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Louisiana Board of Pharmacy

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Volunteer Pharmacists and Pharmacy Technicians: Your Community Needs You! (07-07-272)

Recent events, including Hurricanes Katrina and Rita, and the terrorist attacks of September 11, 2001, have increased the national attention given to public health emergency preparedness. These events underscored the need for an emergency "surge" or supplemental health care workforce that can be mobilized to respond immediately to mass casualty events. Louisiana's Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) provides a systematic process for statewide medical volunteer coordination.

ESAR-VHP establishes a pool of pre-credentialed, ready-to-deploy volunteer health professionals that could be utilized during emergencies. The ESAR-VHP Program is housed in the Center for Community Preparedness within the Louisiana Department of Health and Hospitals, Office of Public Health. Interested pharmacists and pharmacy technicians should contact Mardrah Starks at 225/763-3965 or mmstarks@dhh.la.gov to become a part of the state's volunteer database. Please sign up today! Your community and state need YOU!

This article was contributed by Debbie Mills, tri-regional pharmacist with the Office of Public Health in the Louisiana Department of Health and Hospitals.

Disciplinary Actions (07-07-273)

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

During its November 20, 2003 administrative hearing, the Board took final action in the following matters:

Chau-Mart Eastside Pharmacy (Pharmacy Permit No. 2963), Formal Hearing: Permit revoked; further, owner assessed $5,000 plus investigative, administrative, and hearing costs. Appeal exhausted. *Charges:* 37 counts, including failure to maintain adequate security of prescription department, accountability for shortages of controlled dangerous substances, dispensing controlled substances and other medications without prescriptions, and improper delegation of dispensing function to technicians.

David Keith Chauvin, Sr. (Pharmacist License No. 8584), Formal Hearing: License revoked; further, assessed $5,000 plus investigative, administrative, and hearing costs. Appeal exhausted. *Charges:* 39 counts, including accountability for shortages of controlled dangerous substances, dispensing controlled substances without prescriptions, dispensing of expired medication, and improper delegation of dispensing function to technicians at Chau-Mart Eastside Pharmacy.

During its March 7, 2007 administrative hearing, the Board took final action in the following matters:

Pharmacy 101, Ltd. (Pharmacy Permit No. 5358) re Complaint No. 06-0208, Formal Hearing: Permit suspended; further, owner assessed $5,000 plus investigative, administrative, and hearing costs. *Charges*: two counts, including failure to submit proper report or fee to Louisiana Medical Assistance Trust Fund.

Pharmacy 101, Ltd. (Pharmacy Permit No. 5358) re Complaint No. 06-0202, Formal Hearing: Permit revoked; further, owner assessed $5,000 plus investigative, administrative, and hearing costs. *Charges:* eight counts, including improper change of ownership.

Pharmacy 101, Ltd. (Pharmacy Permit No. 5358) re Complaint No. 06-0047, Formal Hearing: Permit revoked; further, owner assessed $258,572 plus investigative, administrative, and hearing costs. *Charges:* eight counts, including accountability for shortages of controlled dangerous substances.

Westmar Pharmacy (Pharmacy Permit No. 5174), Formal Hearing: Permit revoked; further, owner assessed $10,000 plus investigative, administrative, and

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FDA Issues Guidance on Glycerin Testing to Prevent DEG Poisoning

Spurred to action by repeated instances of diethylene glycol (DEG) poisoning, Food and Drug Administration (FDA) recently issued a guidance for industry entitled "Testing of Glycerin for Diethylene Glycol." This guidance provides recommendations on testing that will help pharmaceutical manufacturers, repackers, and other suppliers of glycerin, and pharmacists who engage in drug compounding, to avoid the use of glycerin that is contaminated with DEG and prevent incidents of DEG poisoning.

