SEPTEMBER 2025

NEW MEXICO BOARD OF PHARMACY

Newsletter to Promote Pharmacy and Drug Law Compliance.

Significant Adverse Drug Events

1) A 63-year-old patient received an incorrect dose of oxycodone, receiving 5 mg instead of 10 mg immediate-release tablets. The prescription was processed correctly; however, the pharmacist incorrectly dispensed the 5 mg tablets. A nurse noticed the error three days later and reported the incident. The pharmacy was retrained on its process of having technicians circle and initial for controlled substance (CS) prescriptions and circle the National Drug Codes before documenting. The pharmacists were retrained on their barcode scanning procedure. The pharmacist on duty, who was not part of the regular staff and was filling in for a two-week period, reported rushing to check all prescriptions to meet the evening delivery time.
2) A gunshot-wounded patient in critical condition was transported by helicopter to a hospital. The flight nurse mistakenly administered a sub-therapeutic dose of epinephrine to the patient who had gone into cardiac arrest two minutes prior to their arrival. The nurse administered 20 mcg of epinephrine from an infusion bag instead of the full cardiac arrest dose of 100 mcg. The nurse attributed the mistake to having task saturation and a lack of mental focus due to the stress of the situation. Per their policy and procedure, a dosing app was to be used to estimate the patient's dose of epinephrine, and staff was retrained accordingly.
3) A four-year-old patient was prescribed compounded omeprazole, 5 mg per day, for reflux. Due to difficulties with

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Significant Adverse Drug Events *(cont)*

the electronic prescribing system, the prescription was sent in for 40 mg capsules with instructions for the medication to be compounded. The instructions were written to take 5 mg/1 mL; however, the prescription label instructed to take 8 mL daily instead of 1 mL, resulting in a dosage of 40 mg. The child was administered the greater dose for nine days. Per the pharmacy, the data entry was incorrect. When the parents came to pick up the compounded medication, a second pharmacist did not double-check the prescription and assumed that the first pharmacist had just missed checking the verification box in their system. The parents of the patient reported that their child experienced worse reflux with the greater dose. However, the Poison Control Center stated that the worsening reflux was not due to the increased dose. The pharmacy staff was retrained to verify the entire prescription in their system and to initiate compounding prescriptions with accurate calculations.

4) An 18-year-old patient was prescribed phenytoin for seizures, taking one 300 mg capsule by mouth every evening. The pharmacy incorrectly dispensed phenytoin 100 mg capsules, with instructions to take one capsule by mouth nightly. The pharmacy had made adaptations to his prescription in the past, matching the daily dose with the lesser strength phenytoin and changing the instructions to have the patient take more capsules. The patient reported having two seizures while on the lower dosage and went to the emergency room after his last seizure. Pharmacy staff reported distractions. The pharmacist was feeling ill at the time and did not properly review the prescription. The normal process was to notify the provider if there was a dose or dosage form change. Pharmacy staff was retrained.

5) A chihuahua was prescribed levetiracetam solution 100 mg/mL to take 0.5 mL by mouth three times daily. The pharmacy dispensed the correct strength but gave incorrect directions to take 5 mL by mouth three times per day. According to the owner, after giving the pet two doses of the medication, it experienced lethargy, vomiting, and was not eating. Per the pharmacy, the leading zero was not written in the instructions, and the prescription was handwritten using light ink. The pharmacy reviewed its process and will now double-check all veterinary prescriptions, verifying the patient's weight, the medication, and the directions. The pharmacists will now refer to the *Merck Veterinary Manual* to ensure correct dosing. The technicians were retrained to minimize distractions and interruptions, thereby improving patient safety. The pharmacy staff was also retrained to enlarge prescription images during the data entry and verification processes.

6) A 31-year-old male patient was hospitalized after a possible dispensing error. The patient was prescribed lamotrigine 200 mg tablets and to take two tablets by mouth daily. The patient reported taking a pink tablet with the inscription "U74," matching the description of quetiapine 50 mg extended-release tablets. Per the patient, he was hospitalized after taking the pink tablet and reported feeling "weird." The pharmacy reviewed its cameras during the production of the lamotrigine prescription but did not notice any discrepancies. The technician utilized a new stock bottle, and their on-hand count for the quetiapine matched what they had on the shelf. The pharmacy asked the patient to come back to check his medication, but he never returned to the pharmacy. The pharmacy staff was able to contact the patient by phone, and when asked if he still had the tablets, he responded that he had multiple pink pills. In response to the incident, the pharmacy reviewed its production practices, including reducing clutter around the workstation, focusing on only one task at a time, and ensuring the proper storage and dispensing of medications.

