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Louisiana Board of Pharmacy News

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Drugs of Concern in the Prescription Monitoring Program (10-07-349)

When the 2006 Louisiana Legislature enacted the Prescription Monitoring Program Act, the law directed dispensers of controlled substances and drugs of concern to report their eligible transactions to the program's database for inquiry and analysis by prescribers and dispensers. When the Louisiana Board of Pharmacy implemented the program in 2009, the Board began with the collection of information for controlled substances in Schedules II through V. The Board is prepared now to add drugs of concern – defined by law to mean drugs other than controlled substances that demonstrate a potential for abuse – to the database. The Board has concluded the required rulemaking process to formally identify drugs of concern, and they include any material, compound, mixture, or preparation containing any quantity of the following substances, including its salts, esters, ethers, isomers, and salts of isomers (whenever the existence of such salts, esters, ethers, isomers, and salts of isomers are possible within the specific chemical designation): **(1) butalbital when in combination with at least 325 milligrams of acetaminophen per dosage unit**, **and (2) tramadol.**

Although the final rule was published in the April 20, 2010 edition of the *Louisiana Register*, the Board has delayed the effective date of the new rule to September 1, 2010. This delay is provided to give pharmacies and other prescribing dispensers additional time to make the necessary adjustments to their dispensing software or other information system components so as to enable the inclusion of drugs of concern in their reports to the monitoring program's database. In the event the pharmacy or other prescribing dispenser is able to include the information for drugs of concern prior to the effective date, they may do so. All pharmacies and prescribing dispensers shall begin reporting their eligible transactions of drugs of concern to the program's database no later than September 1, 2010.

New Rules (10-07-350)

In addition to the new rule for drugs of concern noted above, the Board has published three new final rules in the April 20, 2010 edition of the *Louisiana Register*, all of which became effective that same day.

- A new *§709 – Scope of Practice* was added to *Chapter 7 – Pharmacy Interns*. In addition to describing allowed and prohibited practices of pharmacy interns, the new rule also defines an acceptable staffing ratio for interns in pharmacies. In particular, where a pharmacy has partnered with a college of pharmacy's professional experience program, one pharmacist on duty may supervise no more than three interns participating in that rotation site. Where an intern is not participating in a rotation site, one pharmacist on duty may supervise no more than one intern. These ratios are separate and apart from the staffing ratios applicable to pharmacy technicians and pharmacy technician candidates.
- A new *Paragraph E – Digital Imaging of Prescriptions* was added to *§1123 – Records* in *Chapter 11 – Pharmacies*. Applicable to hard copy prescription forms presented to the pharmacy, the new rule permits a pharmacy to utilize digital imaging technology, provided the technology is capable of capturing, storing, and reproducing the exact image of the prescription, including the reverse side of the prescription form. Further, pharmacies utilizing that technology are permitted to store the hard copy prescription forms in a "date scanned" sequence instead of the "numerical" sequence required by Board rules.
- A new *Paragraph B – Pharmacies Using Common Electronic Files* was added to *§2523 – Transfer of Prescription Information* in *Chapter 25 – Prescriptions, Drugs, and Devices*. The new rule provides that pharmacies using a common electronic file shall no longer be required to physically or electronically transfer prescriptions for information dispensing purposes between or among those pharmacies; however, the common file shall contain complete information as to each pharmacy dispensing each refill. Further, the rule requires that a hard copy of each prescription transferred shall be generated and maintained at the pharmacy refilling the prescription.

Are You Selling or Buying a Pharmacy? (10-07-351)

The Louisiana Pharmacy Practice Act provides that a pharmacy permit is not transferable from one owner to

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FDA Updates 'Medicines in My Home' Patient Education Resources

Food and Drug Administration (FDA) has updated the Medicines in My Home (MIMH) section of the agency's Web site with new resources and materials for patients. MIMH resources teach patients from adolescence through adulthood how to choose over-the-counter (OTC) medicines and how to use them safely. An interactive video teaches users how to understand the drug facts label and make sound medicine decisions. Downloadable documents provide information on caffeine use, choosing appropriate OTC medications, and other related topics. The MIMH Web page can be accessed at *www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm092139.htm.*

DEA Releases e-Prescription for Controlled Substances Interim Final Rule

The Drug Enforcement Administration (DEA) Interim Final Rule on electronic prescriptions for controlled substances was published in the *Federal Register* on March 31, 2010, and was scheduled to go into effect June 1, 2010, subject to Congressional review. The regulations would allow prescribers the option to write prescriptions for controlled substances electronically, and allow pharmacies to receive, dispense, and archive these electronic prescriptions. The regulations are an addition to existing rules, and include stipulations to ensure that a closed system of controls on controlled substances dispensing is maintained. The regulations have the potential to reduce prescription forgery and reduce the number of prescription errors, and should also reduce paperwork and help integrate prescription records into other medical records.

