Accreditation Council for Pharmacy Education-approved, on-demand programs covering subjects such as pharmacotherapy for OUD, comorbid disorders, and chronic pain and OUD. Toolkits and guides are available to assist pharmacists in the areas of intervention, medication management, and naloxone access.

These educational materials and resources can be accessed through the CPNP website.

National Diabetes Prevention Program – How Pharmacists Can Get Involved

Pharmacists can play a key role in preventing type 2 diabetes by helping to expand the reach of the National Diabetes Prevention Program (National DPP) – a program led by the Centers for Disease Control and Prevention (CDC) that makes it easier for patients with prediabetes or who are at risk for type 2 diabetes to participate in evidence-based lifestyle changing programs to reduce their risk and improve overall health. CDC offers an action guide for community pharmacists that outlines ways pharmacies can raise awareness of prediabetes. The National DPP is a partnership among private and public organizations to screen and test for prediabetes and refer people with prediabetes to a CDC-recognized lifestyle change program participating in the National DPP, and deliver the National DPP lifestyle change program. More information about how pharmacists can participate is available on the CDC website.

Surgery Patients Receive More Opioids in the US Than in Other Countries

Patients in the US are prescribed a disproportionally higher number of opioids after surgeries compared to surgery patients in other countries, according to a new study. The study, published in the *Journal of the American College of Surgeons,* reviewed data from 2,024 surgery patients and found that 83% of US patients without pain were prescribed opioids, compared with 8.7% of non-US patients without pain. The authors concluded that US patients are prescribed more amounts of opioids at higher rates regardless of the severeness of their post-surgical pain. The authors recommend that more efforts are made toward ensuring that opioid prescriptions are tailored to patients' needs.

The full text of the study can be accessed by visting *www.journalacs.org/article/S1072-7515(20)32336-X/fulltext.*

Study Finds 94% Drop in Symptomatic COVID-19 Cases With Pfizer's Vaccine

A study by Israel's largest health care provider, health maintenance organization Clalit, reported that there is a 94% drop in symptomatic COVID-19 cases with the Pfizer vaccine. The study represents 600,000 people who received two doses of the Pfizer COVID-19 vaccine in Israel. Clalit, which covers more than half of all Israelis, noted the same group who received the COVID-19 vaccine doses was also 92% less likely to develop serious illness from the virus. The study compared the vaccine recipient group to another group of the same size and medical history who had not received the vaccines. Read the full study here.

NABP Executive Director/Secretary Addresses Pharmacists' Involvement in COVID-19 Vaccination During FIP Webinar

NABP Executive Director/Secretary Lemrey "Al" Carter, PharmD, MS, RPh, presented during the International Pharmaceutical Federation's (FIP's) Regulators' Forum on pharmacists' involvement with COVID-19 vaccination on February 4, 2021. The webinar addressed a new regulatory vaccination preparedness self-assessment tool and risk assessment, the expanded roles for pharmacists, and data FIP has collected on vaccinations by pharmacists. View the webinar here.

House Bill 47 – Elizabeth Whitefield End-of-Life Options Act

Effective June 18, 2021, a health care provider (doctor of medicine, doctor of osteopathic medicine, advanced practice nurse, or physician assistant) may provide a prescription for medical aid in dying to a terminally ill adult who is mentally competent after meeting certain requirements. A prescription for medical aid in dying cannot be filled until 48 hours after the prescription is written unless the prescribing health care provider medically confirms that the individual may die before the expiration of the aforementioned time period. The prescription must include the time and date written as well as the time and date when it may be filled. Health care providers who object, for reasons of conscience, to participating in the provision of medical aid of dying are not required to do so and will not be subject to criminal liability, licensing sanctions, or professional disciplinary action. However, health care providers must inform the individual of their decision and refer them to a provider who is able and willing to carry out the individual's request, or to another individual or entity to assist the requesting individual in seeking medical aid in dying. The full text of the bill is available at *https://nmlegis.gov.*

Disciplinary Actions

Rick Wilson – CS00217124. Voluntary Surrender. During the January 2021 meeting, the Board accepted the surrender of respondent's CS registration.

Robert Cone – CS00213789. Voluntary Surrender. During the February 2021 meeting, the Board ordered that surrender will become effective 30 days after signature. In that time, respondent will:

- begin tapering of opioid doses as appropriate;
- not increase dosage of CS for any patient;
- not initiate or issue any prescriptions for a CS that a patient has not been taking on a chronic or current basis (except to lower a dose);
- not prescribe more than a 60-day supply of any CS; and
- not replace any supply of CS (lost, stolen, etc).
- Respondent must pay investigative costs of $450.

Meds in Motion – license pending. Settlement Agreement. During the April 2021 Board meeting, the respondent was ordered to obtain and maintain proper licensure to deliver prescriptions into New Mexico. Respondent must comply with all laws and regulations in New Mexico governing the operation of a pharmacy and must pay fines plus the cost of investigation in the amount of $2,100.

Phillip Yamauchi – RP00008137. Settlement Agreement. During the April 2021 Board meeting, the respondent agreed to complete a Monitored Treatment Program (MTP) contract. Respondent may not act as a PIC, preceptor, or worksite monitor until completion of the first year of MTP contract. Lastly, respondent agreed to pay the cost of investigation in the amount of $275.

2021 Law Update Schedule

- Upcoming Albuquerque, NM Pharmacy Law Lecture Dates:
  - June 4, 2021
  - July 9, 2021
  - August 6, 2021
  - September 10, 2021
  - October 1, 2021
  - November 5, 2021
  - December 3, 2021
- Upcoming Pharmacy Law Lecture Dates (Outside of Albuquerque):
  - **June 22, 2021**
    Toney Anaya Building
    Rio Grande Room
    Santa Fe, NM
  - **August 31, 2021**
    Eastern New Mexico University
    Roswell Occupational Technology Center
    Room 20
    Roswell, NM
  - **September 14, 2021**
    Blackwater Coffee Co
    Clovis, NM
  - **September 28, 2021**
    Holy Cross Hospital
    Taos, NM
  - **October 26, 2021**
    Alta Vista Regional Hospital
    Las Vegas, NM
  - **November 16, 2021**
    Lea Regional Medical Center
    Hobbs, NM
  - **November 29, 2021**
    MountainView Regional Medical Center
    Las Cruces, NM
  - **November 30, 2021**
    Memorial Medical Center
    Las Cruces

Because of COVID-19 restrictions, some of the law update reviews may be held as webinars. The most up-to-date information on review format and the full list of law updates can be found on the Board website.

Reminder

Be sure to submit Adverse Drug Event reports to the Board within 15 days of discovery. This is required by regulation and could potentially result in disciplinary action if not compliant. This report must include an appropriate root cause analysis with recommendation(s) for improvement.

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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