

Oklahoma State Board of Pharmacy

Published to promote voluntary compliance of pharmacy and drug law.

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Board Meeting – June 8, 2005

Disciplinary Action

The Board took action in three (3) impaired cases: **Case 744 – DPh #12715**, was suspended for ten (10) years until June 8, 2015, and must attend an approved one (1)-day law seminar in 2005 and 2006. Respondent may appear and request probation after June 1, 2006. **Case 745 – DPh #11290**, was suspended indefinitely. Respondent may apply for probation on or after June 8, 2008, provided he enters into and abides by a contract with Oklahoma Pharmacists Helping Pharmacists (OPHP). **Case 739 – DPh #9721**, failed to complete the terms of a previous Board order and was placed on probation for thirty-one (31) months until January 8, 2008.

Board Meeting – July 20, 2005

Disciplinary Action

Nicole Bauer, Tech #8472 – Case 747: Charges: Possession of a controlled dangerous substance (CDS) without a valid prescription and theft of merchandise. Permit revoked.

Ashley Brundridge, Tech #7605 – Case 748: Charges: Possession of a CDS without a valid prescription and theft of merchandise. Permit revoked.

Julie A. Morgan, Tech #7497 – Case 746: Charges: Possession of a CDS without a valid prescription and theft of merchandise. Permit revoked.

Sherry Lynn Ross, DPh #9815, and Sherry's Discount Drug, Inc, #1-2588 – Case 752: Charges: Dispensing a veterinary prescription drug without authorization from a licensed veterinarian. Fine of \$2,000 total.

The Board also took action in one (1) impaired case: **Case 539 – DPh #12317**, had the suspension of his license placed on probation until April 14, 2009.

Board Meeting – August 17, 2005

Disciplinary Action

Jamie Seay, Tech #5907 – Case 750: Charges: Possession of a CDS without a valid prescription and theft of merchandise. Permit revoked.

The Board also took action in one (1) impaired case: **Case 753 – DPh #9650**, was suspended for ten (10) years until August 17, 2015. Respondent may appear and request probation

upon showing three (3) years of continual unbroken compliance with his OPHP contract.

From the Inspectors

◆ **PIC Changes:** There has been an increase in the number of pharmacies without a designated pharmacist-in-charge (PIC) for a period of time. Board rules require that when changing the PIC, a controlled drug inventory must be taken and sent to the Board within ten (10) days and the inventory must list the new PIC. This ten (10)-day time period is just for reporting the change, not for making the change. There should not be a time lag between the old and new PIC. OAC 535:15-3-2(b) states, “each pharmacy, in order to obtain and maintain a pharmacy license, must have a registered pharmacist as the pharmacy manager.”

◆ **Oklahoma Prescribing Clarification:** Oklahoma pharmacies may fill prescriptions written by practitioner assistants, nurse practitioners, and optometrists only if the prescriber is licensed in Oklahoma (ie, by the Oklahoma Medical Board, Oklahoma Nursing Board, or the Oklahoma Optometric Board). A prescription written by an Arkansas nurse practitioner would **not** be valid in Oklahoma.

◆ **Are your licenses current?** Be sure to monitor expiration dates of all Board licenses and permits posted in your pharmacy. Especially pharmacy technicians and pharmacists. It is the responsibility of each registrant to keep the Board informed of any new address, new employment, etc. The inspectors are particularly finding technicians working with expired permits during routine inspections.

Technicians

It would appear that we have a large number of “bad” technicians. In each *Newsletter* we report several cases heard at Board meetings on pharmacy technicians. Technicians do not have as much at risk as pharmacists and some seem to be either unaware or unconcerned about the consequences of their actions. The majority of the cases involve stealing drugs or merchandise, yet pharmacists are usually shocked that a technician would steal from them or the pharmacy.