Confirmation Bias

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. *ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also a FDA MedWatch partner. Call 1-800-FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at* www.ismp.org. *ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.*

Although pharmaceutical companies and regulatory agencies have been working on design changes to improve the situation, ISMP still associates many medication errors with confusion over "look-alike" or "sound-alike" product names. Since patients receive the wrong drug, these sometimes result in serious harm. A common cause of name mix-ups is what human factors experts call "confirmation bias." Confirmation bias refers to a type of selective thinking whereby individuals select what is familiar to them or what they expect to see, rather than what is actually there.

Many errors often occur when pharmacists or technicians, due to familiarity with certain products, see the name of the product they think it is rather than what it actually is. For instance, if a pharmacist reads a poorly written drug name, he or she is most likely to see a name that is most familiar to him or her, overlooking any disconfirming evidence. Another example of this is if a pharmacy technician chooses a medication container based on a mental picture of the item, whether it is a characteristic of the drug label, the shape, size, or color of the container, or the location of the item on a shelf.

Although various compilations of look-alike name pairs are available for posting (see *www.ismp.org/Tools/confuseddrugnames.pdf* for ISMP's List of Confused Drug names, which has recently been updated), these lists have only limited usefulness since it is impossible for practitioners to memorize them in order to know when to check on questionable prescriptions. Also, when confirmation bias occurs, there is never a reason for the practitioner to question the order to begin with.

In many cases, hospital or pharmacy computer systems can be used to reduce the risk of confirmation bias and resulting name mix-ups. Many systems have a "formulary note" field that can be easily adapted to display important information prominently on the computer screen. Similar to a road sign warning about a dangerous intersection ahead, this feature can be used to alert the person inputting the medication when a look-alike or sound-alike danger is present. For example, when Norvasc® is entered into the computer, a formulary note screen appears, alerting the pharmacist that Norvasc often looks like Navane® when handwritten. The pharmacist will then take the necessary steps to confirm the prescription if necessary.

In addition, physically separating drugs with look-alike labels and packaging helps to reduce this confirmation bias as does implementing bar-coding technology for the verification process of drug selection. Employing a simple system that compares computer-generated National Drug Codes (NDC) on prescription labels and NDC codes on manufacturers' containers to verify that the appropriate drug has been selected and dispensed also helps reduce confirmation bias.

It is human nature for people to associate items by certain characteristics. It is very important for the health care community and regulators to recognize the role that confirmation bias may play in medication errors and to work together to address associated problems.

FDA-TRACK Provides Public Access to Agency's Performance Data

The new FDA-TRACK will provide access to updated information about FDA programs, projects, and core responsibilities. The system is part of the FDA transparency initiative and its objectives are represented in the TRACK name which stands for transparency, results, accountability, credibility, and knowledge-sharing. This agency-wide system will track performance measurement data reported from over 100 FDA program offices. Common measures, key center director measures, program measures, and key projects are the measurement areas currently in use, and more information about these areas is available in the FDA-TRACK announcement available at *www.fda.gov/AboutFDA/WhatWeDo/track/default.htm*. FDA-TRACK will continue to be updated and the latest information can be found on the following Web pages: Cross-Agency FDA-TRACK Program Areas available at *www.fda.gov/AboutFDA/WhatWeDo/track/ucm206441.htm*, Center FDA-TRACK Program Areas available at *www.fda.gov/*

AboutFDA/WhatWeDo/track/ucm195008.htm, and Dashboards available at *www.fda.gov/AboutFDA/WhatWeDo/track/ucm195011.htm*. Public feedback on FDA-Track and its measures can be submitted by e-mail to FDATRACK@fda.hhs.gov.

