April 2013

Louisiana Board of Pharmacy News

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Renewal of Pharmacy Technician Certificates (13-04-428)

The renewal cycle for pharmacy technicians will open on May 1, and conclude on June 30. The Louisiana Board of Pharmacy no longer mails renewal application forms; instead, the Board will mail a renewal reminder mailer (not a postcard) just prior to May 1. In the event you do not receive your renewal reminder mailer by May 15, it becomes your responsibility to obtain an application form or renew your certificate online. The renewal reminder mailer will contain your login identification and password to access your account on the Board's Web site. The mailer will remind you of the three options to renew your certificate:

1. Visit the Board's Web site at *www.pharmacy.la.gov* and renew your certificate using a credit card;
2. Visit the same Web site to download and print an application form, then complete and mail the application form with the appropriate fee using a check or money order; or
3. Send a written notice to the Board office (mail, fax, or e-mail) with your name, certificate number, and current mailing address, requesting the Board to mail a paper application form to you.

Certificates renewed online will be mailed within one or two business days; certificates renewed using paper application forms will be mailed within two to four weeks, depending on the volume of paper application forms received for processing.

The online renewal function of the Web site is automatically timed to activate at 12:01 AM on May 1, and to deactivate at midnight on June 30. While the Board makes every effort to maintain the online convenience during the renewal period, the Board's service provider may experience weather-related or other unforeseen technical difficulties from time to time. You have 60 days to renew your certificate, and it is your choice as to when to complete that duty. If you choose to wait until the last day and the Web site is not available, then you will be responsible for the consequences of your failure to renew your certificate in a timely manner.

All technician certificates shall expire on June 30, regardless of the date of issue. You may not practice with an expired certificate. The renewal of an expired certificate will incur an additional $25 penalty as well as an additional $200 reinstatement fee. Applications bearing a postal service postmark of July 2, or later must be accompanied by the additional fee or the package will be returned to the sender incomplete and unprocessed. If it is important for you to know when the Board receives your paper application form, the Board suggests you use the mail tracking service of your choice. Given the volume of renewal applications, the Board will not be able to respond to your request to confirm mail deliveries.

New Rules (13-04-429)

The Board completed the promulgation process for several new rules in February and March. More information about these new rules can be found on the Board's Web site. The 2013 update for the *Louisiana Pharmacy Law Book* is scheduled for publication before the end of April.

- *Regulatory Project 2012-5 ~ Institutional Pharmacies:* Effective February 20
- *Regulatory Project 2012-6 ~ Interstate Remote Processing:* Effective February 20
- *Regulatory Project 2012-7 ~ Security of Prescription Department:* Effective February 20
- *Regulatory Project 2012-8 ~ CDS License for Nonresident Distributor:* Effective February 20
- *Regulatory Project 2012-9 ~ CDS in Emergency Drug Kits:* Effective February 20
- *Regulatory Project 2012-10 ~ Prescription Monitoring Program:* Effective February 20
- *Regulatory Project 2012-11 ~ Durable Medical Equipment:* Effective March 20

New Compliance Officer (13-04-430)

The Board is pleased to announce the appointment of a new pharmacist compliance officer, effective April 8. Carey D. Aaron completed his pharmacy education at the Northeast Louisiana University School of Pharmacy (now University of Louisiana at Monroe College of Pharmacy) in 1995, and has accumulated over 15 years of experience in community pharmacy practice. Mr Aaron resides in the Shreveport, LA, area and will be responsible for inspecting pharmacies and other facilities in the northwestern part of the state.

FDA Issues New Guidelines for Sleep Aids Containing Zolpidem

Food and Drug Administration (FDA) has issued new dosing recommendations for sleep aids containing zolpidem. The new recommendations are based upon new data that shows that when taken at night, blood levels of zolpidem remain high enough in the morning to impair activities that require alertness, such as driving. The new guidelines halve the dosage for women because the new data showed that their bodies take longer to eliminate the drug.

FDA urges drug manufacturers and health care providers to follow the new dosing instructions, which apply to brand name and generic drugs containing zolpidem:

- Ambien®, Edluar™, and Zolpimist®: 5 mg for women, 5 mg or 10 mg for men
- Ambien CR®: 6.25 mg for women, 6.25 mg or 12.5 mg for men

Additionally, manufacturers of these drugs have been instructed to follow the new guidelines and print new patient information drug labels containing the new recommendations.

