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Louisiana Board of Pharmacy News

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Board Elects Officers for 2016 (16-01-502)

During the November 18, 2015 Louisiana Board of Pharmacy meeting, the Board members conducted their annual election of officers, with the following results:

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

Board Meeting Dates for Calendar Year 2016 (16-01-503)

The Board has announced the following tentative meeting dates for calendar year 2016: February 24-25, May 4-5, August 10-11, and November 16-17. All meetings are planned for the Board office in Baton Rouge, LA.

Board Member Appointments (16-01-504)

Appointments of members to the Board are made in accordance with La. R.S. 37:1175, which provides that whenever a vacancy occurs among the members representing one of the eight pharmacy districts, the pharmacists who are bona fide residents of the district in which the vacancy occurs shall nominate from among their number a representative to the Board. Whenever that vacancy shall occur by reason of an expiring term, the nomination shall be made by mail at least 60 days in advance of the expiration date of the term.

The Board's secretary is responsible for mailing a ballot by United States Postal Service First-Class Mail to each pharmacist holding an active license and residing in the district in which the vacancy will occur at the last known address as indicated in the Board's records. The ballot or another enclosed communication will state the date, time, and place for counting ballots. At a gathering open to the public, the secretary and one or more persons designated by him will open and count the ballots. The secretary will then certify to the governor the names of the three nominees in each district receiving the highest number of votes. For each district in which the vacancy will occur, the governor may appoint one of those three nominees to the Board.

The terms of five current Board members will expire on August 24, 2016. The deadline for any address changes relative to this nomination election is April 29, 2016. The ballots with the necessary information will be mailed to the pharmacists in the respective pharmacy districts on or about May 13, 2016. The deadline for the return of ballots to the Board office will be June 17, 2016. The ballots will be opened and counted at the Board office on June 21, 2016; information about the exact time will be included with the ballot.

Board member terms that will expire on August 24, 2016, and their district information are as follows:

- **Richard M. Indovina, Jr:** River Ridge, LA (District 1, composed of the parishes of Jefferson and St Tammany).
- **Deborah H. Simonson:** New Orleans, LA (District 2, composed of the parishes of Orleans, Plaquemines, and St Bernard).
- **Clovis S. Burch:** Shreveport, LA (District 4, composed of the parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, and Webster).
- **Pamela G. Reed:** Baton Rouge (District 6, composed of the parishes of East Baton Rouge, East Feliciana, Livingston, St Helena, Tangipahoa, Washington, and West Feliciana).
- **Ryan M. Dartez:** Lafayette, LA (District 7, composed of the parishes of Acadia, Calcasieu, Cameron, Jefferson Davis, Lafayette, and Vermilion).

Should any pharmacist need a list of pharmacists in his or her own district for purposes related to this nomination election, the Board office will supply one complimentary list upon receipt of a written request by the pharmacist. The expiration date of pharmacist member six-year terms was fixed by the legislature in 2012; therefore, the expiration date of the new appointees' term will be June 20, 2022.

Retirement of Board Compliance Officer (16-01-505)

Pharmacist Compliance Officer Stephen L. Collins announced his retirement from state service effective

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Discontinue Use of Chen Shwezin Sterile Drug Products, FDA Warns

In October 2015, the United States Food and Drug Administration (FDA) issued a statement alerting health care providers and patients not to use drug products intended to be sterile that were made and distributed by Chen Shwezin, Inc, dba Park Compounding Pharmacy of Westlake Village, CA, because of lack of sterility assurance. Following an FDA inspection during which investigators observed unsanitary conditions, including poor sterile production practices, FDA recommended that Park Compounding Pharmacy cease sterile operations and recall all of its non-expired sterile drug products. However, the company had refused to recall its products, according to an FDA safety alert.

At this time, FDA has not received reports of any adverse events associated with the use of products from Park Compounding Pharmacy. FDA recommends that health care providers check their medical supplies, quarantine any sterile drug products from Park Compounding Pharmacy, and not administer them to patients.

More information is available in the FDA safety alert, available at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm465582.htm.*

Seven Persistent Safety Gaffes in Community/Ambulatory Settings That Need to Be Resolved!

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.*

This is the final article of a three-part series on seven persistent safety gaffes of 2014.