Survey Suggests Majority of Patients Seek Pharmacist Advice About OTC Medications

When selecting OTC medications, 82% of pharmacy customers base their decision on a pharmacist's recommendation, according to a survey of over 1,000 pharmacists conducted by the American Pharmacists Association (APhA). Survey results also indicate which products, among 76 categories presented to pharmacists, are most often recommended. The survey results are published in the Pharmacy Today Over-the-Counter Supplement available at *www.imirus.com/tmp/2536/2501/1001/pm2536.pdf*. An APhA news release, available at *www.pharmacist.com/AM/Template.cfm?Section=News_Releases2&Template=/CM/ContentDisplay.cfm&ContentID=23117*, indicates that 90% of patients seek help identifying the most appropriate product and 80% seek counsel regarding using an OTC product with their prescription medications.

California PMP Data Shows Frequency of Doctor Shopping

Early data collected from California's prescription monitoring program (PMP), the Controlled Substances Utilization Review and Evaluation System (CURES), correlates the frequency of patient "doctor shopping," or obtaining multiple prescriptions from various providers, with the number of prescriptions patients receive for additional controlled substances, as reported in *Medical News Today*. The research analysis, presented at the American Academy of Pain Medicine 26th Annual Meeting, showed that patients prescribed a single additional class of a controlled substance, such as benzodiazepines, had a two-fold likelihood of doctor shopping for multiple opioid prescriptions. A 13-fold increase in doctor shopping was seen when more than one additional drug class was involved. Researchers at the University of California, Davis, conducted the analysis using de-identified CURES data, and also found that patients involved in doctor shopping were involved in more than one episode about 50% of the time.

Highest Dose of Zocor Increases Risk of Muscle Injury, FDA Warns

FDA has informed health care practitioners that there is an increased risk of muscle injury in patients taking the highest approved dose of the cholesterol-lowering medication, Zocor® (simvastatin) 80 mg. This information is based on review of data from a large clinical trial and other sources, and FDA is currently reviewing additional data to better understand the relationship between high-dose simvastatin use and muscle injury. More information is included in an FDA Drug Safety Communication at *www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm204882.htm*.

New OxyContin Formulation to Help Prevent Abuse of the Drug

FDA has approved a new formulation of the controlled-release drug OxyContin® which is designed to decrease the likelihood that this medication will be misused or abused, and result in overdose. FDA explains that the new formulation adds in new tamper-resistant features aimed at preserving the controlled release of the active ingredient, oxycodone. The old formulation allowed tampering with the tablet, via cutting, chewing, breaking, or dissolving, which resulted in dangerously high levels of oxycodone being released at once. In accordance with FDA requirements, Purdue Pharma L.P. will conduct a post-marketing study to determine the impact of the new formulation, and the manufacturers will follow a Risk Evaluation and Mitigation Strategy (REMS) for this product. The REMS will include the issuance of a Medication Guide to all patients who use the product. More information is provided on the FDA OxyContin Question and Answer Web page at *www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm207196.htm*.

Use of e-Prescribing Grows Dramatically

The number of electronic prescriptions increased 181% from 2008 to 2009, according to the 2009 National Progress Report on E-Prescribing, published by Surescripts, operator of the largest e-prescription network that connects prescribers' e-prescribing software to pharmacies. Over 190 million e-prescriptions were routed in 2009, compared with 68 million in 2008, and 29 million in 2007. Correlating with those increases, 156,000 prescribers were using e-prescriptions by the end of 2009 compared with 74,000 at the end of 2008, a 109% increase. The report also indicates that 85% of community pharmacies in the United States are connected and able to receive e-prescriptions from prescribers.

Study Shows e-Prescribing Reduces Prescriber Errors

Prescribers using e-prescribing were seven times less likely to make errors than those writing their prescriptions by hand, according to a new study published in the *Journal of General Internal Medicine*. The study, conducted by researchers at Weill Cornell Medical College, focused on 12 community practices and compared the prescriptions of 15 providers using e-prescribing and 15 providers writing prescriptions by hand. The researchers found that two in five handwritten prescriptions contained errors such as incomplete directions, prescribing a medication but omitting the quantity, and prescribing incorrect dosages. Further, comparing handwritten prescriptions and e-prescriptions one year from the start of the study, researchers found that errors dropped from 42.5 % to 6.6% for the providers using e-prescriptions. Errors associated with the handwritten prescriptions in the study increased from 37.3% to 38.4% a Weill Cornell Medical College press release providing more information about the study is available at *http://weill.cornell.edu/news/releases/wcmc/wcmc_2010/02_26_10.shtml*.