The recommended doses of Intermezzo®, a lower dose zolpidem product approved for middle-of-the-night awakenings, are not changing. At the time of Intermezzo's approval in November 2011, the label already recommended a lower dosage for women than for men. Additional details are available in an FDA Drug Safety Communication, available at *www.fda.gov/Drugs/DrugSafety/ucm334033.htm.*

What is the National Medication Error Rate? What Standards Are Available for Benchmarking?

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 an 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.*

A national or other regional medication error rate does not exist. It is not possible to establish a national medication error rate or set a benchmark for medication error rates. Each pharmacy organization is different. The rates that are tracked are a measure of the number of **reports** at a given organization, not the actual number of **events** or the quality of the care given. Most systems for measuring medication errors rely on voluntary reporting of errors and near-miss events. Studies have shown that even in good systems, voluntary reporting only captures the "tip of the iceberg." For this reason, counting **reported** errors yields limited information about how safe a pharmacy actually is. It is very possible that a pharmacy organization with a good reporting system, and thus what appears to be a high error "rate," may have a safer system.

The National Coordinating Council for Medication Error Reporting and Prevention published a statement refuting the use of medication error rates. The statement, which is posted on the council's Web site (*www.nccmerp.org*), states the "Use of medication error rates to compare health care organizations is of no value." The council has taken this position for the following reasons:

- Differences in **culture** among health care organizations can lead to significant differences in the level of reporting of medication errors.
- Differences in the **definition** of a medication error among health care organizations can lead to significant differences in the reporting and classification of medication errors.
- Differences in the **patient populations** served by various health care organizations can lead to significant differences in the number and severity of medication errors occurring among organizations.
- Differences in the **type(s) of reporting and detection systems** for medication errors among health care organizations can lead to significant differences in the number of medication errors recorded.

According to the statement, the council believes that there are no acceptable incidence rates for medication errors. The goal of every health care organization should be to continually improve systems to prevent harm to patients due to medication errors. Pharmacies should monitor actual and potential medication errors that occur within their organization, and investigate the root cause of errors with the goal of identifying ways to improve the medication-use system to prevent future errors and potential patient harm. The value of medication error reporting and other data gathering strategies is to provide the information that allows an organization to identify weaknesses in its medication-use system and to apply lessons learned to improve the system. The sheer number of error reports is less important than the quality of the information collected in the reports, the organization's analysis of the information, and its actions to improve the system to prevent harm to patients.

It is more important to create the open environment that encourages the reporting of errors and near errors than to develop less meaningful comparative error rates.

ISMP Launches Program to Track Vaccine Errors

ISMP has launched a National Vaccine Error Reporting Program (VERP) that allows health care providers to confidentially report vaccine administration errors and near misses. Health care providers from all practice settings, including pharmacies and physicians' offices, are encouraged to report all mistakes related to vaccines, regardless of whether any harm resulted from the incident. The program will help ISMP "better quantify the sources of errors and advocate for vaccine name, labeling, device, information, and other needed product changes to ensure patient safety," stated Michael Cohen, ISMP president. The ISMP VERP was designed with the assistance of the California Department of Public Health and with input from experts in the field, indicates ISMP. Reports sent to the ISMP VERP will be shared with FDA and forwarded to the vaccine manufacturer when applicable. ISMP also plans to work with the Centers for Disease Control and Prevention on information received to address vaccine-related safety. VERP can be accessed at *http://verp.ismp.org/.*

Providers Should Ensure Only Diluted Forms of Acetic Acid Are Used, ISMP Warns

ISMP has issued a National Alert Network (NAN) notice advising that health care organizations should take immediate steps to ensure that only diluted acetic acid solutions are used in patient care. ISMP advises that the use and purchase of glacial acetic acid, the most concentrated form of acetic acid available, should be eliminated. Several cases of severe burns, scarring, and other permanent damage to skin or mucous membranes due to the inadvertent application of glacial acetic acid have been reported to the National Medication Errors Reporting Program operated by ISMP. ISMP provides the following steps for preventing further such events:

