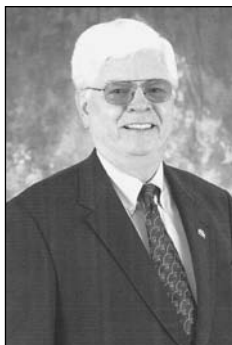


Oklahoma State Board of Pharmacy

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John Lassiter Appointed to Board



Governor Brad Henry has appointed John Lassiter of Del City, OK, to a term ending June 30, 2009. John is a 1963 graduate of Southwestern Oklahoma State University College of Pharmacy. He is owner of Lassiter Drug in Del City. John is a former member of the Oklahoma House of Representatives (1987-1990) and a past president of the Oklahoma Pharmacists Association (OPhA). Currently, he is a member of OPhA, the National Community Pharmacists Association, the American Pharmacists Association,

and the Oklahoma County Pharmacy Association. This is John's second term on the Oklahoma State Board of Pharmacy; he previously served on the Board from 1994-99. Best wishes to John as he serves the public for the next five years.

Board Meeting – March 11, 2004

This meeting was inadvertently left out of the July 2004 Newsletter.

Disciplinary Action

Tascha C. Drennan, Tech #3961 – Case 700: Charges: Possession of a controlled dangerous substance (CDS) without a valid prescription and theft of merchandise. Permit revoked.

Stephanie D. Tabor, Tech #4766 – Case 704: Charges: Conduct in a manner likely to lower public esteem. Permit revoked.

Aaron Moline, Tech #6023 – Case 701: Charges: Possession of a CDS without a valid prescription. Permit revoked.

Harrold Lee Champlin, Jr, DPh #10449 – Case 702: Charges: Failure to establish and maintain effective controls to prevent errors and misfills. Letter of Reprimand and \$500 Fine.

The Board also took action in two (2) impaired cases: **Case 573-A – DPh #9706**, had the probation of his license revoked and was placed on suspension until June 30, 2005. The suspension will be stayed and placed on probation beginning July 1, 2005 until May 31, 2010. In addition, respondent was fined \$900 and must attend a one-day law seminar in 2004 and obtain all-live continuing education (CE) in 2004, 2005, and 2006; **Case 699 – DPh #9961**, was placed on suspension for 10 years until March 11, 2014. The suspension was stayed and placed on probation beginning April 1, 2004. In addition, respondent was fined \$2,000 and must attend a one-day law seminar in 2004.

Board Meeting – June 16, 2004

Disciplinary Action

Traci Byer, Tech #837 – Case 707: Charge: Obtaining a CDS by fraud. Permit revoked.

Stephanie A. Mills, Tech #4466 – Case 708: Charge: CDS theft. Permit revoked.

Stephen Layne Summers, DPh #10608 – Review of Case 668: Probation was extended until December 31, 2004, so that respondent could meet the original case requirement of attending a law seminar.

Joe Hoover, DPh #7837 – Case 713: Charge: Received two or more warning notices within a 12-month period. Letter of reprimand for one year and must attend an approved law seminar within the next year.

The Board also took action in two (2) impaired cases: **Case 643-B – DPh #11307**, had the probation of his license revoked and was placed on suspension until November 19, 2012; **Case 646-A – DPh #8755**, was removed from suspension and placed on probation until November 19, 2012.

Board Meeting – July 20, 2004

Reorganization of the Board

Jim Spoon of Sand Springs, OK, was elected president and Bill Osborn of Miami, OK, was elected vice president of the Board for 2004-2005.

Disciplinary Action

Amy Rodolph, Intern #6659 – Case 717: Charges: Possession of a CDS without a valid prescription; obtaining a CDS by forgery; obtaining a CDS by the use of a false name; forging or increasing the quantity of drugs in prescriptions; attempting diagnosis or treatment that is the legally constituted right or obligation of any practitioner of the healing arts; failing to conduct business in conformity with all federal, state, and municipal laws. Permit revoked.

Greg Wheat, Tech #6151 – Case 709: Charges: Possession of a CDS without a valid prescription and theft of merchandise. Permit revoked.

Kevin P. Cook, Tech #5861 – Case 714: Charges: Possession of a CDS without a valid prescription and theft of merchandise. Permit revoked.