Counterfeit Drug Investigation Leads to Two Arrests

Two individuals have been arrested and face charges related to illegally importing counterfeit weight-loss medication. FDA issued a series of alerts, from 2008 to 2010, about tainted weight-loss pills and counterfeit drugs, and an undercover investigation identified one of the defendants as the alleged trafficker of these tainted and counterfeit drugs. This investigation was a joint effort by FDA Office of Criminal Investigations, US Immigration and Customs Enforcement, and US Postal Inspection Service. More information about the investigation and arrests is available in a US Attorney's Office Press Release at *www.fda.gov/ICECI/CriminalInvestigations/ucm206314.htm*.

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another. You can sell a company, its building, its drugs, and its files, but you cannot sell the permit. You can buy a company, its building, its drugs, and its files, but you cannot buy the permit. The seller shall return his or her permit to the Board, and the buyer shall apply for his or her own permit.

In the event the owner of a pharmacy sells the assets to a buyer and fails to return his or her permit, and then the buyer does not obtain a new permit, then the seller remains responsible to the Board for all of the actions of the permit until it is returned to the Board; further, the new owner would be responsible for operating a pharmacy without a permit.

Medication Disposal Programs (10-07-352)

During its May 5, 2010 meeting, the Board approved guidelines for medication disposal programs in Louisiana. Federal rules prohibit the transfer of previously dispensed controlled substances to any person for whom the product was not prescribed. Board rules prohibit a pharmacy from accepting a previously dispensed prescription drug product for return, exchange, or redispensing once the product has been removed from the pharmacy. With these two restrictions in mind, the Board encourages pharmacists to include information on appropriate disposal methods for unwanted or unused medication during their patient counseling sessions. For those pharmacies electing to participate in formal medication programs, the Board offers the following information.

- *Community Based Medication Disposal Program* – This is a pre-announced event where patients deposit unwanted and unused medications at a pre-designated time at a pre-designated location that has pharmacy and law enforcement supervision. The planner must secure advance approval from the United States Drug Enforcement Administration for the law enforcement officer to accept any controlled substances that may be deposited. The event requires at least one law enforcement officer and at least one pharmacist at the location for the duration of the event. Finally, the pharmacist must have an arrangement with a reverse distributor, or in the alternative, licensed transport of medications to an incineration facility for high temperature destruction.
- *Pharmacy Based Medication Disposal Program* – For as long as the pharmacy elects to participate, the pharmacy may allow patients to deposit unwanted and unused medications in special deposit receptacles. This program requires a pharmacist to screen all deposits – at the time of deposit – to ensure no controlled substances are included in the deposits; with pharmacist screening, no law enforcement agency participation is necessary. The pharmacist must have an arrangement with a reverse distributor, or in the alternative, licensed transport of medications to an incineration facility for high temperature destruction.

New Web Site (10-07-353)

In an effort to improve our ability to communicate information in a timely manner and at reduced cost, the Board staff has been working to publish a new Web site, at a new Web address. We hope to launch the new site by August 1, at our new address, *www.pharmacy.la.gov.* We will post an automatic re-director at our current site address for as long as we maintain that site.

We encourage you to visit our new site and we welcome your comments and suggestions for improvement.

Disciplinary Actions (10-07-354)

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

During its May 5-6, 2010 meeting, the Board took final action in the following matters.

Krystal Renee Domingue (PTC Applicant): Board denied the application and refused to issue the registration.

Anthony Charles Mason (PTC Applicant): Board denied the application and refused to issue the registration.

Edward John Rabalais (PST.009897): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective March 3, 2010.

Michael Thomas Savario (PST.016568): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective March 9, 2010.

Edward John Rabalais (PST.009897): Consent Order. Granted request for reinstatement of the previously suspended license, suspended it for 10 years and stayed the execution thereof, and then placed it on probation for 10 years, beginning May 5, 2010, subject to certain terms as enumerated in the order.

Troy Renard Guilbeaux (PST.017854): Consent Order. Granted request for reinstatement of the previously suspended license, suspended it for five years and stayed the execution thereof, and then placed it on probation for five years, beginning May 5, 2010, subject to certain terms as enumerated in the order.

Jason Conrad Dove (PST.015811): Denied request for reinstatement of the suspended license.