6) Compounded Pain Creams: High Profit Margin and Danger

Some compounding pharmacies have been heavily marketing compounded pain creams directly to consumers via unsolicited calls, suggesting that the creams are more effective and safer than oral or injectable pain medications. Many of the creams contain drugs that can cause central nervous system depression or adverse cardiac effects, and most have not been FDA-approved for use in combination with each other or for topical use. Patients are charged per ingredient, with many creams containing numerous, expensive medications. Toxicity from the creams has been reported to poison control centers, including cases of accidental child exposures and intentional use for multiple family members. Patients are often unaware of the dangers with using the creams, which include unsafe packaging in containers without child-resistant closures. ISMP is specifically concerned about some statements that may be unproven, such as the products' safe use with children. Compounded pain creams need prominent warnings on labels that describe the potential for toxicity, and physicians and pharmacists who prescribe and dispense the creams must provide patients with instructions about possible adverse effects, safe storage, and proper use. ISMP believes regulatory or licensing oversight is necessary.

7) Clear Care: Still Causing Severe Eye Injuries Five Years Later

Since early 2010, ISMP has received scores of reports of painful eye injuries from patients using CLEAR CARE® Cleaning & Disinfecting Solution for contact lenses by Alcon (formerly CIBA VISION), a Novartis company, and similar store-brand products. Hundreds more can be found on Internet listservs. Located on store shelves near other lens disinfectants and solutions, these disinfecting products differ from other commonly used solutions in that they must be used with a special lens case in order to neutralize the 3% hydrogen peroxide component of the solution over at least six hours before putting the lenses back into the eyes. However, many patients have inadvertently used the solution to soak their lenses in a standard lens case, or thought the solution was saline and instilled it directly into their eyes. This has caused severe eye burning, leading many to seek out emergency medical care for corneal burns. In 2012, Alcon made a label enhancement to warn customers to use the special lens case, but the label change has been ineffective. Neither the company nor FDA's Medical Devices division have been persuaded to make effective label improvements before permanent eye injury or blindness occurs. If the labeling and packaging cannot be improved to reduce the harm being reported, perhaps these products should be pulled from the market or available only behind the pharmacy counter.

Risk of Dose Confusion and Medication Errors With Avycaz, FDA Cautions

Confusion about the drug strength displayed on the vial and carton labels has led to some dosing errors with the intravenous antibacterial drug Avycaz™ (ceftazidime and avibactam), warned FDA in September 2015. The agency explained that Avycaz was initially approved with the vial and carton labels displaying the individual strengths of the two active ingredients (2 g/0.5 g); however, the product is dosed based on the sum of the active ingredients (2.5 g). To prevent medication errors, FDA revised the labels to indicate that each

vial contains Avycaz 2.5 g, equivalent to ceftazidime 2 g and avibactam 0.5 g, according to an FDA safety alert.

As of September 2015, FDA had received reports of three medication error cases related to confusion on how the strength was displayed on the Avycaz vial and carton labels. Two cases stated that the errors occurred during preparation of the dose in the pharmacy. The third case described concern about the potential for confusion because the strength displayed for Avycaz differs from how the strength is displayed for other beta-lactam/beta-lactamase drugs. Based on the information provided in the reports, FDA is aware that at least one of the patients received a higher-than-intended dose of Avycaz. As of September 2015, no adverse events were reported.

More details are included in the FDA safety alert, available at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm463595.htm.*

US Compounding, Inc, Recalls All Lots of Sterile Compounded Products

In September 2015, US Compounding, Inc, of Conway, AR, issued a voluntary recall of all lots of sterile products aseptically compounded and packaged by the company, and that remain within expiry, because of a lack of sterility assurance. The affected sterile products were distributed nationwide to patients, providers, hospitals, and clinics between March 14, 2015, and September 9, 2015. The recall does not apply to any nonsterile compounded medications prepared by US Compounding. Providers are advised to discontinue use of the products, quarantine any unused product, and contact US Compounding to arrange the return of any unused sterile compounded products using the information provided in the FDA press release, available at *www.fda.gov/Safety/Recalls/ucm464071.htm.*

The company issued this recall out of an abundance of caution. Providers who have dispensed any sterile product distributed by US Compounding should contact patients to whom product was dispensed and notify them of this recall. A list of all sterile compounded products that have been recalled is provided on FDA's website at *www.fda.gov/Safety/Recalls/ucm464072.htm.*

FDA Investigates the Risks of Using Pain Medicine Tramadol in Young Patients

As of September 2015, FDA is investigating the use of the pain medicine tramadol in young patients because of the rare but serious risk of slowed or difficult breathing. This risk may be increased in patients treated with tramadol for pain after surgery to remove their tonsils and/or adenoids. Tramadol is not FDA-approved for use in patients aged 17 years or younger; however, data show it is being used "off-label" in the pediatric population, according to the safety alert on FDA's website, available at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm463499.htm.*

FDA is evaluating all available information and will communicate final conclusions and recommendations to the public when the review is complete. Health care providers are encouraged to report adverse events or side effects related to the use of these products to FDA's MedWatch Safety Information and Adverse Event Reporting Program.