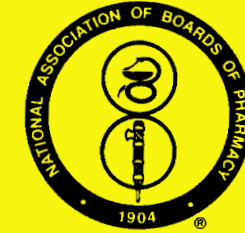
John Douglas Harrison, DPh #8570 – Case 715: Charges: Failure to establish and maintain effective controls to prevent

Continued on page 4



National Pharmacy Compliance News

(Applicability of the contents of articles in the National Pharmacy Compliance News to a particular state or jurisdiction should not be assumed and can only be ascertained by examining the law of such state or jurisdiction.)



New Over-the-Counter Product Labeling

On March 24, 2004, Food and Drug Administration (FDA) passed final rulings requiring content labeling for over-the-counter (OTC) medications that contain levels of calcium, magnesium, sodium, or potassium that might be harmful to persons with certain underlying medical conditions. The final rule was effective April 23, 2004, with compliance expected by September 24, 2005. The labeling changes for oral OTC products were deemed necessary as persons with certain medical conditions such as heart disease, hypertension, kidney disease, kidney stones, or other medical conditions could worsen their condition upon consumption of these products. For example, OTC use of medications containing potassium may cause hyperkalemia in persons with compromised renal function. Under the new rules, oral OTC medications must state the exact amount of a particular ingredient in each dose if they contain:

- ◆ 5 mg or more of sodium in a single dose,
- ◆ 20 mg or more of calcium in a single dose,
- ◆ 8 mg or more of magnesium in a single dose, or
- ◆ 5 mg or more of potassium in a single dose.

The rules also require warnings to alert consumers on sodium-, calcium-, magnesium-, or potassium-restricted diets to consult their physician before using oral products that contain maximum daily doses of:

- ◆ more than 140 mg sodium,
- ◆ more than 3.2 grams calcium,
- ◆ more than 600 mg magnesium, or
- ◆ more than 975 mg potassium.

Currently the new label requirements do not include mouth rinses, fluoride toothpastes, or mouth washes. Detailed information on the rulings can be found in the Federal Register at www.fda.gov/OHRMS/DOCKETS/98fr/04-6479.htm and www.fda.gov/OHRMS/DOCKETS/98fr/04-6480.htm.

FDA Requests Antidepressant Manufacturers to Strengthen Warnings

On March 22, 2004, FDA issued a public health advisory that cautions physicians, their patients, and families and caregivers to closely monitor adults and children with depression. Results of antidepressant studies in children since June 2003 appeared to suggest an increased risk of suicidal thoughts and actions in those children taking certain antidepressants. FDA has initiated a review of these reports, but it is not clear whether or not antidepressants contribute to suicidal thinking and behavior.

As a result of the studies, FDA is asking manufacturers to change the labels of 10 drugs to include stronger cautions and warnings to monitor patients for worsening depression and the emergence of suicidal ideation. The drugs affected include bupropion (Wellbutrin®), citalopram (Celexa™), escitalopram (Lexapro™), fluvoxamine (Luvox® – not FDA approved for treatment of depression in the US), fluoxetine (Prozac®), mirtazapine (Remeron®), nefazodone (Serzone®), paroxetine (Paxil®), venlafaxine (Effexor®), and sertraline (Zoloft®). It should be noted that

Prozac is the only drug approved for use in children with major depressive disorder. Prozac, Zoloft, and Luvox are approved for pediatric patients with obsessive-compulsive disorder.

Patients taking these antidepressants should be monitored for behaviors associated with the drugs such as anxiety, agitation, panic attacks, insomnia, irritability, hostility, impulsivity, akathisia, hypomania, and mania. Physicians are urged to closely monitor patients with bipolar disorder as monotherapy with antidepressants is believed to have the potential to induce manic episodes in such patients. A causal relationship has not been established between physical symptoms and suicidal ideation; however, medications may need to be discontinued when the symptoms are severe, abrupt in onset, or were not part of the presenting symptoms. Further information can be found on CDER's Web site: www.fda.gov/cder/drug/antidepressants/default.htm.

Let Past Experience with Chloral Hydrate Syrup Guide its Safe Use



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.

