



Louisiana Board of Pharmacy

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Election of Board Officers (15-01-478)

During the November 13, 2014 Louisiana Board of Pharmacy meeting, the members conducted their annual election of officers, with the following results:

- ◆ Carl W. Aron, from Monroe, LA, in District 5 – President
- ◆ T. Morris Rabb, from Monroe in District 5 – First Vice President
- ◆ Marty R. McKay, from Woodworth, LA, in District 8 – Second Vice President
- ◆ Chris B. Melancon, from Carencro, LA, in District 7 – Third Vice President
- ◆ Brian A. Bond, from Jena, LA, in District 8 – Secretary

Board Meeting Dates for Calendar Year 2015 (15-01-479)

The Board has announced the following tentative meeting dates for calendar year 2015: February 25-26, May 27-28, August 12-13, and November 18-19. All meetings are planned for the Board office in Baton Rouge, LA.

Status Report on Rulemaking Activities (15-01-480)

The Board continues to promulgate new rules as well as revisions to existing rules. For its clients who have provided their email addresses, the Board sends electronic *Notices of Rulemaking Activity* about these issues.

- ◆ *Regulatory Project 2014-3 ~ Pharmacy Records.* The Board published its Notice of Intent to substantially revise its rules for pharmacy record keeping on March 20, 2014. After two public hearings and some revisions to the original proposal, the Board published the final rule in November 2014, with a delayed effective date of January 1, 2015. The rule substantially revised and updated Subchapter B – Pharmacy Records of *Chapter 11 – Pharmacies* of the Board's rules. In addition, the project made related changes to the records section of *Chapter 12 – Automated Medication Systems* as well as §1509 – Drug Distribution Control of *Chapter 15 – Hospital Pharmacy*.

The rule establishes the standard for positive identification (as opposed to simple identification) to identify an individual who prescribes, dispenses, or administers a prescription drug. The rule then outlines the types of records that require positive identification and those for which simple identification is sufficient. The rule identifies two general types of pharmacy dispensing information systems and requires pharmacies to use one or the other. Regardless of the type used, the rule identifies the data

elements that must be maintained in the pharmacy dispensing information system. The rule describes the requirement for backup and support systems, procedures for purging information systems, and maintaining audit trails, as well as data retention requirements and timelines for data production when requested by the Board. The rule also describes requirements for the filing of prescription forms and certain allowances for prescriptions received by facsimile, computer facsimile, and in electronic format.

- ◆ *Regulatory Project 2014-4 ~ Pharmacy Compounding.* During its August 2014 meeting, the Board received a recommendation from its Regulation Revision Committee taking note of the recently enacted federal legislation (Drug Quality and Security Act of 2013) that limits state-licensed pharmacies to compounding activities in response to patient-specific prescriptions, with no authority for compounding preparations in response to purchase orders from practitioners. The Board voted to allow the previous emergency rule to expire on August 4, and further, voted to issue a new emergency rule that became effective on August 8. That emergency rule seeks to harmonize the Board's rule with the recently enacted federal legislation. The Board republished that emergency rule in December 2014, while pursuing the promulgation of a permanent rule. The Board completed that process and will publish the final rule on January 20, 2015. The permanent final rule will become effective that day and the temporary emergency rule will then expire. The rule revises and updates Subchapter C – Compounding of Drugs in *Chapter 25 – Prescriptions, Drugs, and Devices*.

The rule requires pharmacies engaging in compounding activities of either sterile or nonsterile preparations to do so only pursuant to patient-specific prescriptions. Further, the compounding activities must comply with the relevant chapter of standards in the United States Pharmacopeia: Chapter <795> for nonsterile preparations and Chapter <797> for sterile preparations.

- ◆ *Regulatory Project 2014-5 ~ Prescriptions.* The Board published its Notice of Intent to update its requirements for written and electronic prescriptions in June 2014. Following two public hearings and revisions to the original proposal, the Board will publish the final rule on January 20, 2015; the final rule will become effective that day. The rule revises and updates §2511 – Prescriptions of *Chapter 25 – Prescriptions, Drugs, and Devices* of the Board's rules.