Decreased Potency Reported in Drugs Stored in Becton-Dickinson Syringes

In September 2015, FDA expanded its alert regarding compounded or repackaged drugs stored in Becton-Dickinson (BD) general use syringes to include certain additional syringe sizes including 1 mL, 10 mL, 20 mL, and 30 mL BD syringes, and BD oral syringes. FDA's original alert applied to compounded or repackaged drugs that have been stored in 3 mL and 5 mL BD syringes. The agency expanded the alert based on BD reports that an interaction with the rubber stopper in certain lots of these syringes can cause some drugs stored in these syringes to lose potency if filled and not used immediately. BD reports that the following drugs in particular can be affected by the stoppers, but it does not know whether other drugs can be affected: fentanyl, rocuronium, neostigmine, morphine, midazolam, methadone, atropine, hydromorphone, cisatracurium, and remifentanil. This safety alert does not pertain to BD prefilled, prefillable, heparin flush, saline flush, or insulin syringes, indicates BD in an alert notice. Further, BD's alert notice also has a search tool to assist customers in determining if their lots are affected. FDA advises hospital pharmacies and staff to contact any outsourcers to determine if affected lots of BD syringes were used for compounded or repackaged products. Hospital pharmacies and staff should not administer compounded or repackaged drugs that have been stored in any of these syringes unless there is no suitable alternative available. Adverse reactions may be reported to FDA's MedWatch Safety Information and Adverse Event Reporting program.

More details are included in the FDA Safety Alert, available at *www.fda.gov/Drugs/DrugSafety/ucm458952.htm.*

MediStat Pharmacy Issues Recall of Sterile Drug Products

MediStat Pharmacy, a 503B outsourcing facility in Foley, AL, has initiated a national recall of all sterile injectable products distributed between November 1, 2014, and September 3, 2015. The recall is based on the identification of various pathogens within the compounding environment. Health care providers should check their medical supplies, quarantine any drug products marketed as sterile from MediStat, and not administer them to patients. FDA has received reports of several adverse events that are potentially associated with the drug products made by MediStat. MediStat voluntarily ceased sterile compounding operations in September 2015. FDA asks health care providers and patients to report adverse reactions or quality problems experienced with the use of these products to the FDA's MedWatch Adverse Event Reporting program.

More details are included in an FDA press release, available at *www.fda.gov/Safety/Recalls/ucm461939.htm.*

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November 15, 2015. Mr Collins joined the Board staff in 1998, and since that time, he managed the territory extending from Baton Rouge east to Mississippi and from the north shore of Lake Pontchartrain north to Mississippi. He inspected pharmacies and other health care facilities for compliance with the laws and rules governing pharmacy practice, providing guidance for pharmacists and other health care providers for over 15 years. The Board appreciates his long service to the Board and wishes him well in his future endeavors.

The Board mailed a letter to every pharmacist licensed by the Board informing them of the process and timeline for hiring a new pharmacist compliance officer. The Board hopes to place the new compliance officer in service to the Board no later than March 1, 2016.

Do You Know Who Picked Up That Prescription? (16-01-506)

The Board office continues to receive complaints from law enforcement agencies about pharmacies that release prescriptions for controlled substances (CS) to the wrong persons and then cannot identify the persons who picked up the prescriptions. As a gentle reminder, providing a CS to a person without a prescription is the definition of illegal distribution of CS, a violation of the CS law in this state. Violators are subject to arrest and prosecution, and the penalty upon conviction involves money and jail time, the amount of which depends on the schedule of the CS that was distributed. The law enforcement agencies have asked whether they should arrest and prosecute the pharmacy personnel who distribute CS to the wrong persons or whether they should ask the legislature to impose more stringent controls on all pharmacies dispensing CS prescriptions.

