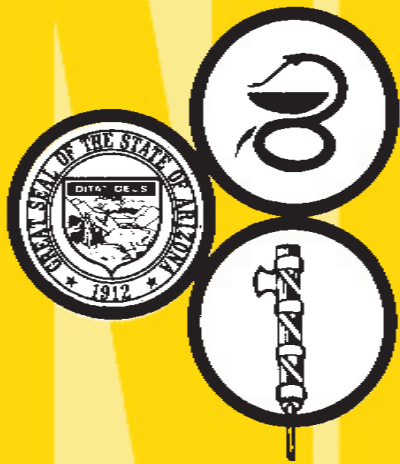


October 2006



Arizona State Board of Pharmacy

4425 W Olive Ave, Suite 140, Glendale, AZ 85302-3844
Web site: www.pharmacy.state.az.us
E-mail: info@azsbp.com

Published to promote voluntary compliance of pharmacy and drug law.

Board Member – Patient Safety Expert

Linda K. McCoy, PharmD, graduated from the University of Cincinnati and has devoted a large part of her professional and private life to serving health care consumers in Arizona and nationally. Linda's interests and expertise have allowed her to focus the majority of her pharmacy career actively working on medication error reduction efforts. She has also been a member of the Arizona State Board of Pharmacy since 2002. For the past several years of her career, she served as the director of Clinical Patient Safety at Good Samaritan Regional Medical Center, one of the largest health care providers in the state. She is one of only four people from Arizona to participate in the national Agency for Healthcare Research and Quality Patient Safety Improvement Corp and completed additional course work in September 2006 to qualify as a patient safety trainer. In Arizona, Linda is a member of the Patient Safety Steering Team for the Arizona Hospital and Healthcare Association and is leading a work group promoting the use of "The Med Form" to encourage consumers to keep an up-to-date list of the medications they are taking. Linda is the only person to ever serve as president of all three major pharmacy organizations: Arizona State Board of Pharmacy, Arizona Pharmacy Association, and the Arizona Society of Hospital Pharmacists. Due to her leadership positions, perhaps no one else in Arizona has developed as broad an understanding of all pharmacy practice settings. Linda is dedicated to continuing her work on the Board of Pharmacy and promises to further promote the safety and welfare of patients in Arizona. Linda recently moved to Prescott, AZ, this year and will no longer commute to Phoenix, AZ. She will be serving the community in Prescott by utilizing her considerable clinical and patient safety skills as the assistant director of Pharmacy Services for Yavapai Regional Medical Center.

New Board Attorney

The Board is pleased to introduce Dawn Walton Lee as the new assistant attorney general representing the state and ultimately the Board of Pharmacy. Dawn is a graduate of the University of Arizona with a degree in psychology

and the Arizona State University School of Law. She has represented many boards and commissions during her six years as an assistant attorney general.

Online Renewals Update

By the time you receive this *Newsletter* you should have also received your biennial credential renewal letters, which should have been mailed out in early September. If you are lucky enough to be required to renew a license or permit this year (most even numbered credentials will be renewing as well as a small number of new odd numbers), you will be pleased to know that online renewal and payment by credit card has been expanded. Pharmacies and certified pharmacy technicians can now renew online as well as pharmacists. Pharmacies will be required to enter their pharmacy permit number and National Council for Prescription Drug Programs number (formerly known as the National Association of Boards of Pharmacy® number) as identifiers to use the online system. Certified technicians will be identified by license number and Pharmacy Technician Certification Board (PTCB) number. A new feature added this year is the ability to print your license or permit on your own printer after payment conformation. No more waiting for the mail. I urge you, please do not procrastinate and wait until the last day because of this feature.

All online renewal systems became active as of September 14, 2006, and will remain active until November 15, 2006. Some credential groups may be active earlier than that, and you can check if a group has been activated by visiting the link <http://az.gov/pharmacy>.

Board compliance officers can now utilize their laptops with internal phone cards to verify licenses and permits online. This new credential verification capability, while in the field, eliminated the need for the Board office to print and issue standardized renewal forms.

FAQ – Continuing Education Pharmacists

Even without a calendar, we at the Board offices know it is renewal time when licensees start calling the Board

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FDA Launches Consumer Educational Program on the Safe Use of OTCs

The United States Food and Drug Administration's (FDA) Center for Drug Evaluation and Research, in cooperation with the National Council on Patient Information and Education and Maryland's Montgomery County Public Schools, has launched "Medicines in My Home," an interactive educational program aimed at informing middle school students about the safe and effective use of over-the-counter (OTC) medicines. Key concepts students will learn from the program are:

- ◆ the Drug Facts label tells you what a medicine treats, if it is right for you and your problem, and how to use the medicine;
- ◆ read the label and follow the directions carefully and correctly;
- ◆ two medicines with the same active ingredient should not be used at the same time; and
- ◆ measure medicines correctly with measuring tools made for medicines.