Chloral hydrate can be used safely to sedate pediatric patients for diagnostic procedures such as endoscopic procedures, CT scans, or MRIs. However, in several error reports over the years we have seen the sad stories of fatalities that have occurred after excessive doses of the drug were dispensed in error. Typically, deaths have occurred in cases where the order was not clear or when untrained individuals, both staff and parents, were involved without adequate supervision or the knowledge that they were administering an overdose. In some cases, to save time, chloral hydrate has been prescribed for use at home prior to travel to the practice site. In one instance, a 500 mg/5 mL concentration was dispensed instead of 250 mg/5 mL, which also is available. Unfortunately, the dose was prescribed by volume (teaspoonful), which made detection of the twofold overdose impossible. In another incidence, 120 mL of syrup was incorrectly dispensed instead of the prescribed 12 mL. The label instructed the mother to give her child the entire bottle, which she did. Without trained personnel and emergency equipment present to treat these accidental overdoses, the children in both cases died.

Recently the tragedy happened again. A prescription was written for a 17-month-old child; the pharmacist read the directions as "30 cc before office visit" and instructed the mother to give her child that amount.

In truth, the physician wanted the child to receive 500 mg 30 minutes before the office visit. The double hash-mark symbol ("), which the physician intended to mean minutes, was misread as cc. Actually, a double hash mark stands for seconds; a single hash mark (') is used for minutes. Neither symbol should be used in medicine, however, because not everyone understands their meaning.

Errors also happen in diagnostic areas where technical support personnel often administer oral conscious sedation even though they are not properly trained. In some cases, an ambiguous physician order such as "give chloral hydrate 5 cc prn sedation" or "... prn agitation," rather than a specific milligram amount and maximum dose, has led to events where multiple doses of chloral hydrate were dispensed from the supply available to personnel. By the time the child fell asleep, the amount administered was a massive overdose leading to respiratory arrest.

Please consider reviewing your process for dispensing oral liquids used for conscious sedation in children, whether to a medical facility or to a family member. We suggest that the following precautions, in addition to package insert recommendations, be employed. Advise physicians that the drug should not be prescribed by volume (eg, "5 mL," "one teaspoonful," etc). There are two available concentrations of this drug. Instead, the specific milligram dose should be expressed. The prescription should state that it is for pre-procedure sedation. In hospital situations or when pharmacies dispense to health care facilities, prescriptions are best dispensed for each patient in labeled, unit-dose, oral syringes; providing the product in bulk packages as floor stock is less safe. We believe it is safest for pharmacists to not dispense prescriptions for patient use in the home when it is for pre-procedure sedation. Should the caregiver receive such a prescription, he or she should be advised that they are safest for the dose to be administered where the procedure will be performed. Official labeling for Versed® Syrup, another drug used for conscious sedation in children, notes that the syrup is intended for use only in monitored settings, never the home. Also, as noted in the product's boxed warning, only health care professionals trained in conscious sedation procedures and authorized to administer conscious sedation drugs should do so. Careful monitoring by direct visual observation is necessary and age-/size- appropriate resuscitation equipment must be readily available. The American Academy of Pediatrics agrees; the Academy's current "Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures" (*Pediatrics* 2002; 110:836-838)

recommend that children should not receive sedative or anxiolytic medications without supervision by skilled medical personnel. These medications should be administered by, or in the presence of, individuals skilled in airway management and cardiopulmonary resuscitation and administered in a health care facility where appropriate monitoring, including continuous pulse oximetry, can be instituted.

One final argument for administering children's sedation on site is to ensure proper timing in case of unpredictable schedule delays.

NABP Releases Updated NAPLEX Blueprint

NABP has released the updated blueprint for the North American Pharmacist Licensure Examination™ (NAPLEX®). The blueprint is available for viewing on NABP's Web site, www.nabp.net, as of September 2004. Examinations based on the updated blueprint will be administered beginning spring 2005.

Changes to the NAPLEX blueprint include the addition of competency statements addressing dietary supplements and pharmacotherapeutic equivalency as well as integration of the skill of communicating with patients and other health care providers in the entire examination blueprint instead of focusing it within a single competency area as with the current NAPLEX. The examination continues to consist of three major areas that are divided into several competency and subcompetency statements.

The updated blueprint and competency statements require a new passing standard. However, the NAPLEX continues to be a computer-adaptive examination that requires a scaled score of 75 or greater to pass. Calculation of the score is the same as in the past: the score is calculated by first determining the candidate's ability level on the NAPLEX and then comparing this to the predetermined minimum acceptable ability level established for the NAPLEX. The new passing standard will go into effect along with the updated blueprint in spring 2005.