- Remove glacial acetic acid, which has no use in its current form in clinical medicine, from the pharmacy and replace with vinegar (5% solution) or commercially available diluted acetic acid 0.25% (for irrigation) or 2% (for otic use).
- Restrict purchasing so that pharmacy staff is purchasing acetic acid for all procedural areas.
- Restrict choices for purchasing so that glacial acetic acid is not selected by mistake.
- Ensure the correct strength is ordered.
- Educate staff about the differences between glacial acetic acid and diluted forms of acetic acid.
- Order 5% as "vinegar," which reduces the potential for confusion with glacial acetic acid.
- Verify the product by requiring an independent double-check of acetic acid solutions before dispensing or applying the product.

Information on the cases reported and common reasons for the cases are included in the NAN alert, which is available on the ISMP Web site at *www.ismp.org/NAN/files/20130121.pdf.*

New FDA Training Video

FDA Drug Info Rounds, a series of online training videos, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better medication decisions. In the latest Drug Info Rounds video, pharmacists discuss how FDA Drug Safety Communications let health care providers, patients, and consumers know about newly observed potential risks of FDA-approved drugs. Drug Info Rounds videos are developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research, Office of Communications, and Division of Drug Information and are available on the FDA Web site at *www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm.*

Progress Made in Implementing Recommendations Intended to Prevent Acetaminophen Overdose

Compelling progress has been made by stakeholders seeking to address the public health issue of acetaminophen overdose, indicates a white paper published by the National Council for Prescription Drug Programs (NCPDP). In 2011, NCPDP made recommendations that the health care industry take actions to support the safe use of acetaminophen, including recommending that pharmacies produce prescription labels with the complete spelling of acetaminophen and eliminating use of abbreviations such as "acet" or "APAP." Previous to that, in July 2010, the National Association of Boards of Pharmacy® (NABP®) recommended that "state boards of pharmacy prohibit the use of the abbreviation 'APAP' on prescription labels, and require that 'acetaminophen' be spelled out to assist in preventing the well-recognized danger of acetaminophen induced hepatotoxicity." The recommendation was based on established policy and a letter, sent by FDA to state boards of pharmacy, regarding the pharmacist's role in educating patients about acetaminophen induced hepatotoxicity caused by unintentional overdose. The recommendation was also consistent with the report of the NABP Task Force on Uniform Prescription Labeling Requirements, which made recommendations to encourage use of prescription labels that are organized in a patient-centered manner. NCPDP reports that pharmacy retailers "estimated to collectively represent more than half of the prescriptions dispensed in 2011, have either implemented or committed to a phased implementation" of the recommendation to use the complete spelling of acetaminophen on prescription labels. "This update to our white paper provides additional guidance for those industry stakeholders who have not yet implemented the new pharmacy labeling practices for acetaminophen-containing medicines," states Lee Ann Stember, president, NCPDP. The updated white paper is accompanied by a bulletin (PDF), available at *www.ncpdp.org/pdf/wp/NCPDPAcetaminophenInfoBulletin_PharmacyStakeholders.pdf,* developed for pharmacists that summarizes some of NCPDP's key recommendations regarding acetaminophen. In addition, the white paper, available for download at *www.ncpdp.org/ind_WP.aspx,* includes a list of resources for pharmacists to use in educating staff and pharmacy staff to use in educating patients (see Appendix D of the white paper). More information is available in an NCPDP news release available at *www.ncpdp.org/press/013113_NCPDP_Acetaminophen%20WP_FINAL.pdf.*

Pharmacists Rated High for Honesty and Ethical Standards in Gallup's 2012 Poll

Pharmacists ranked as the second most trusted profession in the 2012 Gallup Poll that asked consumers to rate 22 professions according to their honesty and ethical standards. Pharmacists were ranked as very high or high in this category by 75% of those surveyed, with nurses ranking first at 85%, and medical doctors third at 70%. Additional information on the results of the 2012 poll is available on the Gallup Web site at *www.gallup.com/poll/159035/congress-retains-low-honesty-rating.aspx*.

