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Louisiana Board of Pharmacy News

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Election of Officers (11-01-368)

During the November 9, 2010 Louisiana Board of Pharmacy meeting, the members conducted their annual election of officers, with the following results:

Carl W. Aron, from Monroe in District 5 – President

T. Morris Rabb, from Monroe in District 5 – First Vice President

Marty R. McKay, from Woodworth in District 8 – Second Vice President

Joseph L. Adams, from Mandeville in District 1 – Third Vice President

Lois R. Anderson, from Shreveport in District 4 – Secretary

Board Meeting Dates for Calendar Year 2011 (11-01-369)

The Board has set the following tentative meeting dates for calendar year 2011:

February 16-17	August 17-18
May 4-5	November 16-17

All meetings are planned to be held in the Board office in Baton Rouge, LA.

Pharmacies – Are You Obtaining Drugs from a Legitimate Distributor? (11-01-370)

The Louisiana Board of Wholesale Drug Distributors maintains a Web site at *www.lsbwdd.org;* you can verify the credentials of any distributor licensed to conduct business in this state. Further, if they are distributing controlled substances, you can verify their controlled dangerous substances license on the Board's Web site at *www.pharmacy.la.gov.* The Board encourages you to minimize your risk of counterfeit or diverted drugs. Make sure your distributor is licensed to conduct business in Louisiana.

Pharmacists and Pharmacy Technicians Needed for Disaster Team (11-01-371)

In 1981, then President Ronald Reagan created the Emergency Mobilization Preparedness Board, which later evolved into the National Disaster Medical System (NDMS). NDMS is composed of 75 local Disaster Medical Assistance Teams (DMATs); Louisiana is one of the most recent additions to the system. NDMS can be activated by a presidential declaration of a disaster, or by a request for major medical assistance from a state health officer. Once activated, DMATs (primarily funded by the United States Department of Health and Human Services) are deployed to stricken areas to establish acute care medical facilities. The team then receives, stabilizes, treats, and evacuates sick and injured patients to more definitive care facilities around the US.

The newly formed Louisiana 1 Disaster Medical Assistance Team (LA-1 DMAT) has an immediate need for pharmacists and pharmacy technicians to join the other medical providers, including physicians, nurses, physician assistants, nurse practitioners, respiratory therapists and technicians, paramedics, logistic personnel, etc. In particular, pharmacists with a hospital affiliation are desired. If you are interested in affiliating with the LA-1 DMAT, the Board encourages you to learn more by visiting its Web site at *www.la1dmat.com*. (This article is abstracted from materials furnished by the Office of Public Health Pharmacy Services Program in the Department of Health and Hospitals.)

Disciplinary Actions (11-01-372)

Although every effort is made to ensure this information is correct, you should contact the Board office at 225/925-6496 to verify the accuracy of any listing before making any decision based on this information.

During its August 12, 2010 formal administrative hearing, the Board took final action in the following matters:

Taddese Tewelde (PST.011262): License suspended for an indefinite period of time; and further, the acceptance of any future application for reinstatement conditioned upon certain terms, including (1) service of at least 10 years of active suspension, and (2) payment of all assessments, including a fine of $45,720 plus investigative and hearing costs.

Tewelde's Lafitte Drugs (PHY.001159): Permit suspended for five years with execution thereof stayed, then placed on probation for five years, subject to certain terms, including (1) no access to prescription department by owner, Taddese Tewelde, and (2) payment of all assessments, including a fine of $106,680 plus investigative and hearing costs.

Christina Morales (CPT.009112): Certificate revoked; and further, assessed a fine of $5,000 plus investigative and hearing costs.

Maurice Terrell Mitchell (PTC.014393): Registration revoked; and further, assessed a fine of $5,000 plus investigative and hearing costs.

During its November 9-10, 2010 meeting and hearing, the Board took final action in the following matters:

Hayley Elizabeth Nugent (PTC Applicant): Denied the application and refused to issue the registration.

Brett Joseph Bertrand (PST.016794): Accepted voluntary surrender, resulting in suspension of the license for an indefinite period of time, effective October 6, 2010.

Jennifer Elizabeth Koruna (PST.016255): Accepted voluntary surrender, resulting in suspension of the license for an indefinite period of time, effective November 4, 2010.

Barry Jude Fleet (PST.011407): Accepted voluntary surrender, resulting in suspension of the license for an indefinite period of time, effective November 5, 2010.