For more information about the NAPLEX, contact the Customer Service Department by calling 847/698-6227 or visit the Association's Web site at www.nabp.net.

December 2004 FPGEE Date and Location Announced

On December 4, 2004, NABP will again administer a paper-and-pencil Foreign Pharmacy Graduate Equivalency Examination® (FPGEE®). The examination is being offered at three United States locations: Northlake (Chicago area), IL; New York, NY; and San Mateo, CA. Candidates who have been accepted to sit for the December 4, 2004 administration were mailed their admission tickets in early fall.

To prepare for the December examination, candidates may take the Pre-FPGEE™, a Web-based practice examination for the FPGEE. The practice examination is accessible at www.nabp.net and www.pre-fpgee.com.

For more information on the FPGEE, visit NABP's Web site at www.nabp.net.

Continued from page 1

prescription errors or misfills. Fine of \$250 and must complete a two-hour video CE course on prescription error correction within 90 days.

Robert C. Lacy, DPh #13193 – Case 718: Charges: Possession of a CDS without a valid prescription; obtaining CDS by fraud; theft of merchandise; engaging in the practice of pharmacy while incapacitated or while abusing liquors or other chemical substances; attempting diagnosis or treatment that might infringe upon the legally constituted rights or obligation of any practitioner of the healing arts; exercising conduct and habits inconsistent with the rules of professional conduct established by the Board; failing to conduct business as a pharmacist at all times in conformity with all federal, state, and municipal laws. License revoked.

The Board also took action in one (1) impaired case: **Case 716 – Jeffrey Marburger, DPh #11364**, had his license permanently revoked.

From the Inspectors

A sample Pseudoephedrine (PSE) Transaction Log is available from the Board's Web site at www.pharmacy.state.ok.us.

Fifty-Year Gold Certificates Issued

The following individuals have been issued gold certificates in recognition for the distinction of having been registered pharmacists for 50 years. The Oklahoma State Board of Pharmacy recognizes these pharmacists and gratefully acknowledges their years of contribution to the pharmacy profession. These individuals may take great pride in being part of such an honorable profession for so long. **1954-2004:** Derrell G. Andrus, Dean Baker, Don Barker, John W. Carter, Jr, Wilbur Cave, Murray Cohen, R. Don Coody, James Louis Farrow, Edwin K. Greene, Jean Paul Isbell, Betty Jean Jespersen, Warren M. Jespersen, Robert W. Kelly, John M. Little, William H. Pittman, Joe A. Plemons, Bobby G. Ramsey, Ben D. Steen, Kermit B. Stuart, Benjamin M. Traylor, Park Willis, and James B. Wright.

Committee Members Needed

The Board needs volunteers for a committee on recycling of drugs from nursing homes. If you are interested, please contact the Board.

Newsletter Survey

The Board is interested in hearing from pharmacists about the *Newsletter*. Please respond to the following questions either by mail, e-mail, or fax:

- ◆ Would you rather receive this *Newsletter* by mail as a hard copy or online (ie, the Internet)?
- ◆ If you would rather receive the *Newsletter* online, would you prefer to receive an e-mail or to view the *Newsletter* from the Board's Web site?
- ◆ What type of information would you like to see included in the Board's *Newsletter*?

Your response may be mailed to Oklahoma State Board of Pharmacy, 4545 N Lincoln Blvd, Suite 112, Oklahoma City, OK 73105-3488; faxed to 405/521-3758; or e-mailed to pharmacy@osbp.state.ok.us.

Reminder

Board rules require that all registrants (pharmacists, technicians, and interns) notify the Board in writing of a change of address or employment within ten (10) days.

New Pharmacists

Names of new pharmacists licensed by the Board may be viewed on our Web site, www.pharmacy.state.ok.us, under "Announcements." The list is updated quarterly.

Oklahoma Pharmacists Helping Pharmacists

If you or a pharmacist you care about is suffering from chemical dependency, there is a solution. Oklahoma Pharmacists Helping Pharmacists (OPHP) is readily available for help. Pharmacists in Oklahoma, Texas, and Louisiana may call the OPHP Help-Line at 1-800/260-7574 ext 5. All others may call OPHP at 405/528-3338. All calls are confidential.

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