How easy would it be to scam your pharmacy? How carefully do you check persons picking up prescriptions for CS? When your patient is unable to personally pick up his or her prescription, has your patient given you permission to release his or her prescription to someone else? How do all of your colleagues in your pharmacy know that permission exists? And when the mistake does happen, can you identify the person who actually picked up the prescription? Do your pharmacy records document your proper dispensing of CS – or will they end up as evidence in your trial for the illegal distribution of CS? If your pharmacy is unable to determine to whom it releases CS medications, should the Board reconsider whether or not your pharmacy permit is being operated in the best interest of the public's health, safety, and welfare?

Status Report on Rulemaking Activities (16-01-507)

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

- *Regulatory Project 2015-4 ~ Compounding for Office Use for Veterinarians*. During the Board's November 18, 2015 meeting, the Board evaluated the comments and testimony offered during the August 26, 2015 public hearing on this proposal. The members determined that although there appears to be clear authority for compounding veterinary products pursuant to the receipt of patient-specific prescriptions, there does not appear to be clear authority for compounding veterinary products for office use by veterinarians. Since the proposed revision to the rule enables compounding for office use for veterinarians, the members determined the rule should contain language warning that pharmacies opting to practice under that rule should do so with the awareness that such practice may be a violation of federal laws and rules, and that no immunity would be available through the Board's rules. The Board referred the proposed rule back to the Board's Regulation Revision Committee for consideration of the development of such a disclaimer, or in the alternative, remove the authority for compounding for office use for veterinarians until there is clear federal authority for such practice. In the interim, the Board directed staff to republish the current emergency rule, which allows the compounding for office use for veterinarians, but only to certain limits as described in the rule.
- *Regulatory Project 2015-9 ~ Accreditation of Pharmacy Technician Training Programs*. In June 2013, the Board amended its rules for pharmacy technicians to require the completion of a nationally accredited pharmacy technician training program as one of the qualifications to obtain a pharmacy technician certificate, and further, delayed the implementation of that requirement until January 1, 2016, in order to give interested stakeholders time to achieve national accreditation. During its November 18, 2015 meeting, several chain pharmacies petitioned the Board to delay the implementation of that requirement until 2020 because of their concern with some of the standards required for national accreditation. They also requested that when implemented, the requirement be applied to the application for the pharmacy technician candidate registration instead of the application for the pharmacy technician certificate. The Board referred the request to move the requirement from the pharmacy technician certificate to the pharmacy technician candidate registration to the Board's Regulation Revision Committee for consideration of the development of language to accomplish that change. Since the implementation date of the current rule was only a few weeks later, the Board determined an emergency rule was necessary to delay the implementation of the accreditation requirement to give the Board time to complete the rulemaking process. The Board adopted an emergency rule that changed the provisions of §905.A.3.b such that the implementation date of the accreditation requirement was changed to January 1, 2017, and further, directed staff to republish that emergency rule as necessary until the rule revision was completed.

Disciplinary Actions (16-01-508)

During its August 2015 meeting, the Board took final action in the following matters.

Kelly Brocato Suttles (CPT.004783): *Formal Hearing* – For her admission to the diversion of hydrocodone tablets from her employer pharmacy, the Board revoked the certificate, and further, assessed a fine of $1,000 plus administrative, investigative, and hearing costs, and further, conditioned the acceptance of any future application for the reinstatement of the certificate or any other credential issued by the Board upon the satisfaction of certain requirements identified in the hearing order.

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Chasity Danae Maddie (CPT.008217): *Formal Hearing* – For her admission to the diversion of promethazine/codeine syrup from her employer pharmacy, the Board revoked the certificate, and further, assessed a fine of $1,000 plus administrative, investigative, and hearing costs, and further, conditioned the acceptance of any future application for the reinstatement of the certificate or any other credential issued by the Board upon the satisfaction of certain requirements identified in the hearing order.

Christopher Captain Turnage (CPT.012350): *Formal Hearing* – For his failure to provide information to the Board relative to his March 2015 arrest, the Board revoked his certificate, and further, assessed a fine of $1,000 plus administrative, investigative, and hearing costs, and further, conditioned the acceptance of any future application for the reinstatement of the certificate or any other credential issued by the Board upon the satisfaction of certain requirements identified in the hearing order.