Patricia Babin Hogan (CPT.001158): Consent Order. Granted request for reinstatement of the previously suspended certificate, conditioned its issuance upon the satisfaction of certain requirements identified in the order, and then once reinstated, ordered the suspension of the certificate for five years and stayed the execution thereof, and then ordered the certificate to be placed on probation for five years, beginning on the date of reinstatement, subject to certain terms as enumerated in the order.

Charles Scott Weatherford (PST.015275): Consent Order. Granted request for modification of probationary terms to allow him to accept appointment as pharmacist-in-charge of any pharmacy, with all other terms remaining in force for the balance of probation, which terminates November 6, 2010.

LHC Group Pharmaceutical Services (PHY.005205): Consent Order. Permit owner assessed a fine of $2,500 plus costs for improper transfer of controlled substances on behalf of several regional hospitals.

David Wayne Nagem (PST.013223): Consent Order. Suspended license for five years, beginning March 31, 2010, and assessed a fine of $5,000 plus costs, and further, prohibited the acceptance of any application for reinstatement until

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July 1, 2010, for dispensing over 180 refill prescriptions for one patient over 22 months, all without prescriber authorization.

Angela Lindsey Hill (PST.013099): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective March 3, 2010.

Angela Ortego Miller (PST.015749): Consent Order. Issued letter of reprimand and assessed costs for allowing unlicensed personnel to perform professional functions in a prescription department while serving as the pharmacist-in-charge of Begneaud's Pharmacy.

James Robert Lang (PST.010884): Consent Order. Revoked previously imposed probation, suspended license for 10 years and stayed the execution thereof, and then placed it on probation for 10 years, beginning March 31, 2010, and further, assessed a fine of $10,000 plus costs for violation of probationary terms – failure to remove expired drugs, dispensing controlled substances pursuant to written prescriptions bearing invalid electronic signatures, and failure to maintain proper staffing ratios for technicians and pharmacists, all while serving as pharmacist-in-charge of Many Professional Pharmacy.

Thompson's Family Pharmacy (PHY.001388): Consent Order. Suspended permit for five years and stayed the execution thereof, and then placed it on probation for five years, beginning March 31, 2010, and further, assessed a fine of $2,500 plus costs for failure to segregate expired drugs from current stock, failure to indicate date received on all invoices for controlled substances, failure to conduct complete inventory of products containing pseudoephedrine in a timely manner, and failure to maintain copy of policy and procedure manual in the prescription department, all after multiple warnings from compliance officer.

Larry Robert Thompson (PST.009795): Consent Order. Suspended license for five years and stayed the execution thereof, then placed it on probation for five years, beginning March 31, 2010, and further, assessed costs for failure to heed multiple warnings from compliance officer while serving as pharmacist-in-charge of Thompson's Family Pharmacy.

Walgreen Pharmacy No. 03610 (PHY.003786): Consent Order. Assessed a fine of $2,500 plus costs for failure to maintain proper staffing ratios of technicians and pharmacists.

CVS Pharmacy No. 5615 (PHY.005784): Consent Order. Suspended permit for six months and stayed the execution thereof, and then placed it on probation for six months, beginning April 1, 2010, and further, assessed a fine of $10,000 plus costs for allowing two technician candidates with expired credentials to perform professional functions in the prescription department.

Charles Erwin Seymour (PST.010052): Consent Order. Issued letter of reprimand and fined $1,000 plus costs for allowing two technician candidates with expired credentials to perform professional functions in the prescription department while serving as the pharmacist-in-charge at CVS Pharmacy No. 5615.

Walter Marionneaux Barker (PST.016181): Consent Order. Issued letter of reprimand and fined $500 plus costs for allowing two technician candidates with expired credentials to perform professional functions in the prescription department while serving as a staff pharmacist on duty at CVS Pharmacy No. 5615.

HealthSouth Specialty Hospital of North Louisiana (PHY.004215): Consent Order. Assessed a fine of $2,500 plus costs for allowing an unlicensed person to perform professional functions in the prescription department.

Tamica Blake May (PST.015923): Consent Order. Assessed costs for allowing an unlicensed person to perform professional functions in the prescription department, while serving as the pharmacist-in-charge of HealthSouth Specialty Hospital of North Louisiana.

Russo's Health Mart Pharmacy (CDS.000755.PHY): Consent Order. Revoked controlled dangerous substance license, effective May 1, 2010, for dispensing unauthorized prescriptions for controlled substances.