Pharmacists should also be aware that for those individuals who want to become technicians, the answers they give on their technician application are very important. If they are not

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DEA Amends Rule for Reports of Theft or Significant Loss of Controlled Substances

Drug Enforcement Administration's (DEA) amended regulations regarding reports by registrants of theft or significant loss of controlled substances became effective September 12, 2005. Changes were made to the regulations, found in Title 21 of the Code of Federal Regulations, Part 1300 to 1399, due to confusion as to what constitutes a significant loss and when and how initial notice of a theft or loss should be provided to DEA. Specifically, DEA made changes in order to clarify the exact meaning of the phrases "upon discovery" and "significant loss."

Regarding the timing of initial theft or loss reports, DEA inserted the word "immediately" before the phrase "upon discovery." While DEA Form 106 is not immediately necessary if the registrant needs time to investigate the facts surrounding a theft or significant loss, he or she should provide, in writing, initial notification of the event. This notification may be a short statement provided by fax. DEA notes that faxing is not the only method a registrant may use, but that the notification should be in writing. If the investigation of a theft or significant loss lasts longer than two months, registrants should provide updates to DEA.

To help registrants determine whether or not a loss is "significant," DEA has added to the rule a list of factors to be considered. DEA recognizes that no single objective standard can be applied to all registrants – what constitutes a significant loss for one registrant may be construed as comparatively insignificant for another. If a registrant is in doubt as to whether or not the loss is significant, DEA advises the registrant to err on the side of caution in alerting the appropriate law enforcement authorities.

Regarding "in-transit losses of controlled substance," DEA intends that all in-transit losses be reported, not just significant losses; therefore, the text is being amended to reflect this.

Changes to the regulations were reported in the August 12, 2005 edition of the *Federal Register*.

FDA Releases Update on Combating Counterfeit Drugs

Food and Drug Administration (FDA) recently released "Combating Counterfeit Drugs: A Report of the Food and Drug Administration Annual Update (Update)." This Update follows up on the agency's initial February 18, 2004 report addressing counterfeit drugs. Since the 2004 report, which identified measures that can be taken to better protect Americans from counterfeit drugs, FDA has worked with manufacturers, wholesale distributors, pharmacies, consumer groups, technology specialists, standard setting bodies, State and Federal agencies,

international governmental entities, and others to advance the measures outlined in the 2004 report such as the development and implementation of electronic product codes and radio frequency identification. In its 2005 Update, FDA notes that significant progress is being made in securing drug products and packaging, securing the movement of the product, enhancing regulatory oversight, increasing penalties for counterfeiters, heightened vigilance and awareness of counterfeits, and increasing international collaboration. However, more work needs to be done to further secure the United States' drug supply.

In 2004, FDA's Office of Criminal Investigations initiated 58 counterfeit drug cases, a significant increase over the 30 cases in 2003; however, the agency notes that this is likely due to increased vigilance. FDA also states that most of the suspect counterfeits discovered in 2004 were found in smaller quantities than those found in 2003.

The Update reviews steps taken and future actions required for track-and-trace technology, authentication technology, regulatory oversight and enforcement (electronic pedigree), state efforts, secure business practices, heightened vigilance and awareness, counterfeit alert network, and education. The full Update can be accessed at www.fda.gov/oc/initiatives/counterfeit/update2005.html.

"Fax noise" = Medication Errors in the making



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, Suite 810, Huntingdon Valley, PA 19006. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.

Problem: Most health care practitioners would agree that fax machines have facilitated communication of prescriptions. But there are inherent problems associated with this technology. In fact, an article in the *Journal of Managed Care Pharmacy* found that prescriptions received by fax required a greater number of clarification calls than those received by other methods of communication.¹ ISMP received a report from a long-term care facility about a patient who had been

Compliance News

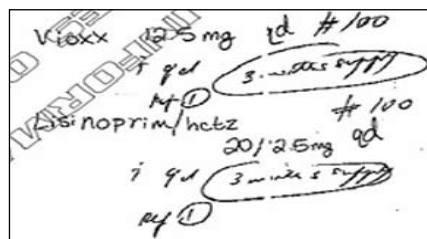
Compliance News to a particular state or jurisdiction should not be assumed (the law of such state or jurisdiction.)