DEG contamination of glycerin can be detected by using specific analytical test procedures described in the United States Pharmacopeia monograph for glycerin, which quantifies the amount of DEG present at a detection level of 0.1%, as recommended by the interagency Diethylene Glycol Contamination Prevention Workshop of 1997. The guidance is available on the FDA Web site at *www.fda.gov/cder/guidance/7654fnl.htm.* FDA is accepting electronic comments on the guidance at *www.fda.gov/dockets/ecomments.*

Improperly Compounded Colchicine Blamed for Recent Deaths

Compounded colchicine that was 10 times as potent as labeled was responsible for two recent deaths in Oregon and Washington, the *Portland Tribune* reported on April 27, 2007. State officials are investigating the drug's role in a third death, also in Oregon. The drug was sent to a Portland, OR, clinic by ApothéCure, Inc, a Dallas, TX-based compounding pharmacy that distributes its drugs throughout the country. The two patients who died had received injections of colchicine as a treatment for back pain. Lab tests revealed that the colchicine administered in the two deaths had a potency of 4 mg/ml, rather than the 0.5 mg/ml stated on labels. According to Gary A. Schnabel, executive director of the Oregon State Board of Pharmacy, ApothéCure, a licensed Texas pharmacy, may be operating as a manufacturer. Both the Oregon Board and the Texas State Board of Pharmacy have opened investigations into the incident. The Texas Board advised ApothéCure to stop making colchicine; the company agreed, the *Portland Tribune* reported. On May 2, FDA announced the recall of all strengths, sizes, and lots of injectable colchicine compounded and sold by ApothéCure within the last year. The FDA MedWatch Safety summary on this issue is available at *www.fda.gov/medwatch/safety/2007/safety07.htm#Colchicine.*

New Podcasts Provide Emerging Drug Safety Information

FDA recently supplemented its print- and Web-based public health advisories with the launch of an audio broadcast service providing emerging drug safety information. The broadcasts, commonly known as podcasts, can be transmitted to personal computers and personal audio players. The service is part of FDA's ongoing effort to broaden and speed its communications on the safety of marketed medications when unexpected adverse events are reported to FDA. Since FDA launched the service in February 2007, broadcasts have addressed the potential hazards of local anesthetics used in hair removal; the voluntary market withdrawals of drugs to treat the symptoms of Parkinson's disease and irritable bowel syndrome; and serious adverse events associated with agents that reduce the need for blood transfusions in cancer patients. The broadcasts are available on the FDA Web site at *www.fda.gov/cder/drug/podcast/default.htm.*

Prevent Tragedies Caused by Syringe Tip Caps

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that works closely with United States Pharmacopeia (USP) and FDA in analyzing 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, then publishes its recommendations. If you would like to report a problem confidentially to these organizations, go to the ISMP Web site (www.ismp.org) for links with USP, ISMP, and FDA. Or call 1-800/23-ERROR to report directly to the USP-ISMP Medication Errors Reporting Program. ISMP address: 1800 Byberry Rd, Huntingdon Valley, PA 19006. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

Over the past several years, there have been a number of reports where children have swallowed or choked on hypodermic syringe caps that were overlooked by parents and left on the syringes administering the medication. In 2001, a 5-month-old child asphyxiated when a cap from a Becton Dickinson 3 ml hypodermic syringe ejected into his throat during medication administration. In this case, a pediatrician provided the parents with the hypodermic syringe (without the needle) to administer Vantin® (cefpodoxime) suspension. With the cap intact, the father inserted the syringe into the Vantin, pulled back the plunger, and the medication flowed into the syringe. To him, the cap appeared to be part of the syringe. When he placed the syringe containing the medication into the baby's mouth, the cap flew off and became lodged in his airway. The baby was taken to the hospital where a procedure was performed to remove the cap; however, he did not survive.

Despite these reports, the mother of a 9-month-old child recently notified the Institute for Safe Medication Practices about a near fatal experience involving her child. Her community pharmacist gave her a parenteral syringe (without the needle) to help her accurately measure and administer an oral rehydration liquid for her daughter. Unfortunately, the pharmacist's good intention resulted in patient harm. The mother was unaware that the syringe tip held a small, translucent cap; however, despite this, she was able to withdraw the oral liquid. Then as she administered the liquid, the cap on the end of the syringe ejected and became lodged in the child's throat, causing airway obstruction. Fortunately, the child recovered.

Although parenteral syringes are not designed for oral administration, health care practitioners may provide them to patients or caregivers to measure oral liquids without realizing how dangerous this practice may be. Some syringe

manufacturers place the small, translucent caps on parenteral syringes packaged without needles as a protective cover. However, practitioners may not realize the cap is there or may not inform patients or caregivers of the need for its removal prior to use. The danger arises due to the fact that the cap does not provide a good seal. Subsequently, medications can be drawn into many of these syringes without removing the caps. If not removed before administration, the force of pushing the plunger can eject the cap and cause it to lodge in a child's trachea.