Disclaimer: These suggestions are made by the pharmacist submitting the Significant Adverse Drug Event report. The publication of recommendations is not an indication of endorsement by the New Mexico Board of Pharmacy.

New Mexicans Can Compare Prescription Costs Online

New Mexicans can now use the All-Payer Claims Database (APCD) public portal to compare costs on prescriptions statewide. The portal went live in August 2024 and was developed to expand health care pricing transparency in compliance with the Health Information Systems Act and the APCD rule. The portal will allow New Mexican patients to compare health care prices and access information on health care quality, aiding them in making informed choices regarding their care. As of June 2025, the portal also includes prescription costs.

"New Mexicans can use the public portal to see the average costs for doctor visits, medical procedures and prescriptions," said Ervin Garcia, Health Systems Epidemiology Program Manager for the New Mexico Department of Health (NMDOH), in *nmhealth.org*. "The portal is now available in Spanish, increasing access to this valuable service." About 900 people have accessed the portal in the last three months, Garcia said. To access the portal, visit New Mexico APCD.

See the article, "New Mexicans Can Compare Prescription Costs Online," for more information.

2025 Legislative Update

Continuing education (CE) audits may now be completed by Board staff, and the mandatory fine for deficient CE completion has been removed. The changes in New Mexico Administrative Code (NMAC) 16.19.4.10 will increase audit efficiency and allow licensees the opportunity to meet CE requirements identified as deficient by audits, outside of the disciplinary process.

Custodial care facilities can now stock opioid antagonists (rather than naloxone specifically) and epinephrine auto-injectors. The updates to NMAC 16.19.4.11 will allow greater flexibility and availability of stock medication in custodial facilities.

For wholesale distributors, third-party logistics providers, and repackagers, the surety bond requirement in NMAC 16.19.8.9 was removed. The change aligns with statute, which specifies that the Board "may" require surety bonds (versus "shall").

Under NMAC 16.19.12.20, the pharmacist license reinstatement fee has increased from $25 to $100. The change aligns with statute.

In NMAC 16.19.30.7, for compounding nonsterile pharmaceuticals, the beyond-use dating methods used for compounded preparations apply to conventionally manufactured products to which flavoring is added.

Disciplinary Actions

The Board took the following actions during its July meeting:

Edwina Mondragon – pharmacy technician applicant, default denial.

Ian Schneider, PT00007743 – pharmacy technician, voluntary surrender.

Anthony Gurule – pharmacy technician applicant, default denial.

Don Hedges, CS00009802 – practitioner-CS registration, voluntary surrender.

Jessica Barrera, CS00232196 – practitioner-CS registration, voluntary surrender.

Arthur Lopez III* – authorized the requested restricted reinstatement of his pharmacist license.

2025 Pharmacy Law Update: Monthly Webinars, 2-4 PM

Please contact the Board at least a week prior to a Board-sponsored law update (via email at pharmacy.board@rld.nm.gov) to reserve your spot and register. Please include your name, pharmacist license number, the date and time of the session you wish to attend, and your contact information in the message. *Remember, the law update given by the Board, while presented at no charge, does not have an Accreditation Council for Pharmacy Education number and is not reported to CPE Monitor®. The Board law updates will be held by webinar.

Registration is open to licensees regardless of their area of residence. Throughout 2025, the Board will hold a law update on the first Friday of each month from 2-4 PM. If you wish to attend a pharmacy law update that is sponsored by the New Mexico Pharmacists Association (NMPhA) or the New Mexico Society of Health-System Pharmacists (NMSHP), please contact the organizations directly to reserve your spot. Please note that the dates and times for the NMPhA- or NMSHP-sponsored law updates vary.

The following 2025 law webinars are scheduled:

- October 3, 2025
  Registration closes on October 1.
- November 7, 2025
  Registration closes on November 5.
- December 5, 2025
  Registration closes on December 3.

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