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Disciplinary Actions (13-04-431)

During its December 2012 meeting, the Board took final action in the following matters:

David Collins Evans (PST.01481): Accepted voluntary surrender, resulting in suspension of the license for an indefinite period of time, effective August 27, 2012.

Nancy Lynn Odom (PST.014796): Accepted voluntary surrender, resulting in suspension of the license for an indefinite period of time, effective September 21, 2012.

Steve John Soteropulos (PST.011704): Accepted voluntary surrender, resulting in suspension of the license for an indefinite period of time, effective November 5, 2012.

Nicholas Matthew Bullard (PNT.046745): Accepted voluntary surrender, resulting in suspension of the registration for an indefinite period of time, effective November 30, 2012.

Michael Wayne Lindsey (PST.015624): Granted request for reinstatement of the previously suspended license, converted the suspensive period from an indefinite term to a term of 10 years and stayed the execution of the suspension, and then placed the license on probation for 10 years, effective December 12, 2012, subject to certain terms enumerated in the consent agreement.

Michael Scott Gallotte (PST.020036): Authorized the issuance of license by reciprocity on January 1, 2013, suspended the newly issued license for a period of time ending November 18, 2019, and stayed the execution of the suspension, and then placed the license on probation for the entire suspensive period, subject to certain terms enumerated in the consent agreement.

Northlake Pharmacy (PHY.006184): Revoked the permit; for five counts, including failure to properly close pharmacy and dispose of patient prescription records.

Michael Roger Chamberlain (PST.014768): Issued letter of reprimand and assessed a fine of $1,000 plus costs; for seven counts, including failure to properly close Northlake Pharmacy.

Steven's Pharmacy (PHY.004535 and CDS.038660): Suspended the permits for five years and stayed the execution thereof, and then placed the permits on probation for five years, effective October 1, 2012, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $10,000 plus costs; for eight counts, including failure to report theft or loss of controlled substances (CS) and accountability for shortages of CS.

Steven Walter Gough (PST.013199): Suspended the license for five years and stayed the execution thereof, and then placed the license on probation for five years, effective October 1, 2012, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $5,000 plus costs; for eight counts, including failure to report theft or loss of CS as well as accountability for shortages of CS as pharmacist-in-charge (PIC) of Steven's Pharmacy.

Danna Marie Harris (CPT.010899): Issued letter of reprimand, and further, assessed costs; for six counts, including continuing to practice with an expired credential.

Walgreens Pharmacy No. 11413 (PHY.005926): Assessed a fine of $1,000 plus costs; for seven counts, including allowing multiple pharmacists to administer immunizations without the proper credentials to do so.

Emile Henry Clay III (PST.017461): Issued letter of reprimand, and further, assessed a fine of $500 plus costs; for seven counts, including administration of immunizations without the proper credentials from the Board to do so.

Emma Osiris Dolmo (PST.017273): Issued letter of reprimand, and further, assessed a fine of $250 plus costs; for seven counts, including administration of immunizations without the proper credentials from the Board to do so.

Village Pharmacy of Port Vincent (PHY.006278 and CDS.039387): Revoked the permit, and further, permanently prohibited the acceptance of any future application for the reinstatement of the permit, and further, assessed investigative costs; for 17 counts, including dispensing fraudulent prescriptions for CS, failure to exercise corresponding responsibility for dispensing prescriptions for CS, failure to comply with reporting requirements for the Louisiana Prescription Monitoring Program, and failure to maintain accurate prescription records for CS.

Kirkland Daniel Jeane (PST.018892): Revoked the license, and further, permanently prohibited the acceptance of any future application for the reinstatement of the license, and further, permanently prohibited any ownership interest in any pharmacy licensed by the Board; for 22 counts, as owner and PIC of Village Pharmacy of Port Vincent.

Stacy Shields Corcoran (CPT.005104): Revoked the certificate, and further, permanently prohibited any future application for reinstatement of the certificate or for any other credential issued by the Board; for five counts, including diversion of CS from her employer pharmacy.

Shaasta Monique Moore (CPT.009526): Revoked the certificate, and further, permanently prohibited any future application for reinstatement of the certificate or for any other credential issued by the Board; for five counts, including the acceptance of forged prescriptions at her employer pharmacy.