Safe practice recommendations: Consider the following strategies to help protect your patients from tragedies caused by syringe tip caps.

- **Increase awareness.** Share this and previous errors with staff to illustrate why parenteral syringes should never be used for oral liquid medications. Show staff a video from FDA and ISMP highlighting this issue (access the video link at: *www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=3#6*).
- **Product availability.** Ensure that **oral** syringes (without caps) or other appropriate measuring devices are readily available for distribution or purchase at your practice site. Verify that the dosage can be accurately measured using the oral syringe. It may be necessary to keep a few different sizes on hand to ensure proper measurement of smaller doses.
- **Limit access.** If parenteral syringes must be stocked for use with injectable products, purchase syringes that are not packaged with the translucent caps to minimize the likelihood of this error.
- **Warning labels.** Add warning labels that state, "not for use with oral liquids" to boxes or storage bins containing parenteral syringes.
- **Educate patients and caregivers.** Provide education to patients and caregivers regarding proper use of an oral syringe (or other measuring device). Demonstrate how to measure and administer the dose and inform them about how to clean the device, if it is to be reused. Several years ago, Becton Dickinson voluntarily elected to package parenteral syringes without the small caps in response to this serious issue. However, since some manufacturers still include a cap on parenteral syringes, the danger of asphyxiation with the cap is still present. We have again contacted FDA to alert them about this problem. They have stated that they will be following up with each syringe manufacturer with the goal to get the syringe caps removed. At the very minimum, we believe that the packaging of parenteral syringes should be required to clearly state, "not for oral use" or "not for use with oral liquids."

New FDA Web Page Warns Against Buying Isotretinoin Online

FDA has launched a special Web page to warn consumers about the dangers of buying isotretinoin online. Improperly used, isotretinoin can cause severe side effects, including birth defects and serious mental health problems. The Web page, *www.fda.gov/buyonline/accutane*, is positioned as a search result on Internet search engines when consumers initiate an online search for the drug under any one of its four names (isotretinoin is sold under the brand name of Accutane® and in generic versions called Amnesteem™, Claravis™, and Sotret®). The Web page warns that the drug "should only be taken under the close supervision" of a physician and a pharmacist, and provides links to related information, including ways to check that drugs purchased online come from legitimate pharmacies.

To reduce risks, FDA and the manufacturers of isotretinoin have implemented a strict distribution program called iPLEDGE to ensure that women using isotretinoin do not become pregnant, and that women who are pregnant do not use isotretinoin. Isotretinoin is available only at pharmacies that are registered for this distribution program. Additionally, the distribution program is designed to prevent the sale of isotretinoin over the Internet. Dispensing must comply with the agency's risk management requirements.

Tampering Results in Misbranding of Ziagen as Combivir

GlaxoSmithKline and FDA warned health care professionals of an apparent third-party tampering that resulted in the misbranding of Ziagen® as Combivir® and employed counterfeit labels for Combivir tablets. Two 60-count misbranded bottles of Combivir tablets contained 300 mg tablets of Ziagen.

The counterfeit labels identified are Lot No. 6ZP9760 with expiration dates of April 2010 and April 2009. The incident appears to be isolated and limited in scope to one pharmacy in California.

Pharmacists are advised to immediately examine the contents of each bottle of Combivir in their pharmacies to confirm that the bottles contain the correct medication. If a bottle contains anything other than Combivir tablets, pharmacists are advised to notify the manufacturer.

The letter from GlaxoSmithKline and FDA, containing photos of actual Combivir and Ziagen tablets, is posted on the FDA Web site at *www.fda.gov/medwatch/safety/2007/Ziagen_Dear_RPh_03-29-2007.pdf*.

FDA Issues Halt on Manufacture, Distribution of Unapproved Suppository Drugs

FDA notified health care professionals and consumers that companies must stop manufacturing and distributing unapproved suppository drug products containing trimethobenzamide hydrochloride.