Russo's Health Mart Pharmacy (PHY.000755): Consent Order. Suspended permit for five years and stayed execution thereof, then placed it on probation for five years, beginning April 1, 2010, and further, assessed a fine of $25,000 plus costs, and further, prohibited access to prescription department by owner, Salvadore Joseph Russo, for dispensing approximately 550 unauthorized prescriptions for controlled substances and other prescription drugs.

Salvadore Joseph Russo (PST.010667): Consent Order. Suspended license for an indefinite period of time, and further, assessed a fine of $25,000 plus costs, and further, prohibited the acceptance of any application for reinstatement until May 6, 2020, for dispensing unauthorized prescriptions for controlled substances and other prescription drugs, while serving as the pharmacist-in-charge of Russo's Health Mart Pharmacy.

Costco Pharmacy No. 581 (PHY.005965): Consent Order. Assessed a fine of $3,000 plus costs for failure to report required information to the prescription monitoring program.

Medical Analysis Pharmacy (PHY.005689): Consent Order. Assessed a fine of $3,000 plus costs for failure to report required information to the prescription monitoring program.

F & M Specialty Pharmacy – LA (PHY.005202): Consent Order. Assessed a fine of $3,000 plus costs for failure to report required information to the prescription monitoring program.

F & M Specialty Pharmacy – MS (PHY.004865): Consent Order. Assessed a fine of $3,000 plus costs for failure to report required information to the prescription monitoring program.

Touro Infirmary Pharmacy (PHY.005533): Consent Order. Issued a letter of reprimand and assessed a fine of $7,500 plus costs for allowing an unlicensed person to perform professional functions in the prescription department.

Lee Benton Hankins (PST.014142): Consent Order. Issued a letter of reprimand and assessed a fine of $5,000 plus costs for misrepresentation of credentials and for allowing an unlicensed person to perform professional functions in the prescription department, while serving as the pharmacist-in-charge of Touro Infirmary Pharmacy.

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Sarah Lucinda Stell (CPT.007587): Consent Order. Revoked certificate, and further, issued permanent prohibition on the acceptance of any future application for reinstatement for diversion of controlled substances from employer pharmacy.

Chanen Marie Dunn (CPT.009061): Consent Order. Revoked certificate, and further, issued permanent prohibition on the acceptance of any future application for reinstatement for diversion of controlled substances from employer pharmacy.

Britton Bennett LeFebre (CPT.009347): Consent Order. Revoked certificate, and further, issued permanent prohibition on the acceptance of any future application for reinstatement for diversion of controlled substances from employer pharmacy.

Brooke Hoa Le (PST.014099): Consent Order. Issued a letter of reprimand and assessed a fine of $250 plus costs for failure to comply with continuing education requirements, in connection with annual audit.

John Scott Soileau (PST.014858): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective February 15, 2010.

Thrift Clinic Pharmacy (PHY.004400): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective February 15, 2010.

Richard Wayne Harmon (CDS.010243.MD): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective February 15, 2010.

Michelle Bergeron Keller (CPT.007903): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective March 31, 2010.

Angela Waldron Allums (PST.014219): Accepted voluntary surrender, resulting in active suspension for an indefinite period of time, effective May 3, 2010.

On these same dates, the Board also issued letters of reprimand to one pharmacy and two pharmacists, as well as a letter of warning to one pharmacy. In addition, they granted requests for the reinstatement of lapsed credentials from one pharmacy and two pharmacists.

Correction to Previous Entry

Erica Nicole Llorance (PTC.015242): Consent Order. Revoked registration, and further, issued permanent prohibition on the acceptance of any future application for reinstatement for testing positive for an illegal substance during a random drug screen by employer pharmacy.

We regret the error in the previous entry.

Calendar Notes (10-07-355)

The next Board meeting and administrative hearing will be August 11-12, 2010, at the Board office. The office will be closed September 6, in observance of Labor Day.

Special Note (10-07-356)

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

Lagniappe (10-07-357)

"Revolve your world around the customer and more customers will revolve around you." – *Heather Williams*

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.

Malcolm J. Broussard, RPh - State News Editor
Carmen A. Catizone, MS, RPh, DPh - National News Editor & Executive Editor
Larissa Doucette - Communications Manager

LOUISIANA BOARD OF PHARMACY

1600 Feehanville Drive
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