The rule establishes a minimum set of data required for all prescriptions regardless of the medium used – oral, written, or electronic. With respect to the signature on written prescription

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DEA Finalizes Rule on CS Prescription Drug Disposal

In September 2014, Drug Enforcement Administration (DEA) published its final rule, titled the Disposal of Controlled Substances, that allows some DEA registrants to modify their registration to become authorized collectors. Under the new rule, some DEA registrants, including retail pharmacies, hospitals/clinics with an on-site pharmacy, manufacturers, distributors, reverse distributors, and narcotic treatment programs, may modify their registration with DEA to become authorized collectors. The final rule implements the Secure and Responsible Drug Disposal Act of 2010, which authorized DEA to develop and implement regulations that would allow authorized entities other than law enforcement to collect unused and unwanted prescription drugs, including controlled substances (CS), for disposal purposes. Proper disposal of unused prescription medication is a key method of preventing and reducing prescription drug abuse. The final rule took effect on October 9, 2014.

The full rule is available on the *Federal Register* website at www.federalregister.gov/articles/2014/09/09/2014-20926/disposal-of-controlled-substances.

System-Based Causes of Vaccine Errors

 This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization 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 provides legal protection and confidentiality for submitted patient safety data and error reports. Help others by reporting actual and potential medication errors to the ISMP National Medication Errors Reporting Program Report online at www.ismp.org. Email: ismpinfo@ismp.org.

Immunizations are widely recognized as one of the most successful and cost-effective health interventions ever introduced worldwide. However, errors with vaccines can result in an unintended and unrecognized source of vulnerability. While the immediate impact of a vaccine-related error on a patient may not be serious, such errors may render the vaccine ineffective or reduce its effectiveness, leaving patients unprotected against serious diseases such as hepatitis A, hepatitis B, diphtheria, tetanus, measles, cervical cancer, and many others. In September 2012, ISMP (in cooperation with the California Department of Public Health) established the ISMP National Vaccine Errors Reporting Program (VERP) to collect data about the type of vaccine errors occurring and the reasons they occur. In ISMP's November 28, 2013 newsletter (www.ismp.org/sc?id=307), ISMP provided a summary analysis of error reports submitted to the ISMP VERP during its first year. The vaccinations that are most frequently associated with errors included *Haemophilus influenzae* type b conjugate (Hib); diphtheria and tetanus toxoids, acellular pertussis

adsorbed, and inactivated poliovirus (DTaP-IPV); tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis adsorbed (Tdap); diphtheria, tetanus toxoid, and acellular pertussis adsorbed (DTaP); hepatitis A (HepA); hepatitis B (HepB); human papillomavirus quadrivalent (types 6, 11, 16, and 18), recombinant (HPV4); zoster; and measles, mumps, rubella, and varicella (MMRV). The most common contributing factors associated with the reported vaccine errors included mistakes in choosing age-dependent formulations of vaccines intended to prevent the same diseases; unfamiliarity with the vaccine, particularly its dose, dosing schedule, age specifications, route of administration, and the vaccine's various components (eg, combination vaccines, diluents, and powder); failure to check or verify the patient's age, health record, or state registry; similar vaccine names and abbreviations; similar and confusing vaccine labeling and packaging; unsafe storage conditions (eg, stored near other similar vaccines or unwanted temperature fluctuations); and expiration dates not noticed or misunderstood.

Practice Recommendations. Involve the patient or parent(s)/caregiver(s) in a vaccine verification process by:

- 1) Documenting the vaccine name, formulation (pediatric or adult, if applicable), lot number, and expiration date on the patient's vaccine record **prior** to preparation/administration of the vaccine,
- 2) Bringing the vial and syringe or the prefilled syringe along with the immunization record into the exam room,
- 3) Asking the patient or parent/caregiver to simultaneously verify the information on the immunization record while a health care provider reads the information on the label aloud,
- 4) Asking the patient or parent/caregiver if the verified vaccine is what he or she expected to be administered (based on an immunization schedule provided to the patient or parent/caregiver previously),
- 5) Preparing and administering the vaccine immediately after verification, and
- 6) Documenting the vaccine on the patient's medical record.