The program emphasizes that medicines should be used only with permission from an adult and that if there are questions about medicine use, ask a pharmacist or doctor. Materials are provided to encourage students to share what they learn with their families so that all family members can learn to use OTC medicines more safely. Program information can be found at www.fda.gov/medsinmyhome.

HHS Warns Public of Heroin and Fentanyl Deadly Combo

In efforts to warn the public and health care professional communities regarding a recent rash of drug-related deaths due to an illicit street drug combination consisting of the prescription medication fentanyl and either heroin or cocaine, the Department of Health and Human Services (HHS) released a fact sheet containing specific information with the goal of saving lives.

A letter from H. Westley Clark, director of HHS Center for Substance Abuse Treatment, to health care professionals warned that in "just one week, an estimated 33 individuals in the Detroit, MI area are reported to have died after using this fatal mix of drugs; the same drug combination may have been responsible for more than 100 deaths in the same region last September [2005]." Philadelphia, PA; Chicago, IL; St Louis, MO; and Camden, NJ have also recently experienced similar clusters of drug-related deaths.

Fentanyl, an injectable Schedule II prescription opioid analgesic, is roughly 50 to 80 times more potent than morphine but can also be produced in clandestine laboratories in powder form and then mixed with or substituted for heroin. Fentanyl-related overdoses can result in sudden death through respiratory arrest, cardiac arrest, severe respiratory depression, cardiovascular collapse, or severe anaphylactic reaction. In some cases, heroin or cocaine users are aware they are purchasing this dangerous combination of drugs and in other cases, they are not. Because the potency of street-sold heroin or cocaine is amplified markedly by fentanyl and because the inclusion of fentanyl

may not be disclosed, any use, even a reduced dose, can result in overdose or death. The fact sheet advises that suspected overdoses should be treated rapidly with a naloxone injection, 0.4 to 2 mg intravenously, subcutaneously, or intramuscularly every two to three minutes, which should rapidly reverse symptoms related to a narcotic overdose; if there is no response after 10 minutes, then a different diagnosis should be considered.

For additional information, contact Kenneth Hoffman at the Substance Abuse and Mental Health Services Administration at 240/276-2701 or via e-mail at Kenneth.Hoffman@samhsa.hhs.gov.

Pharmacy Technicians and Medication Error Prevention



This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that works closely with United States Pharmacopeia (USP) and FDA in analyzing medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, then publishes its recommendations. If you would like to report a problem confidentially to these organizations, go to the ISMP Web site (www.ismp.org) for links with USP, ISMP, and FDA. Or call 1-800/23-ERROR to report directly to the USP-ISMP Medication Errors Reporting Program. ISMP address: 1800 Byberry Rd, Huntingdon Valley, PA 19006. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

In an October 2005 article in the *American Journal of Health-System Pharmacists*, the results of a random nationwide survey of more than 800 pharmacy technicians' views about their medication errors was published (Desselle SP. Certified pharmacy technicians' views of their medication preparation errors and educational needs. *Am J Health-Syst Pharm*. October 1, 2005; 62:1992-97). Most of the technicians worked in community pharmacies, but more than a quarter (27%) were employed in hospitals.

As one might expect in both settings, interruptions and inadequate staffing were among the most frequent factors perceived to contribute to technician medication preparation errors. Inadequate staffing was perceived as especially problematic in chain pharmacies, while inadequate supervision by pharmacists was cited as a factor more frequently by hospital technicians. It also may come as no surprise that the pharmacists' most frequently cited response to an error that was caught during the checking process was to make the technician aware of the error and require him or her to correct it. However, only about 17% of the technicians reported that the pharmacist had used the error as an opportunity to provide instructions on how to avoid the same or similar errors in the future.

While many of these respondents attributed this responsibility to the organization as a whole, not necessarily the individual pharmacist who detects an error, it appears technicians may not be receiving guidance about system and process changes that can help avert errors. After an



error is corrected, the checking pharmacist should find time that same day (or the next day, if necessary) to review the error with the technician and suggest ways to avoid it, including safer behavioral choices if applicable. Later, during pharmacy staff meetings or other forms of intradepartmental communication, errors, their causes, and ways to prevent them should be shared with all staff in a way that does not embarrass those who were possibly involved in the errors.