Continued on page 4

DEA Policy Statement on Role of Agents in Communicating CS Prescriptions

Drug Enforcement Administration (DEA) issued a statement of policy that clarifies the proper role of a duly authorized agent of a DEA-registered individual practitioner in communicating controlled substance (CS) prescription information to a pharmacy. The statement, published October 6, 2010, in the *Federal Register,* reminds health care providers that a prescription for a CS medication must be issued by a DEA-registered practitioner acting in the usual course of professional practice. Such a practitioner may authorize an agent to "perform a limited role in communicating such prescriptions to a pharmacy in order to make the prescription process more efficient," and the guidance emphasizes that medical determinations to prescribe CS medications may be made by the practitioner only.

The specific circumstances in which an agent may assist in communicating prescription information to a pharmacy are detailed and include:

- An authorized agent may prepare the prescription, based on the instructions of the prescribing practitioner, for the signature of that DEA-registered practitioner.
- For a Schedule III-V drug, an authorized agent may transmit a practitioner-signed prescription to a pharmacy via facsimile, or may communicate the prescription orally to a pharmacy on behalf of the practitioner.
- An authorized agent may transmit by facsimile a practitioner-signed Schedule II prescription for a patient in a hospice or long-term care facility (LTCF) on behalf of the practitioner.

The guidance also makes clear that generally, Schedule II prescriptions may not be transmitted by facsimile and that hospice and LTCFs are exceptions. Further, Schedule II prescriptions may only be communicated orally by the DEA-registered practitioner and only in emergency situations. DEA stresses that the practitioner should decide who may act as his or her authorized agent and advises that such designation be established in writing. An example written agreement is included in the policy statement, along with additional guidance related to designating an authorized agent. DEA also notes that as electronic prescribing for CS is implemented and its use increases, the role of the agent in communicating CS prescriptions will likely be reduced over time. The DEA policy statement is available on the *Federal Register* Web site at *www.federalregister.gov/articles/2010/10/06/2010-25136/role-of-authorized-agents-in-communicating-controlled-substance-prescriptions-to-pharmacies.*

FDA and NABP Partner to Help Prevent Acetaminophen Toxicity

In partnership with the National Association of Boards of Pharmacy® (NABP®), and as part of its Safe Use Initiative, Food and Drug Administration (FDA) encourages pharmacies to stop using the abbreviation APAP and to spell out the drug name, acetaminophen, in effort to help patients avoid acetaminophen toxicity. As explained in an FDA drug safety notice, liver injury due to acetaminophen overdose is a serious public health problem, and by spelling out the drug name on prescription labels, pharmacies are enabling patients to know when their medication contains the drug. Patients can then compare their prescription and over-the-counter medications to determine whether both contain acetaminophen and avoid taking two medicines containing the drug. The FDA drug safety notice provides more information and is available at *www.fda.gov/Drugs/DrugSafety/ucm230396.htm.*

In July 2010, NABP recommended that the state boards of pharmacy prohibit the use of the abbreviation APAP on prescription labels, and require that acetaminophen be spelled out. In situations where the board is unable to mandate such a provision, NABP recommended that the boards strongly encourage practitioners to follow this guideline. More information is available on the NABP Web site at *www.nabp.net/news/nabp-recommends-boards-of-pharmacy-prohibit-use-of-acetaminophen-abbreviation/.*

The ISMP Ambulatory Care Action Agenda: Learn from Others' Mistakes

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency 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 is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also a FDA MedWatch partner. Call 1-800-FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at* www.ismp.org. *ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.*

No news is **not** good news when it comes to patient safety. Each organization needs to accurately assess how susceptible its systems are to the errors that have happened in other organizations, and acknowledge that the absence of similar errors is not evidence of safety. Personal experience is a powerful teacher, but the price is too high to learn all we need to know from firsthand experiences. Learning from the mistakes of others is imperative.

A great way to utilize the ISMP Medication Safety Alert!® Community/Ambulatory Care Edition is by using the Ambulatory Care Action Agenda*. Three times a year, selected items are prepared for you and your staff to stimulate discussion and collaborative action to reduce the risk of medication errors previously reported to the ISMP Medication Errors Reporting Program (MERP). The agenda topics appeared in the ISMP Medication Safety Alert! Community/Ambulatory Care Edition during the preceding four

months. Each item includes a brief description of the medication safety problem, recommendations to reduce the risk of errors, and the issue number to locate additional information as desired.