FDA Warns of Growing Network of Rogue Wholesale Drug Distributors

Through a new educational program called Know Your Source, Food and Drug Administration (FDA) is warning pharmacists and other health care providers to watch for counterfeit and unapproved drugs. Aimed at protecting patients from unsafe and ineffective drugs, the program advises providers to only purchase drugs from wholesale drug distributors licensed in their state. Further, FDA offers tips to providers to protect patients, including being wary of offers too good to be true, and ensuring that all drugs received are FDA-approved medications.

Another way that pharmacies can be assured of the legitimacy of a wholesale distributor is to look for the National Association of Boards of Pharmacy® (NABP®) Verified-Accredited Wholesale Distributors® (VAWD®) Seal. Those wholesale distributors that achieve VAWD accreditation are in compliance with state and federal laws, as well as NABP's VAWD criteria. Wholesale distributors that display the VAWD Seal as part of their accreditation have undergone a criteria compliance review, including a rigorous



review of their operating policies and procedures, licensure verification, survey of facility and operations, background checks, and screening through the NABP Clearinghouse. Accredited facilities are reviewed annually and undergo a site survey every three years. Created in 2004, the accreditation program plays a pivotal role in preventing counterfeit drugs from entering the United States drug supply.

Additional information about the VAWD program is available in the Programs section of the NABP website. Know Your Source is available at www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm389121.htm.

PTCB Implements Changes to CE Requirements

In 2015, the Pharmacy Technician Certification Board (PTCB) will implement two changes in recertification requirements for certified pharmacy technicians (CPhTs) in accordance with its certification program changes announced in 2013. First, any continuing education (CE) hours earned by a CPhT will need to be pharmacy technician-specific in order to qualify toward recertification. Second, PTCB will reduce the number of allowable "in-service" CE hours from 10 to five. PTCB's certification program changes are intended to support and advance improved patient care and safety throughout pharmacy practice, a PTCB press release indicates. The changes are the result of a PTCB initiative that began with a 2011 summit on future directions for pharmacy technicians.

Additional information can be accessed on the PTCB website at www.ptcb.org.

Security Guidelines Available as Rate of Pharmacy Robberies Still a Concern

Nationally, pharmacy robberies dipped slightly from 745 in 2012, to 713 in 2013, according to a report compiled by *Drug Topics* using DEA statistics. The 10 states that had the most robberies are in stark contrast to other states that had no robberies (South Dakota, North Dakota, and Alaska) or as few as one or two (such as Montana and Illinois), reports *Drug Topics*. However, fueled by the prescription drug abuse epidemic, pharmacy robberies still pose a threat to the safety of personnel and customers. The report lists the top 10 states that had the most pharmacy thefts in 2013. Arizona experienced the most pharmacy robberies in 2013 with 77 incidents, and Indiana took second place with 71 robberies. The report, titled "Top 10 states for pharmacy robberies," may be found at <http://drugtopics.modernmedicine.com/drug-topics/content/tags/arizona/top-10-states-pharmacy-robberies?page=full>.

NABP partnered with DEA to create an educational pamphlet identifying key strategies pharmacists can take to secure their stores against robberies, which can be downloaded at www.deadiversion.usdoj.gov/pubs/brochures/pharmtheft.pdf. In addition, some boards of pharmacy have identified best practices for preventing pharmacy theft, and have supported these practices through regulations or recommendations for their licensees. For example, the New Jersey State Board of Pharmacy's *Pharmacy Security Best Practices* document recommends that all Schedule II and III CS be stored in a "safe or substantially constructed steel cabinet that is locked at all times," with only licensed pharmacists having access.

Additional recommendations include annual pharmacist-in-charge self-assessments and interfacing with prescribers and customers, among others. The best practices document can be downloaded from the New Jersey Consumer Affairs website at www.njconsumeraffairs.gov/press/05012013.pdf.

Private organizations have also developed resources to assist pharmacies in improving security. One such resource is the RxPATROL program, which works with law enforcement, the pharmacy community, and security professionals to maintain a database containing detailed information about pharmacy robberies and other losses. In addition, the RxPATROL website, www.rxpatrol.com, provides training videos and a pharmacy security checklist.

Further, NABP members directed the Association to convene a task force to review strategies that states have taken to prevent theft and drug diversion. The Task Force to Examine Strategies for Preventing and Reacting to Pharmacy Robberies and Thefts met on October 22-23, 2014, to discuss these issues.