These products, used to treat nausea and vomiting in adults and children, have been marketed under various names, including Tigan®, Tebamide™, T-Gen, Trimazide, and Trimethobenz. Drugs containing trimethobenzamide in suppository form lack evidence of effectiveness. This action does not affect oral capsules and injectable products containing trimethobenzamide that have been approved by FDA.

FDA urges consumers currently using trimethobenzamide suppositories or who have questions or concerns to contact their health care professionals. Alternative products approved to effectively treat nausea and vomiting are available in a variety of forms.

The MedWatch safety summary and a link to the full press release are available at *www.fda.gov/medwatch/safety/2007/safety07.htm#trimethobenzamide*.

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hearing costs. *Charges:* 10 counts, including failure to maintain accurate prescription drug records, possession of misbranded drugs, and accountability for shortages of controlled dangerous substances.

Pier Anderson Jackson (Pharmacist License No. 14150), Voluntary Consent Agreement: License suspended for five years; execution stayed; placed on probation for five years; further, assessed investigative and administrative costs. *Charges:* seven counts, including failure to maintain accurate prescription drug records, possession of misbranded drugs, and accountability for shortages of controlled dangerous substances at Westmar Pharmacy.

Southern Discount Drugs (Pharmacy Permit No. 5144), Voluntary Consent Agreement: Permit revoked; further, owner assessed $3,000 plus investigative and administrative costs. *Charges:* 10 counts, including repeated dispensing of controlled dangerous substances pursuant to forged prescriptions and failure to maintain corresponding responsibility for dispensing of legitimate prescriptions.

Thadrian Marquis Johnson (Pharmacist License No. 13542), Voluntary Consent Agreement: License suspended for two years; execution stayed; placed on probation for two years; further, assessed $3,000 plus investigative and administrative costs. *Charges:* 12 counts, including repeated dispensing of controlled dangerous substances pursuant to forged prescriptions and failure to maintain corresponding responsibility for dispensing of legitimate prescriptions at Southern Discount Drugs.

River Road Discount Pharmacy (Pharmacy Permit No. 5573), Voluntary Consent Agreement: Permit revoked; further, reinstatement prohibited and owners barred from any future ownership of pharmacies in Louisiana. *Charges:* 19 counts, including unauthorized and unsecured access to prescription department, shortages of controlled dangerous substances, possession of misbranded drugs, and interference with authority of the pharmacist-in-charge.

Mary Grace Constantino Oden (Pharmacist License No. 10761), Voluntary Consent Agreement: License suspended for one year; execution stayed; placed on probation for one year; further, assessed $1,000 plus investigative and administrative costs. *Charges:* 11 counts, including failure to maintain proper prescription drug records, possession of misbranded drugs, and accountability for shortages of controlled dangerous substances at River Road Discount Pharmacy.

Advanced Healthcare Pharmacy (Pharmacy Permit No. 5301), Voluntary Consent Agreement: Permit revoked; further, owners barred from any future ownership of pharmacies in Louisiana; further, owners assessed $100,000 plus administrative costs. *Charges:* 48 counts, including dispensing prescriptions based solely on electronic questionnaires, advertising of controlled dangerous substances on pharmacy's Website, possession of misbranded drugs, failure to secure prescription department, improper access to patient prescription information outside prescription department, improper ratio of pharmacy technicians, and possession of prescription drugs, including controlled dangerous substances, at unlicensed site.

Jimmy Charles Hill (Pharmacist License No. 11155), Voluntary Consent Agreement: License suspended for 10 years; execution stayed for all but first 45 days, then placed on probation for remainder of 10-year period; further, assessed $22,000 plus investigative and administrative costs. *Charges:* 14 counts, including dispensing prescriptions based solely on electronic questionnaires, failure to perform drug utilization review, failure to maintain corresponding responsibility for dispensing legitimate prescriptions, and failure to maintain pharmacist-in-charge responsibilities at Advanced Healthcare Pharmacy.

Ginger Brewer Hebron (Pharmacist License No. 10621), Voluntary Consent Agreement: License suspended for two years; execution stayed; placed on probation for two years; further, assessed $1,200 plus investigative and administrative costs. *Charges:* 13 counts, including dispensing prescriptions based solely on electronic questionnaires, failure to maintain corresponding responsibility for dispensing legitimate prescriptions, and failure to maintain pharmacist-in-charge responsibilities at Advanced Healthcare Pharmacy.