One or Both Nostrils?

Submitted by ISMP

Although many nasal sprays are intended for administration in each nostril for a single dose, there are notable exceptions. For example, some medications are meant to be delivered via the nasal passage but **not** sprayed into each nostril. Calcitonin salmon (**Fortical**[®], **Micalcin**[®]) is a prime example. Patients should administer a single spray (200 international units) into one nostril daily, using alternate nostrils each day. Other examples in metered-dose or unit-dose nasal spray containers include butorphanol, desmopressin (**DDAVP**[®]), sumatriptan (**Imitrex**[®]), and zolmitriptan (**Zomig**[®]).

Some pharmacy and/or physician electronic prescribing systems have been preprogrammed to print directions that default to "spray in each nostril" when nasal sprays are selected. For the previously mentioned drugs, this would result in the administration of a double dose of medication. One health care facility recently reported that about 50 patients, who had been prescribed medications intended to be given into one nostril, had prescription container labels that instructed the patients to administer the spray into both nostrils. Some physicians might anticipate patients' confusion and write the prescription for "half" doses in each nostril. Even if instructed to use the spray in one nostril, patients who administer other nasal medications in both nostrils may spray these medications into both nostrils without thinking.

Explicit verbal directions and written instructions that emphasize administration via one nostril only are critical to avoid an overdose.

FDA/ISMP National Campaign to Help Eliminate Ambiguous Medical Abbreviations

FDA and the ISMP have launched a national education campaign that focuses on eliminating the use of potentially harmful abbreviations by health care professionals, medical students, medical writers, and the pharmaceutical industry. The campaign addresses the use of error-prone abbreviations in all forms of medical communication, including written medication orders, computer-generated labels, medication administration records, pharmacy or prescriber computer order entry screens, and commercial medication labeling, packaging, and advertising. For more information visit www.fda.gov/cder/drug/MedErrors.

DEA Provides Retail Training Materials

Drug Enforcement Administration (DEA) recently announced the availability of training materials regarding self-certification training for regulated retail sellers of non-prescription drug products containing

ephedrine, pseudoephedrine, and phenylpropanolamine as required by the Combat Methamphetamine Epidemic Act of 2005 (Title VII of Public Law 109-177).

Two sets of training materials have been developed: one for regulated persons who are mobile retail vendors, and one for regulated persons who are not mobile retail vendors. Both sets of training materials may be found on the Diversion Control Program Web site, www.deadiversion.usdoj.gov, under "Combat Methamphetamine Epidemic Act of 2005."

DEA notes that regulated sellers must use the content of these training materials in the training of their employees who sell scheduled listed chemical products. A regulated seller may utilize additional content in its training program, but DEA's posted material must be included.

DEA is continuing to work to promulgate regulations to implement the Combat Methamphetamine Epidemic Act of 2005.

FDA Announces Release of Guidance on Useful Written Consumer Medication Information

In the July 18, 2006 *Federal Register*, FDA announced the availability of a guidance entitled "Useful Written Consumer Medication Information (CMI)." This guidance is intended to assist individuals or organizations (eg, pharmacies, private vendors, health care associations) in developing useful written consumer medication information to comply with Public Law 104-180. CMI is written information about prescription drugs developed by organizations or individuals, other than a drug's manufacturer, that is intended for distribution to consumers at the time of dispensing. Since neither FDA nor the drug's manufacturer reviews or approves CMI, FDA recommends that the developers of written medication information use the factors discussed in this guidance to help ensure that their CMI is useful to consumers.

This guidance can be accessed at www.fda.gov/cder/guidance/7139fnl.htm.

2007 Survey of Pharmacy Law Available Soon

NABP's 2007 *Survey of Pharmacy Law* CD-ROM will be available in early December 2006. New topics include whether or not licensure for wholesale distributors of non-prescription drugs is required and the recognition of Verified-Accredited Wholesale Distributors[™] accreditation.

The *Survey* consists of four sections: organizational law, licensing law, drug law, and census data. The *Survey* can be obtained for \$20 from NABP by downloading the publication order form from www.nabp.net and mailing in the form and a money order to NABP. The CD-ROM is provided free of charge to all final-year pharmacy students through a grant from AstraZeneca Pharmaceuticals. If you do not have Web access or would like more information on the *Survey*, please contact NABP at 847/391-4406 or via e-mail at custserv@nabp.net.