Melisa Ann Cowan (CPT.004438): Revoked the certificate, and further, permanently prohibited any future application for reinstatement of the certificate or for any other credential issued by the Board; for five counts, including diversion of CS from her employer pharmacy.

Robert Joseph Gaspard, Jr (PTC.017871): Revoked the registration, and further, permanently prohibited any future application for reinstatement of the registration or for any other credential issued by the Board; for five counts, including diversion of CS from his employer pharmacy.

Franck's Compounding Pharmacy (PHY.005484): Accepted voluntary surrender of the credential, resulting in active suspension of the pharmacy permit for an indefinite period of time, effective August 31, 2012.

Paul Ryan Lemaire (PST.018503): Accepted voluntary surrender of the credential, resulting in active suspension of the license for an indefinite period of time, effective October 15, 2012.

New England Compounding Center (PHY.005145): Accepted voluntary surrender of the credential, resulting in active suspension of the pharmacy permit for an indefinite period of time, effective October 29, 2012.

Barry James Cadden (PST.017479): Accepted voluntary surrender of the credential, resulting in active suspension

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of the license for an indefinite period of time, effective December 3, 2012.

Ginger Marisa Greenwood (SWP.000222): Accepted voluntary surrender of the credential, resulting in active suspension of the special work permit for an indefinite period of time, effective December 12, 2012.

During the same meeting, the Board granted approval of four petitions for modification of previous orders from three pharmacists and one pharmacy intern. The Board also granted approval of reinstatement applications for lapsed credentials for one pharmacist and two technicians contingent upon the satisfaction of certain terms in the consent agreement, and for one technician with no further action required. The Board also issued a letter of warning to one pharmacy and a letter of reprimand to one pharmacy technician. Finally, the Board suspended the controlled dangerous substance (CDS) licenses for four physicians and one physician assistant whose medical licenses were suspended by the Louisiana State Board of Medical Examiners as well as for one physician who had surrendered his Drug Enforcement Administration registration.

During its March 2013 meeting, the Board took final action in the following matters:

Kerry Michael Finney (PST.013535): Granted request for reinstatement of the previously suspended license, converted the suspensive period from an indefinite term to a term of 15 years and stayed the execution of the suspension, and then placed the license on probation for 15 years, effective March 6, 2013, subject to certain terms enumerated in the consent agreement.

Wade Randall Veillon (PST.011709): Granted request for reinstatement of the previously suspended license, converted the suspensive period from an indefinite term to a term of 15 years and stayed the execution of the suspension, and then placed the license on probation for 15 years, effective March 6, 2013, subject to certain terms enumerated in the consent agreement.

Steve John Soteropulos (PST.011704): Granted request for reinstatement of the previously suspended license, converted the suspensive period from an indefinite term to a term of 15 years and stayed the execution of the suspension, and then placed the license on probation for 15 years, effective March 6, 2013, subject to certain terms enumerated in the consent agreement.

Roger Thi Ly (PST Applicant): Denied application for licensure by reciprocity and refused to issue the license for disciplinary action in another jurisdiction.

Derek Anthony Sapone (PST Applicant): Denied application for licensure by reciprocity and refused to issue the license for failure to declare prior history.

David Allen Guillory (PST.015750): Suspended license for 54 months and stayed the execution thereof, and then placed the license on probation for 54 months, effective March 6, 2013, subject to certain terms enumerated in the consent agreement.

CVS Pharmacy No. 5349 (PHY.005943): Assessed a fine of $25,000 plus costs; for five counts, including allowing a technician candidate to work with an expired registration for four months.

Madisonville Compounding, LLC, dba The Compounding Corner (PHY.006070 and CDS.039279): Suspended both credentials for one year and stayed the execution thereof, and then placed both credentials on probation for one year, effective January 1, 2013, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $5,000 plus costs; for seven counts, including distribution of samples to physicians for further resale.

Kristian Raymond Hahn (PST.016625): Suspended the license for one year and stayed the execution thereof, and then placed the license on probation for one year, effective January 1, 2013, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $5,000 plus costs; for nine counts, including accountability as owner and PIC of The Compounding Corner for distribution of samples to physicians for further resale.