James Robert Lang (Pharmacist License No. 10884), Voluntary Consent Agreement: License suspended for five years; execution stayed; placed on probation for five years; further, assessed $5,000 plus investigative and administrative costs. *Charges:* five counts, including distribution of samples.

John Bull Pharmacy (CDS License No. C-001609), Voluntary Surrender: Accepted voluntary surrender; license suspended for an indefinite period of time, effective February 1, 2007.

Avee Pharmacy (Pharmacy Permit No. 5647), Voluntary Surrender: Accepted voluntary surrender; permit suspended for an indefinite period of time, effective February 19, 2007.

Terry Lee Bonnie (Technician Certificate No. 3949), Voluntary Consent Agreement: Certificate revoked; further, reinstatement permanently barred. *Charges:* six counts, including theft of controlled dangerous substances from employer pharmacy.

Shelita LaGrange Mott (Technician Certificate No. 3349), Voluntary Consent Agreement: Certificate revoked; further, reinstatement permanently barred. *Charges:* nine counts, including unlawful possession of controlled dangerous substances in Schedules II, III, IV, and V.

Janice Marie Heard (Technician Certificate No. 1002), Voluntary Consent Agreement: Certificate revoked; further, reinstatement permanently barred.

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Charges: six counts, including theft of controlled dangerous substances from employer pharmacy.

Winter Faye Thelemann (Technician Certificate No. 6615), Voluntary Consent Agreement: Certificate revoked; further, reinstatement permanently barred. *Charges:* six counts, including improper refilling of controlled dangerous substance prescriptions at employer pharmacy.

Elizabeth Lynn O'Quin (Technician Certificate No. 7021), Voluntary Consent Agreement: Certificate revoked; further, reinstatement permanently barred. *Charges:* five counts, including theft of controlled dangerous substances from employer pharmacy.

James Brett Harrington (Technician Certificate No. 6660), Voluntary Consent Agreement: Certificate revoked; further, reinstatement permanently barred. *Charges:* seven counts, including unlawful possession of controlled dangerous substances in Schedules I and III.

Louis Oliver Lenfant, Jr. (Pharmacist License No. 10793), Voluntary Consent Agreement: License reinstated on probation for remainder of original 10-year suspension, terminating May 12, 2015.

On this same date, the Board also issued Letters of Warning to one pharmacist and two pharmacy permit holders, as well as Letters of Reprimand to one pharmacist and two pharmacy permit holders. With respect to the reinstatement of expired credentials, the Board granted requests from two pharmacists. With respect to impaired practitioners, the Board accepted the voluntary surrender of license from two pharmacists, granted requests for probated reinstatement from three pharmacists, and granted requests for probation modification from two pharmacists.

During its May 10, 2007 administrative hearing, the Board took final action in the following matters:

Kimberly Greer (Technician Certificate No. 3714), Voluntary Consent Agreement: Certificate revoked; further, reinstatement permanently barred. *Charges:* six counts, including possession of Schedule III controlled dangerous substance with intent to distribute.

Monroe Medical Clinic Pharmacy (Pharmacy Permit No. 4928), Voluntary Consent Agreement: Permit suspended for one year; execution stayed; placed on probation for one year; further, assessed $3,500 plus investigative and administrative costs. *Charges:* nine counts, including dispensing prescriptions based solely on electronic questionnaires.

Candy Melissa Jones (Pharmacist License No. 15546), Voluntary Consent Agreement: License suspended for one year; execution stayed; placed on probation for one year; further, assessed $1,000 plus administrative costs. *Charges:* 10 counts, including dispensing prescriptions based solely on electronic questionnaires.

Randolph Eugene McEwen (Pharmacist License No. 14282), Voluntary Consent Agreement: Assessed $5,000 plus investigative and administrative costs. *Charges:* five counts, including improper closure of First Dose Pharmacy and improper transfer of confidential patient prescriptions.

First Dose Pharmacy (Pharmacy Permit No. 5498), Voluntary Consent Agreement: Assessed $5,000 plus investigative and administrative costs. *Charges:* two counts, including permitting an unlicensed person to assist in the practice of pharmacy.