Assured Brand Naproxen Tablets Recalled Due to Packaging Error

In October 2014, Contract Packaging Resources of Greensboro, NC, a drug repackaging company, issued a voluntary recall of nearly 12,000 boxes of Assured brand naproxen sodium tablets because some cartons contain bottles of 200 mg ibuprofen softgels instead, a press release posted to the FDA website indicates. The packaging error affected boxes of Assured brand naproxen sodium tablets 220 mg, 15 count (Lot Number FH4102A), which were distributed to and sold at Dollar Tree stores and on the Dollar Tree website. Contract Packaging Resources is contacting customers to arrange for replacement of all recalled products. Adverse reactions or quality problems experienced with the use of this product may be reported to FDA's MedWatch Adverse Event Reporting Program.

More information is available on the FDA website at www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm419769.htm.

Martin Avenue Pharmacy Issues Voluntary Recall for All Sterile Compounded Preparations

Martin Avenue Pharmacy, Inc. of Naperville, IL, issued a voluntary recall for all in-date compounded sterile preparations due to a lack of sterility assurance in August 2014. Following a recent FDA inspection that revealed "quality control procedures that present a risk to sterility assurance," the company issued the recall out of an abundance of caution, indicates a news release posted to the FDA website. Martin Avenue Pharmacy supplied compounded sterile preparations to offices of licensed medical professionals and individuals in multiple states including Illinois, Wisconsin, Ohio, Michigan, Florida, Alabama, and Texas until August 20, 2014. A full list of recalled products is available on the Martin Avenue Pharmacy website (registration required). FDA urges consumers and health care providers to report adverse events or side effects related to the use of these products to FDA's MedWatch Safety Information Adverse Event Reporting Program.

More information is available on the FDA website at www.fda.gov/Safety/Recalls/ucm412431.htm.

forms (including those sent by facsimile), a manual signature is required. Examples of invalid signatures include rubber stamps, signatures of anyone other than the prescriber, and computer-generated signatures.

- ◆ **Regulatory Project 2014-6 ~ Special Event Pharmacy Permit.** The Board published its Notice of Intent on September 20, 2014, to develop a new classification of pharmacy permit intended for use by certain organizations, eg, medical missions, for limited periods of time. Following a public hearing, the Board will complete the rulemaking process and publish the final rule on January 20, 2015, and it will become effective that same day.

The rule creates a new Subchapter B – Special Event Pharmacy Permit within *Chapter 24 – Limited Service Providers*. The rule will enable sponsors of certain types of special public health-related events to apply for and receive a pharmacy permit for the purpose of operating a pharmacy for a limited period of time during the special event. The rule establishes licensing procedures as well as standards of practice.

- ◆ **Regulatory Project 2015-1 ~ Dispenser Reporting to Prescription Monitoring Program.** As indicated in the last issue of this *Newsletter* (October 2014), the 2014 Louisiana State Legislature passed Act 472, which amended the Louisiana Prescription Monitoring Program (PMP) law to revise the deadline by which pharmacies and other dispensers of prescriptions for controlled substances (CS) are required to report those prescription transactions to the PMP database **from** the previous deadline of seven days after the date of dispensing **to** the next business day after the date of dispensing. That law became effective on August 1, 2014.

The Board published its Notice of Intent to amend §2911 – Reporting of Prescription Monitoring Information in *Chapter 29 – Prescription Monitoring Program* of the Board's rules to make the same change required by the legislative act. A public hearing has been scheduled for January 28, 2015, to receive comments and testimony on the proposed rule.

- ◆ **Regulatory Project 2015-2 ~ Expiration Date of Schedule II Prescriptions.** As indicated in the last issue of this *Newsletter* (October 2014), the 2014 Louisiana State Legislature passed Act 865, which amended the Louisiana Uniform Controlled Dangerous Substances Law to establish a 90-day expiration date for prescriptions written for any medication listed in Schedule II. That law became effective on August 1, 2014.

The Board published its Notice of Intent to amend §2745 – Prescriptions and §2747 – Dispensing Requirements in *Chapter 27 – Controlled Dangerous Substances* of the Board's rules to make the same change required by the legislative act. A public hearing has been scheduled for January 28, 2015, to receive comments and testimony on the proposed rule.