Inca Enterprises, Inc, dba Medic's Compounding Lab (PHY.003693 and CDS.039204): Suspended both credentials for one year and stayed the execution thereof, and then placed both credentials on probation for one year, effective January 1, 2013, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $5,000 plus costs; for 21 counts, including dispensing over 65,000 prescriptions for CS over a period of 39 months for patients at three weight loss clinics prior to the establishment of legitimate physician-patient relationships.

David Stanley Burch (PST.014279): Suspended the license for one year and stayed the execution thereof, and then placed the license on probation for one year, effective January 1, 2013, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $5,000 plus costs; for 22 counts, including accountability as PIC of Medic's Compounding Lab for improper dispensing of prescriptions for CS.

QVL Pharmacy No. 224 (PHY.005538 and CDS.038926): Suspended both credentials for two years and stayed the execution thereof, and then placed both credentials on probation for two years, effective January 1, 2013, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $25,000 plus costs; for 22 counts, including accountability for multiple pharmacists dispensing over 450 prescriptions for CS pursuant to fraudulent prescriptions, failure to provide records as requested, and alleged Medicaid fraud.

Lawrence Jackson, Jr (PST.014930): Continued the license on active suspension for an indefinite period of time, and further, extended the earliest opportunity for any future reinstatement application to October 1, 2015, and further, assessed a fine of $10,000 plus costs; for 25 counts, including accountability as PIC of QVL Pharmacy No. 224 for improper dispensing of prescriptions for CS.

Eugene John McKeon (PST.009123): Suspended the license for one year and stayed the execution thereof, and then placed the license on probation for one year, effective January 1, 2013, subject to certain terms enumerated in the consent agreement, and further, assessed a fine of $5,000 plus costs; for 18 counts, including accountability as a staff pharmacist at QVL Pharmacy No. 224 for improper dispensing of prescriptions for CS.

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Clayton Thomas Aldridge (PTC.017735): Revoked the registration, and further, permanently prohibited any future application for reinstatement of the registration or for any other credential issued by the Board; for five counts, including alleged diversion of CS from his employer pharmacy.

LaStacia Ja'Monique Moore (CPT.007015): Revoked the certificate, and further, permanently prohibited any future application for reinstatement of the certificate or for any other credential issued by the Board; for five counts, including alleged diversion of CS from her employer pharmacy.

Phyllis Deann Lanclos (CPT.003186): Revoked the certificate, and further, permanently prohibited any future application for reinstatement of the certificate or for any other credential issued by the Board; for five counts, including alleged diversion of CS from her employer pharmacy.

Tenisha Roshonda McGee (CPT.008022): Revoked the certificate, and further, permanently prohibited any future application for reinstatement of the certificate or for any other credential issued by the Board; for five counts, including alleged diversion of CS from her employer pharmacy.

Tiffany Annette Pitre (CPT.001615): Accepted the voluntary surrender of the credential, resulting in active suspension of the certificate for an indefinite period of time, effective January 18, 2013.

Michael Andrew Wallace (CPT.007041): Accepted the voluntary surrender of the credential, resulting in active suspension of the certificate for an indefinite period of time, effective March 6, 2013.

During the same meeting, the Board granted approval for the reinstatement of a lapsed license for a pharmacist, as well as conditional approval for the reinstatement of lapsed credentials for one pharmacist and four technicians, pending satisfaction of certain terms enumerated in their consent agreements. The Board also issued a letter of warning to the owner of a pharmacy permit as well as letters of reprimand to three pharmacists, and further, suspended the CDS licenses for three physicians whose medical licenses were suspended by the Louisiana State Board of Medical Examiners.

Notice of Correction (13-04-432)

In the October 2012 *Newsletter,* the Board incorrectly reported Edwards Healthcare Services, Inc, as the owner of GE Pharmacy Services. The Board regrets the error. The corrected entry follows here:

TEMEG Holdings, Inc, dba GE Pharmacy Services: Assessed costs; for three counts, including failure to obtain new pharmacy permit following change of ownership of permit.

Calendar Notes (13-04-433)

The next Board meeting and administrative hearing will be May 29-30, 2013, at the Board office. The office will be closed July 4, in observance of Independence Day.

Special Note (13-04-434)

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.

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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