Porsha Carnesha Aldredge (PTC.022305): *Formal Hearing* – For her failure to provide information to the Board relative to her February 2015 arrest, the Board revoked her registration, and further, assessed a fine of $1,000 plus administrative, investigative, and hearing costs, and further, conditioned the acceptance of any future application for the reinstatement of the registration or any other credential issued by the Board upon the satisfaction of certain requirements identified in the hearing order.

Christy Le'Ann Bourque (PTC.021055): *Formal Hearing* – For her admission to the diversion of hydrocodone tablets from her employer pharmacy, the Board revoked the certificate, and further, assessed a fine of $1,000 plus administrative, investigative, and hearing costs, and further, conditioned the acceptance of any future application for the reinstatement of the registration or any other credential issued by the Board upon the satisfaction of certain requirements identified in the hearing order.

During its November 2015 meeting, the Board took final action in the following matters.

Larry Wade (PTC.023402): For his failure to disclose his entire criminal history on his application for a new pharmacy technician candidate registration, the Board authorized the issuance of the registration, suspended it for 18 months and stayed the execution of the suspension, then placed the newly issued registration on probation for 18 months, effective November 18, 2015, subject to certain terms enumerated in the consent agreement.

LaTashua Yvette Mitchell (PTC.023403): In consideration of the prior criminal history disclosed on her application for a new pharmacy technician registration, the Board authorized the issuance of the registration, suspended it for 18 months and stayed the execution of the suspension, then placed the newly issued registration on probation for 18 months, effective November 18, 2015, subject to certain terms enumerated in the consent agreement.

Kollam, Inc, dba Safe Pharmacy (PHY.006997): For its dispensing of nine prescriptions into Louisiana during the seven months preceding its acquisition of a permit to do so, and for responding in the negative when specifically asked about such activity on its application for the permit, and for its failure to report all eligible prescription transactions to the state prescription monitoring program (PMP), and for its continued operation of the permit without a current Louisiana-licensed pharmacist-in-charge (PIC), the Board assessed a fine of $35,000 plus administrative and investigative costs.

Brandon Kyle Hendrickson (PST.020622): As the PIC of Kollam, Inc, dba Safe Pharmacy, he was held accountable for the operation of the permit in violation of the laws and rules by dispensing prescriptions into the state without a permit, for failure to report transactions to the PMP, and for not timely renewing his pharmacist license, resulting in the operation of the permit without a currently licensed PIC. The Board assessed a fine of $5,000 plus administrative costs.

Park Irmat Drug Co, Inc, dba Irmat Pharmacy (PHY.007007): For its dispensing of 194 prescriptions into Louisiana during the two years preceding its acquisition of a permit to do so, and for responding in the negative when specifically asked about such activity on its application for the permit, the Board assessed a fine of $30,000 plus administrative and investigative costs.

Majeste's St Claude Pharmacy, Inc, dba St Claude Pharmacy (PHY.005760): For its shortage of CS during an audit of the one-year period from May 6, 2013, to May 1, 2014: (1) 145,142 tablets of hydrocodone, (2) 117,030 tablets of carisoprodol, (3) 19,606 tablets of alprazolam, (4) 19,212 mL of promethazine/codeine syrup, and (5) 2,843 tablets of phentermine, the Board revoked the permit, and further, permanently prohibited the acceptance of any future application for the reinstatement of the permit.

Gregory Jon Wendling (PST.013246): As the owner of Majeste's St Claude Pharmacy, Inc, dba St Claude Pharmacy, he was held accountable for the shortage of CS identified above. The Board suspended his license for one year and stayed the execution of the suspension, then placed his license on probation for one year, effective November 18, 2015, subject to certain terms enumerated in the consent agreement; and further, assessed a fine of $25,000 plus administrative and investigative costs; and further, issued two lifetime restrictions: (1) shall not hold any ownership interest in any pharmacy licensed by the Board, and (2) shall not hold a PIC position at any pharmacy licensed by the Board.

William Paul Collins (PST.013528): As the PIC of Majeste's St Claude Pharmacy, Inc, dba St Claude Pharmacy, he was held accountable for the shortage of CS described above. The Board assessed a fine of $5,000 plus administrative costs, and further, suspended his PIC privilege for an indefinite period of time, effective November 18, 2015.

Ashley Nicole Rausin (CPT.011112): For her admission to the diversion of SUBOXONE® and phentermine from her employer pharmacy, the Board revoked her certificate, and further, permanently prohibited the acceptance of any future application for the reinstatement of the certificate or any other credential issued by the Board.