Disciplinary Actions (15-01-481)

During its November 2014 meeting, the Board took final action in the following matters.

Medical Arts Pharmacy Services, Inc, dba Medical Arts Pharmacy (PHY Applicant): For its forgery of the name and signature of the pharmacist-in-charge (PIC) on its application for a pharmacy permit, the Board denied the application and refused to issue the permit.

Louisiana CVS Pharmacy, LLC, dba CVS Pharmacy No. 5306 (PHY.005788 and CDS.039634): For its failure to appoint a replacement PIC for 15 months, for the continued operation of the pharmacy without a PIC, and for its fraudulent renewal application, the Board suspended the pharmacy permit and state CS license for two years and stayed the execution of the suspension, then placed both credentials on probation for two years, effective November 13, 2014, and further, assessed a fine of \$100,000 plus administrative and investigative costs.

Louisiana CVS Pharmacy, LLC, dba CVS Pharmacy No. 5612 (PHY.005769): For its failure to appoint a replacement PIC for

five months, and for the continued operation of the pharmacy without a PIC, the Board assessed a fine of \$25,000 plus administrative and investigative costs.

Norman August Higginbotham (PST.015486): For his failure to properly perform the required tasks as departing PIC of CVS Pharmacy No. 5612, the Board issued a letter of reprimand, and further, assessed a fine of \$2,500 plus administrative costs.

Louisiana CVS Pharmacy, LLC, dba CVS Pharmacy No. 1939 (PHY.006316): For its failure to appoint a replacement PIC for one month, and for the continued operation of the pharmacy without a PIC, the Board assessed a fine of \$15,000 plus administrative and investigative costs.

Louisiana CVS Pharmacy, LLC, dba CVS Pharmacy No. 8999 (PHY.006285): For its failure to appoint a replacement PIC for one month, and for the continued operation of the pharmacy without a PIC, the Board assessed a fine of \$15,000 plus administrative and investigative costs.

Louisiana CVS Pharmacy, LLC, dba CVS Pharmacy No. 1017 (PHY.006018): For its failure to appoint a replacement PIC for one month, and for the continued operation of the pharmacy without a PIC, the Board assessed a fine of \$15,000 plus administrative and investigative costs.

Vital Care of Miss-Lou, Inc, dba Vital Care (PHY.006301): For its failure to obtain a new pharmacy permit when the ownership changed in 2012, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$5,000 plus administrative and investigative costs.

Tanya Lynnette Black (CPT.006606): Board accepted the voluntary surrender of the credential, resulting in the active suspension of the technician certificate for an indefinite period of time, effective September 10, 2014.

Institutional Pharmacy Solutions, LLC, dba Institutional Pharmacy Solutions (PHY.006424): For its improper possession of prescription records dispensed by another pharmacy, and for the improper reporting of prescription transaction data to the state PMP, the Board assessed a fine of \$25,000 plus administrative and investigative costs.

OK Compounding, LLC, dba OK Compounding (PHY Applicant): For dispensing over 180 prescriptions into Louisiana without the required permit to do so, and for its resident state pharmacy permit being placed on probation, the Board denied the application and refused to issue the permit, and further, permanently prohibited the acceptance of any future application for a pharmacy permit, and furthermore, assessed a fine of \$5,000 plus administrative costs.

Crystal Tavaralynne Hobdy (CPT.008861): For her repeated failure to disclose criminal history record information on multiple renewal applications, the Board suspended the technician certificate for three years and stayed the execution of the suspension, then placed the certificate on probation for three years, effective November 13, 2014, and further, assessed administrative costs.

Randal Riverside Corporation dba Matlock Pharmacy (PHY.006883): For dispensing over 900 prescriptions into Louisiana without the required permit to do so, and for its repeated denials of that activity, the Board suspended the pharmacy permit for five years and stayed the execution of the suspension, then placed the pharmacy permit on probation for five years, effective November 13, 2014, and further, assessed a fine of \$50,000 plus administrative and investigative costs.

Medco Health Solutions of Willingboro, LLC, dba Medco Health Solutions of Willingboro (PHY.004730): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative and investigative costs.