Randolph Eugene McEwen (Pharmacist License No. 14282), Voluntary Consent Agreement: License suspended for five years; and further, assessed $5,000 plus administrative costs. *Charges:* six counts, including permitting an unlicensed person to practice pharmacy at First Dose Pharmacy.

First Dose Pharmacy (Pharmacy Permit No. 5498), Voluntary Consent Agreement: Permit revoked; further reinstatement permanently barred. *Charges:* 13 counts, including dispensing of prescriptions based solely on electronic questionnaires.

Randolph Eugene McEwen (Pharmacist License No. 14282), Voluntary Consent Agreement: License suspended for five years; further, assessed $15,000 plus investigative and administrative costs; and further, permanently barred from future ownership of pharmacies in Louisiana. *Charges:* 20 counts, including dispensing prescriptions based solely on electronic questionnaires, failure to counsel patients, and failure to maintain corresponding responsibility for dispensing of legitimate prescriptions at First Dose Pharmacy.

Barry Jon Sylvester (Pharmacist License No. 14795), Voluntary Consent Agreement: License suspended for two years; execution stayed; placed on probation for two years; and further, assessed $500 plus administrative costs. *Charges:* 20 counts, dispensing prescriptions based solely on electronic questionnaires, failure to counsel patients, and failure to maintain corresponding responsibility for dispensing of legitimate prescriptions at First Dose Pharmacy.

Leesville Drug Co. (Pharmacy Permit No. 662), Voluntary Consent Agreement: Permit suspended for 10 years; execution stayed; placed on probation 10 years; and further, assessed $25,000 plus investigative and administrative costs. *Charges:* 17 counts, including improper possession of drug samples, mislabeling and misbranding of prescription drugs, improper access to prescription drug records outside the prescription department, and shortages of controlled dangerous substances.

Blane Edwin Perry (Pharmacist License No. 11249), Voluntary Consent Agreement: License suspended for 10 years; further, assessed $10,000 plus investigative and administrative costs; and further, reinstatement conditioned upon at least two years of active suspension and payment of all assessments. *Charges:* 23 counts, including improper possession of drug

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samples, mislabeling and misbranding of prescription drugs, improper access to patient prescription records outside the prescription department, and shortages of controlled dangerous substances at Leesville Drug Co.

Paul Van Bentem (Technician Certificate No. 7426), Voluntary Consent Agreement: Issued Letter of Warning to respondent; further, assessed investigative and administrative costs; and further, imposed the acquisition of 300 hours of experience as described in the agreement. *Charges:* two counts, including the failure to obtain the required amount of experience prior to certification.

Phien The Nguyen (Technician Candidate Registration No. 12563), Voluntary Surrender: Accepted voluntary surrender; registration suspended for an indefinite period of time, effective April 24, 2007.

Kathy Anne Bull (Technician Candidate Registration No. 11710), Voluntary Surrender: Accepted voluntary surrender; registration suspended for an indefinite period of time, effective April 18, 2007.

Desire Narcotic Rehabilitation Center (CDS License No. 15310), Voluntary Surrender: Accepted voluntary surrender; license suspended for an indefinite period of time, effective April 30, 2007.

Barney Thomas Dotson (Pharmacist License No. 14629), Voluntary Surrender: Accepted voluntary surrender; license suspended for an indefinite period of time, effective May 8, 2007.

Esplanade Pharmacy (CDS License No. C-004579), Voluntary Surrender: Accepted voluntary surrender; license suspended for an indefinite period of time, effective May 9, 2007.

On this same date, the Board also issued Letters of Warning to one pharmacist and five pharmacy permits, as well as Letters of Reprimand to six pharmacists, one technician, and two pharmacy permits. With respect to impaired practitioners, the Board accepted the voluntary surrender of five pharmacist licenses, granted a request for reinstatement from one pharmacist, and granted a request for probation modification from one pharmacist. With respect to the reinstatement of expired credentials, the Board granted requests from two pharmacists.

Calendar Notes (07-07-274)

The next Board meeting and administrative hearing will be August 9-10, 2007, at the Board office. The office will be closed July 4 in observance of Independence Day, as well as September 3 in observance of Labor Day.

Special Note (07-07-275)

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. We encourage you to keep them in the back of the *Louisiana Pharmacy Law Book* for future reference.

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 voluntary 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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