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office about continuing education (CE) requirements. The requirements to renew a pharmacist license are during the two years preceding the application for renewal, the licensee shall have participated in 30 contact hours (3 CEUs) of CE activity sponsored by an approved provider as defined in R4-23-110, of which at least three contact hours (0.3 CEUs) are approved courses in pharmacy law. A pharmacist licensed for less than 24 months shall obtain CE units in an amount determined by multiplying 1.25 hours times the number of months between the date of initial licensure and the next license renewal date.

Certified Technicians

Certified technicians shall have participated in 20 contact hours (2 CEUs) of CE activity sponsored by an approved provider as defined in R4-23-110, and at least two of the contact hours (0.2 CEUs) shall be approved courses in pharmacy law. For a pharmacy technician licensed less than 24 months, the CE contact hours are calculated by multiplying 0.83 hours times the number of months between the date of initial licensure and the licensee's next license renewal date.

Disciplinary Actions – Board of Pharmacy (Actions since July 2006 Newsletter)

Notice: Before making a prescription-dispensing or other decision pursuant to information in this issue, you are encouraged to verify the current condition of a license with the appropriate licensing agency (Board).

David Clapp (S09617) – Pharmacist License Restored/Reinstated. Effective July 19, 2006.

James Green (S05337) – Pharmacist License Revoked. Effective August 2, 2006.

Jeffrey Hannibal (S11674) – Pharmacist License Revoked. Effective August 2, 2006.

Robin Perkins (T07490) – Technician License Revoked. Effective August 2, 2006.

Dione Valazquez (T08567) – Technician License Revoked. Effective August 2, 2006.

Disciplinary Actions – Other Health Care Practitioner Boards

Michael S. Biscoe, MD (#20915) – License Reactivated. Five-year Probation. Effective June 9, 2006.

Franc William Brodar, MD (#24079) – Respondent Shall Not Practice Clinical Medicine or Direct Patient Care and is Prohibited from Prescribing Any Form of Treatment, Including Prescription Medicine until Physician Applies to the Board and Receives Permission to do so. Effective July 14, 2006.

Richard Carino, MD (#25808) – License Summarily Suspended Pending Formal Hearing Before an Administrative Judge. Effective June 9, 2006.

William V. Gaul, MD (#13319) – Respondent Shall Not Practice Clinical Medicine or Direct Patient Care and is Prohibited from Prescribing Any Form of Treatment,

Including Prescription Medicine until Physician Applies to the Board and Receives Permission to do so. Effective June 8, 2006.

Mary Groves, MD (#30315) – License Suspended until Reapplication to the Board. Effective June 9, 2005.

Jeri B. Hassman, MD (#16132) – Letter of Reprimand with Two-year Probation. Respondent may not Perform Joint and Soft Tissue Injections During Probation. Effective June 9, 2006.

Kevin Hoffert, MD (#13766) – License Inactivation with Cause. Respondent Shall Not Practice Medicine within Arizona or within Any Other State until License is Reactivated by the Board. Effective July 12, 2006.

Bruce Hunter, MD (#24075) – License Revoked. Effective June 8, 2006.

Walter L. Jacobs, MD (#3829) – License Revoked. Effective June 8, 2006.

Arnold L. Kendall, MD (#4336) – Respondent Shall Not Practice Clinical Medicine or Direct Patient Care and is Prohibited from Prescribing Any Treatment, Including Prescription Medicine until Physician Applies to the Board and Receives Permission to do so. Effective June 1, 2006.

Melanie Kohout, MD (#23105) – License Inactivation with Cause. Respondent Shall Not Practice Medicine within Arizona or within Any Other State until License is Reactivated by the Board. Effective May 24, 2006.

William Donald Leighton, MD (#12814) – Respondent Shall Not Practice Clinical Medicine or Direct Patient Care and is Prohibited from Prescribing Any Form of Treatment, Including Prescription Medicine until Physician Applies to the Board and Receives Permission to do so. Effective July 10, 2006.

William S. Masland, MD (#6352) – Letter of Reprimand. Effective June 9, 2006.

Lance A. May, MD (#34267) – License Revoked. Effective June 8, 2006.

Bradley A. Schwartz, MD (#26807) – License Revoked based on Felony Murder Conviction. Effective May 30, 2006.

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The *Arizona State Board of Pharmacy News* is published by the Arizona State Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, to promote voluntary compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of the Foundation or the Board unless expressly so stated.

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