The Action Agenda is presented in a format that allows community practice sites to document their medication safety activities, which is important for internal quality improvement efforts but also important for any external accrediting or regulatory organizations. Each pharmacy practice site should convene a staff meeting to discuss each item in the Action Agenda. The staff should ask themselves, "Can this error occur at our site?" If the answer is "yes," the ISMP recommendations for prevention should be reviewed for applicability at that specific site. If the recommendations are germane to the practice site, the columns on the Action Agenda indicating "Organization Assessment" and "Action required/Assignment" should be completed and a reasonable time set for completion. The staff should reconvene in three months time to determine if the proposed recommendation strategies have been implemented, if they are still pertinent, and if other strategies have been offered or considered since the initial meeting.

According to the 2011 *Survey of Pharmacy Law,* published by NABP, at least 19 states regulate, require, or recommend a continuous quality improvement (CQI) program to monitor and prevent quality related events. The purpose of the CQI program is to detect, document, and assess prescription errors in order to determine the cause, develop an appropriate response, and prevent future errors. Utilization of the Action Agenda to review externally reported errors combined with review and analysis of internally reported events constitutes a feasible and effective CQI program.

*The Action Agenda is available at no charge on the ISMP Web site, *www.ismp.org/Tools/communitySafetyProgram.asp.*

Iowa Tracks Group Using Fraudulent CS Prescriptions

The Iowa Department of Public Safety seeks assistance in tracking a group of individuals using fraudulent prescriptions to obtain CS. Specifically, four unidentified individuals have obtained oxycodone using fraudulent prescriptions at a number of pharmacies in Iowa. Similar cases have occurred in Missouri, and it is believed that the same group of people is involved. The subjects are reported to have used multiple aliases, to be in their 20s or 30s, and to have paid in cash. They have also been reported to use crutches when dropping off and picking up prescriptions. The fraudulent prescriptions were on legitimate prescription paper with valid prescriber names, but the addresses on them had been computer generated. Similar cases or relevant information can be reported to Criminal Intelligence Analyst Crystal Munson at the Mid-Iowa Narcotics Enforcement Task Force by calling 515/270-8233, extension 119, or by e-mailing crystal.munson@polkcountyiowa.gov.

Stolen Carbatrol, Adderall XR Surfacing in Supply Chain

Shire, along with FDA, alerts pharmacists and distributors that certain lots of Carbatrol® that were stolen on October 17, 2008, have been found in the supply chain as expired returns. The stolen shipment also contained Adderall XR®. The manufacturer warns that more stolen product may still be on the market and that stolen Carbatrol and Adderall XR should not be used or sold because the safety and effectiveness of the product could have been compromised by improper storage and handling or tampering while outside of the legitimate supply chain. The following products and lot numbers are affected:

- Adderall XR 15 mg, Lot No: A38146A, Expiration Date: 02/29/2012
- Carbatrol 200 mg, Lot No: A40918A, Expiration Date: 04/30/2010
- Carbatrol 200 mg, Lot No: A40919A, Expiration Date: 04/30/2010
- Carbatrol 200 mg, Lot No: A41575A, Expiration Date: 05/31/2010

These lots of Carbatrol and Adderall XR were stolen while in transit from Shire's manufacturing facility in North Carolina to Shire Distribution Center in Kentucky. FDA seeks assistance and asks that any information regarding the stolen Carbatrol or Adderall XR, including suspicious or unsolicited offers for these products, be reported by contacting FDA's Office of Criminal Investigations (OCI) at 800/551-3989, or by visiting the OCI Web site at *www.accessdata.fda.gov/scripts/email/oc/oci/contact.cfm.*

Survey of Pharmacy Law's 60th Edition Now Available!

Celebrating its 60th edition as a convenient reference source for individuals seeking an overview of the state laws and regulations that govern pharmacy practice, the updated 2011 *Survey of Pharmacy Law* is now available.

The *Survey,* produced in a CD format, consists of four sections including a state-by-state overview of organizational law, licensing law, drug law, and census data. Newly added this year, a question in Section 18, Drug Control Regulations, asks whether or not states have CS or drugs of concern scheduled differently than the federal Controlled Substances Act.

Updates for the 2011 *Survey* were graciously provided by the state boards of pharmacy. In addition to the boards' support, NABP requested data from relevant health care associations for the *Survey's* prescribing authority and dispensing authority laws in Sections 24 and 25, and laws pertaining to the possession of non-controlled legend drugs and possession of CS in Sections 26 and 27.