Northside Pharmacy, LLC, dba Global Pharmacy (PHY.007110): For its dispensing of 229 prescriptions into Louisiana during the 11 months prior to its acquisition of a permit to do so, and for responding in the negative when specifically asked about such activity on its application

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for the permit, the Board assessed a fine of $50,000 plus administrative and investigative costs.

Walgreen Louisiana Co, Inc, dba Walgreen Pharmacy No. 07197 (PHY.004999): For its negligence in allowing a person to practice with an expired pharmacy technician candidate registration in its pharmacy for approximately one month, the Board assessed a fine of $10,000 plus administrative and investigative costs.

Louisiana CVS Pharmacy, LLC, dba CVS Pharmacy No. 5296 (PHY.005851): For its failure to notify the Board of a change in its PIC for approximately six weeks, the Board assessed a fine of $50,000 plus administrative and investigative costs.

Charles Paul Guidry (PST.020067): The Board accepted the voluntary surrender of the credential, resulting in the active suspension of the license for an indefinite period of time, effective November 3, 2015.

Kelly Ann Smith (CPT.012498): The Board accepted the voluntary surrender of the credential, resulting in the active suspension of the certificate for an indefinite period of time, effective October 5, 2015.

Andrea Katherine Bourque (PST.019587): The Board accepted the voluntary surrender of the credential, resulting in the active suspension of the license for an indefinite period of time, effective October 13, 2015.

Hoa Thi Pham (PNT.046513): The Board granted her request for the reinstatement of the previously suspended registration, conditioned upon certain requirements, then converted the duration of the suspensive period from an indefinite term to a term of five years and stayed the execution of the suspension, then placed the newly reinstated registration on probation for five years, effective November 18, 2015, subject to certain terms enumerated in the consent agreement.

Benji Joseph Juneau (PST.016348): The Board granted his request for early termination of the probationary period scheduled to conclude on November 16, 2021, and further, restored his license to active and unrestricted status.

Clay Devoe Jones (PST.015687): The Board granted his request for early termination of the probationary period scheduled to conclude on February 21, 2018, and further, restored his license to active and unrestricted status.

Amy Rebecca Douglass (PST.021377): In consideration of the information supplied on her application for a new pharmacist license, the Board authorized the issuance of the license, then immediately suspended the license for 12 years, five months, and 27 days and stayed the execution of the suspension, then placed the newly issued license on probation for a period of time ending May 15, 2028, subject to certain terms enumerated in the consent agreement.

Stephen Leonard Collins (PST.011311): The Board suspended the license for five years and stayed the execution of the suspension, then placed the license on probation for five years, effective November 18, 2015, subject to certain terms enumerated in the consent agreement.

Physician Choice Pharmacy, LLC, dba Physician Choice Pharmacy (PHY.006739): For its dispensing of two prescriptions into Louisiana during the time its permit was expired, the Board authorized the reinstatement of the permit conditioned upon its satisfaction of the fine and costs assessed: $15,000 plus administrative and investigative costs.

Shantelle Dionne Payton (CPT.010037): The Board granted her request for the reinstatement of the previously suspended certificate, converted the duration of the suspensive period from an indefinite term to a term of three years and stayed the execution of the suspension, then placed the certificate on probation for three years, effective November 18, 2015, subject to certain terms enumerated in the consent agreement.

Jennifer LaCole Farmer (CPT.008812): The Board granted her request for the reinstatement of the previously suspended certificate, converted the duration of the suspensive period from an indefinite term to a term of three years and stayed the execution of the suspension, then placed the certificate on probation for three years, effective November 18, 2015, subject to certain terms enumerated in the consent agreement.

During the same meeting, the Board issued letters of reprimand to one pharmacy permit, four pharmacists, and 10 pharmacy technicians; and further, granted a request from one pharmacist for the modification of previously imposed probationary terms; and further, suspended the controlled dangerous substance license for one physician and one advanced nurse practitioner, both of whom had voluntarily surrendered their professional licenses, as well as one dentist who had surrendered his federal Drug Enforcement Administration registration.

Calendar Notes (16-01-509)

The Board office will be closed on January 11, in observance of Governor's Inauguration Day; January 18, for Martin Luther King, Jr Day; February 9, for Mardi Gras Day; and March 25, for Good Friday.

Special Note (16-01-510)

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. Electronic copies dating back to 2000 are posted on the Board's website.

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