Medco Health Solutions of Las Vegas, LLC, dba Medco Health Solutions of Las Vegas (PHY.003521): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative costs.

Medco Health Solutions of Fairfield, LLC, dba Medco Health Solutions of Fairfield (PHY.004237): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative costs.

Medco Health Solutions of Columbus West, Ltd, dba Medco Health Solutions of Columbus West (PHY.003595): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative costs.

Medco Health Solutions of Hidden River, LLC, dba Medco Health Solutions of Hidden River (PHY.004927): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative costs.

Medco Health Solutions of Texas, LLC, dba Medco Health Solutions of Fort Worth (PHY.003606): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative costs.

Medco Health Solutions of Columbus North, Ltd, dba Medco Health Solutions of Dublin (PHY.004530): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative costs.

Medco Health Solutions of Netpark, LLC, dba Medco Health Solutions of Netpark (PHY.004853): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative and investigative costs.

Medco Health Solutions of North Versailles, LLC, dba Medco Health Solutions of North Versailles (PHY.003580): For its failure to obtain a new pharmacy permit when the ownership changed in 2009, and for the continued operation of the pharmacy without its own valid pharmacy permit, the Board assessed a fine of \$20,000 plus administrative costs.

Tiffany Cathleen Luse Upshaw (PST.018936): Board granted request for reinstatement of the previously suspended license, then placed the license on probation for five years, effective November 13, 2014, subject to certain terms enumerated in the consent agreement.

Casey Ann Kendall (PST.017305): Board granted request for probation modification, then removed all probationary terms and restored the license to active and unrestricted status.

Edward John Rabalais (PST.009897): Board granted request for probation modification, then removed all probationary terms and restored the license to active and unrestricted status.

Bobby Trondell Thompson (PST.020854): Board approved application for licensure by reciprocity, then placed the license on probation for five years, effective November 13, 2014, subject to certain terms enumerated in the consent agreement.

Lakyn Hope Manuel (CPT.009959): For her failure to disclose criminal history record information on her most recent renewal application, the Board assessed a fine of \$250 plus administrative costs.

Colin Michael Browder (CPT.010907): For his alleged diversion of CS from his employer pharmacy, the Board revoked the technician certificate, effective October 9, 2014, and further, permanently prohibited the acceptance of any future application for the reinstatement of the certificate, or for any other credential issued by the Board.

Bonnie Irene Sherman (CPT.011152): For her failure to disclose criminal history record information on her most recent renewal application, the Board assessed a fine of \$250 plus administrative costs.

Cassandra Leticia Rochelle Thomas (CPT.006932): For her failure to disclose criminal history record information on her most recent renewal application, the Board assessed a fine of \$250 plus administrative costs.

Nicole Graham Russo (CPT.009361): For her failure to disclose criminal history record information on her most recent renewal application, the Board assessed a fine of \$250 plus administrative costs.

Jennifer Violet Gibson (CPT.010456): Board accepted the voluntary surrender of the credential, resulting in the active suspension of the technician certificate for an indefinite period of time, effective November 5, 2014.

Myrna Lynn Williams (PST.013793): Board accepted the voluntary surrender of the credential, resulting in the active suspension of the license for an indefinite period of time, effective September 2, 2014.

Jerry Samuel Adkins (PST.014585): Board accepted the voluntary surrender of the credential, resulting in the active suspension of the license for an indefinite period of time, effective October 24, 2014.

Sara Lynn Henning (CPT.009568): Board accepted the voluntary surrender of the credential, resulting in the active suspension of the certificate for an indefinite period of time, effective October 30, 2014.

During the same meeting, the Board granted conditional approval for the reinstatement of an expired certificate for one technician, pending satisfaction of certain terms enumerated in his or her consent agreement. The Board also issued a letter of reprimand to one pharmacist. Finally, the Board suspended the controlled dangerous substance licenses for eight physicians whose medical licenses were suspended by the Louisiana State Board of Medical Examiners.

Calendar Notes (15-01-482)

The Board office will be closed on January 19, in observance of Martin Luther King, Jr, Day; February 17, in observance of Mardi Gras Day; and April 3, in observance of Good Friday.

Special Note (15-01-483)

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.