The *Survey* can be purchased online for $195 by visiting the Publications section of the NABP Web site at *www.nabp.net/publications.*

All final-year pharmacy students receive the *Survey* free of charge through the generous grant of Purdue Pharma L.P.

For more information on the *Survey,* please contact Customer Service via phone at 847/391-4406 or via e-mail at custserv@nabp.net.

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Angela Waldron Allums (PST.014219): Granted request for reinstatement of the previously suspended license, suspended it for one year with execution thereof stayed, and then placed the license on probation for one year, effective November 9, 2010, subject to certain terms as enumerated in the consent agreement for improper return of previously dispensed prescription to pharmacy's dispensing stock.

Kimiko Tiesha Austin (CPT.005676): Denied request for reinstatement of previously suspended certificate.

Rashida Carter (PST.017283): Suspended the license for one year and stayed the execution thereof, and then placed license on probation for one year, effective October 1, 2010, subject to certain terms as enumerated in the consent agreement; and further, assessed a fine of $3,500 plus investigative and hearing costs for 11 counts, including dispensing over 300 forged prescriptions for controlled substances at Health First Pharmacy.

Lyndria Monnette Page (CPT.007882): Suspended the certificate for five years and stayed the execution thereof, and then placed certificate on probation for five years, effective October 1, 2010, subject to certain terms as enumerated in the consent agreement for violation of terms of previous non-disciplinary monitoring agreement.

Jose Gonzalo Zavaleta (CDS.026408-MD): Accepted voluntary surrender, resulting in suspension of the license for an indefinite period of time, effective September 2, 2010.

Jimmy Martin Taylor II (PST.014644): Granted request for reinstatement of previously suspended license, suspended it for five years and stayed the execution thereof, and then placed the license on probation for five years, effective October 1, 2010, subject to certain terms as enumerated in the consent agreement; and further, assessed a fine of $2,500 plus investigative and hearing costs for six counts, including forgery and dispensing of prescription for controlled substances.

Michael James Adkins (PST.014603): Suspended the license for five years and stayed the execution thereof, and then placed license on probation for five years, effective October 1, 2010, subject to certain terms as enumerated in the consent agreement; and further, assessed a fine of $5,000 plus investigative and hearing costs for 10 counts, including filling and refilling prescriptions without prescriber authorization, and failure to notify Board of prior arrest.

Dustin Cale Smith (CPT.009425): Revoked the certificate; and further, prohibited any future application for reinstatement of the certificate; for five counts, including alleged diversion of controlled substances from employer pharmacy, Walgreen Pharmacy No. 10537.

Ron Christopher Clark (CPT.005033): Revoked the certificate; and further, prohibited any future application for reinstatement of the certificate for five counts, including alleged diversion of controlled substances from employer pharmacy, Baton Rouge General Hospital Pharmacy.

Allison Ann Walters (CPT.002625): Revoked the certificate; and further, prohibited any future application for reinstatement of the certificate for alleged diversion of controlled substances from employer pharmacy, CVS Pharmacy No. 5511.

Darren Wayne Davis (PST.014653): Issued a letter of reprimand; and further, assessed a fine of $500 plus hearing costs for six counts, including unlawful access to prescription monitoring program information and unlawful use of information gained through such access.

At the same meeting in November, the Board also issued letters of reprimand to three pharmacists, one pharmacy, and two pharmacy technician candidates; and further, levied assessments against four pharmacy permits and one pharmacist; and finally, granted conditional reinstatement orders for previously lapsed credentials for one pharmacy and four pharmacy technicians.

Calendar Notes (11-01-373)

The next Board meeting and administrative hearing will be February 16-17, 2011, at the Board office. The office will be closed January 17 in observance of Martin Luther King, Jr, Day and March 8 in observance of Mardi Gras Day.

Special Note (11-01-374)

The *Louisiana Board of Pharmacy Newsletter* is considered an official method of notification to pharmacies, pharmacists, pharmacy interns, pharmacy technicians, and pharmacy technician candidates credentialed by the Board. **These *Newsletters* will be used in administrative hearings as proof of notification.** Please read them carefully. The Board encourages you to keep them in the back of the *Louisiana Pharmacy Law Book* for future reference.

Lagniappe (11-01-375)

"With respect to wit, I learned that there was not much difference between the half and the whole." Thoreau, "Visitors," *Walden,* 1854.

The *Louisiana Board of Pharmacy News* is published by the Louisiana Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, 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 the Foundation or the Board unless expressly so stated.

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