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# NEW MEXICO BOARD OF PHARMACY

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*newsletter to promote pharmacy and drug law compliance*

## **Significant Adverse Drug Events**

1. A 14-year-old female patient was prescribed Augmentin®/clindamycin/lansoprazole via electronic prescription for the treatment of *Helicobacter pylori* bacteria. According to the pharmacist, the prescription was filled as amoxicillin/clav because the electronic prescription was misread from Augmentin/clin; lansoprazole was cut off from the rest of the drug name and present on the line below. According to the pharmacist, this occurred on a busy day when the pharmacy was short-staffed. The patient did not report side effects as a result of taking the medication; however, the prescriber had to be contacted for the correct medication. The pharmacist attributes the error to the electronic prescription format and overworked staff. As a result of the error, the pharmacist has retrained staff on the importance of double-checking prescription entries.
2. A 76-year-old male patient with HIV and chronic kidney disease was prescribed alfuzosin 10 mg extended-release tablets. During the drug utilization review (DUR), the pharmacist performing the final check reportedly missed an interaction due to what the pharmacist-in-charge (PIC) described as “warning fatigue.” Six days after receiving the medication from the pharmacy, the patient was admitted to the emergency room due to a syncopal episode where he split his lip. The pharmacist indicated that he contacted the pharmacy software vendor to change how DUR alerts are viewed, addressed, and documented. The pharmacist also had staff retrained on how DUR alerts are reviewed and overridden.
3. A 66-year-old male patient with low testosterone was given testosterone 1% 25 mg packets instead of his refill for testosterone 1% 50 mg packets. After taking the incorrect dose for approximately one month, the patient reported symptoms of low testosterone and vitality issues. The pharmacist attributed the error to verification of the concentration but not the package size. As a result of the error, the pharmacist provided in-service training on testosterone concentrations and package sizes.

4. A 48-year-old female patient received oxycodone and amlodipine intended for another patient with the same last name. After taking one dose of each incorrect medication, the patient did not report any adverse effects, but did not return the incorrect medications. According to the pharmacist, the technician believed the prescriptions to be for the patient's husband and did not verify both dates of birth per protocol. As a result of the dispensing error, the pharmacist retrained staff on company standard operating procedures for releasing prescriptions to patients.
  
5. A 55-year-old female patient was prescribed dacarbazine 720 mg IV for treatment of Hodgkin's lymphoma; however, the compounding clinic administered cisplatin 43 mg IV. Approximately half of the 500 mL bag was administered before the error was caught. Upon evaluation, no physical harm or lab abnormalities were identified as a result of administering the incorrect medication. The pharmacist attributes the error to manipulating multiple hazardous drugs simultaneously and consequently mixing up the labels. As a result of the error, the pharmacist required reeducation of staff and a brainstorming session on how to reduce compounding haste. The pharmacist also expressed an intention to investigate technological advancements that may help ensure safer chemotherapy preparation.

**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.

### ***Fifty-Year Pharmacists***

The following is the current list of pharmacists who have been licensed by the state of New Mexico for at least 50 years and who also maintain an active license. The Board thanks you for your service and dedication to the profession of pharmacy and the citizens of New Mexico.

This year there are five newcomers to this distinguished list. They are Martin Koslin, Delbert W. Lopez, Albert M. Lucero, Paul McSherry, and John Stroh. Thank you for all you do.

- Nick H. Brown
- Grace Colvin
- George E. Downs
- Robert Ghattas
- Richard Gomez
- Richard A. Haverland
- Dale L. Kemper
- Jack F. Lerner
- Delbert W. Lopez
- Allan Ludwick
- Paul McSherry
- Larry D. Quintana
- Wilfred O. Chavez
- Drexel Douglas
- Arturo Figueroa
- Ronald Jack Glenn
- Edwin Gonzales
- Lowell M. Irby
- Martin Koslin
- William J. Long
- Albert M. Lucero
- Lewis Dale McCleskey
- Daniel M. Pearce
- John Stroh

## ***HIV Post-Exposure Prophylaxis and Point-of-Care Testing***

During the April 2021 Board meeting, pharmacist prescriptive authority for the prescribing of HIV post-exposure prophylaxis therapy in conjunction with point-of-care testing was approved by the Board. Pharmacists who wish to obtain this prescriptive authority must go through Board-approved training and adhere to the Board-approved protocol. Portions of this training that are in addition to the required Accreditation Council for Pharmacy Education-accredited training for prescriptive authority are approved as acceptable toward the 30-hour continuing pharmacy education requirement outlined in 16.19.4.10 New Mexico Administrative Code (NMAC).

## ***Regulation Updates***

- **16.19.4 NMAC – Written recommendation for medical cannabis.** The restriction on a pharmacist clinician writing a recommendation for the use of medical cannabis was removed from regulation.
- **16.19.20 NMAC – Changes to the scheduling status of certain substances.** The following were added to the list of Schedule I substances: isotonitazene, crotonyl fentanyl, and valeryl fentanyl. Remimazolam was added to the list of Schedule IV substances, and cenobamate was added to the list of Schedule V substances. Marijuana, tetrahydrocannabinols, and hashish were descheduled and removed from the list of hallucinogenic substances.
- **16.19.30 NMAC – Changes to the compounding of nonsterile pharmaceuticals.** Added a provision whereby a PIC must ensure availability of current reference source for the type of compounding conducted. Also, removed the restriction on compounded controlled substance (CS) veterinary preparations for in-office use. Lastly, added conditions for distribution by a pharmacy of compounded CS veterinary preparations for in-office use.
- **16.19.31 NMAC – Emergency Provisions.** Added a section outlining Board authority to authorize extensions for unavailable training or testing during a declared emergency. This includes pharmacist license under reciprocity, technician registration, or pharmacist prescriptive authority.

Additional information related to regulation updates can be found by visiting the Board's [website](#).

## ***Disciplinary Actions***

**Joe's Pharmacy – PH0002411.** Settlement agreement. During the May 2021 Board meeting, the respondent agreed to the following:

- Immediately cease procurement of all dangerous drugs
- Inventory and provide report of all dangerous drugs to the Board

- Complete proper disposition of all drugs within 30 days
- Provide two-year audit of all dangerous drugs within 45 days
- Surrender of pharmacy license within 60 days
- Provide an audit of all dangerous drugs for the time period between acceptance of the order and surrender of the pharmacy license

**Shirley Jojola – RP00004528.** Settlement agreement. During the May 2021 Board meeting, the respondent agreed to transfer PIC duties to another pharmacist. Respondent agreed to never again act as a PIC or consultant pharmacist in the state of New Mexico. Respondent agreed to a probationary period of five years. Lastly, respondent agreed not to own or operate a facility requiring licensure by the Board and will never again apply to do so.

**Michael Leon Otero – PT00000059.** Settlement agreement. During the May 2021 Board meeting, the respondent agreed to surrender his Board-issued licenses after completing an audit of his pharmacy. Respondent also agreed not to own a facility requiring licensure by the Board and will never again apply to do so. Lastly, the respondent agreed not to participate in any activity requiring licensure by the Board and will never again apply to do so.

More information on disciplinary actions can be found on the Board's [website](#).

## **2021 Law Update Schedule**

### ***Upcoming Albuquerque Pharmacy Law Lecture Dates:***

- September 10, 2021
- October 1, 2021
- November 5, 2021
- December 3, 2021

### ***Upcoming Pharmacy Law Lecture Dates (Outside of Albuquerque):***

- **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 coronavirus disease 2019 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](#).

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