receiving **Neurontin**[®] (gabapentin) 600 mg TID [three times a day]. However, an order had been faxed to the pharmacy to change the Neurontin dose to “**300 mg** 1 tab QID [four times a day].” The change was made and the new dose was sent to the facility. Later, when the pharmacist received the original order from the long-term care facility and compared it with the faxed copy, he realized that the physician had actually requested a change to “**800 mg** 1 tab QID.” The left side of the order had been cut off during the fax transmission, making the “8” look like a “3.” Fortunately, since the pharmacist had been sent the original order for comparison, he quickly realized the mistake. Unfortunately, not all pharmacies receive the original prescription for comparison purposes.

In another report received by ISMP, a faxed prescription was received at a pharmacy for what appeared to be **Monopril**[®] (fosinopril) **10 mg** #90 one tablet daily. Despite the fact that the fax machine created a definite vertical streak that ran between the drug name and the strength, the pharmacist felt confident in her interpretation of the prescription. Unfortunately, it was later discovered that the prescription was actually for **40 mg**. The streak had run through the “4” in 40 mg, making it look like 10 mg instead.

The following prescription (see image below) was faxed to a mail-order pharmacy. Look at the bottom order for “Lisinopril/hctz.” (Note: ISMP does not condone the use of the abbreviation “hctz.”) The pharmacist interpreted this order as “20/25 mg.” But what the prescriber had actually written was “20/12.5 mg.” A subtle vertical gap in the faxed copy (which can be seen “breaking” the circles around “3 months supply”) had obliterated the “1” in 12.5. In addition, the pharmacist reading the order had mis-



interpreted the decimal point as one of many stray marks on the faxed prescription.

Safe Practice Recommendations: “Fax noise” (the random marks and streaks on faxes) is an inherent problem with this form of communication, which may be more common in old or poorly maintained fax machines. Usually, fax noise is just an inconvenience. In the case of prescriptions, however, there is a very real chance that a patient could be harmed by misinterpretations caused by fax noise. To manage this risk, safeguards should be instilled into the fax process. Such safeguards include a careful review of all prescriptions received by fax for fax noise. If the transmission has fax noise in the area of the order, the prescriber should be contacted to confirm the prescription. Whenever pos-

sible, compare the faxed order against the original prescription. Prescribers should consider giving a copy of the prescription to the patient to present at the pharmacy for verification. To prevent confusion or duplication of the prescription at a different pharmacy, the copy could be stamped with a statement such as “Verification Copy ONLY” to indicate that the prescription was already faxed to a particular pharmacy. Maintenance should be regularly scheduled for fax machines on both the sending and receiving end. If maintenance fails to improve fax quality, the machine should be replaced.

¹ Feifer RA et al. Mail-order prescriptions requiring clarification contact with the prescriber: prevalence, reasons, and implications. *JMCP* 2003;9:346-352.

December 2005 FPGEE Date and Locations Announced

On December 3, 2005, 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 Francisco, CA. Candidates who have been accepted to sit for the December 3, 2005 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.

2006 Survey of Pharmacy Law

NABP’s 2006 *Survey of Pharmacy Law* CD-ROM will be available in late November 2005. New topics include the number of wholesale drug distributors and laws and/or regulations concerning the sales of over-the-counter pseudoephedrine, and information concerning emergency contraception.

The *Survey* consists of four sections: organizational law, licensing law, drug law, and census data. Most charts specify terms that can be used when conducting searches on NABP’s NABPLAW[®] Online state pharmacy law and rules database. 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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truthful on their explanation of an arrest or conviction, they will be denied a permit. In addition, when hiring someone that has been a pharmacy technician in the past but does not have a current pharmacy technician permit, these individuals **cannot apply for a new permit but must complete an application for reinstatement (visit www.pharmacy.ok.gov).**

Pharmacists need to do a better, more professional job in training and supervising technicians.

1. Carefully follow your technician training guidelines. (Board guidelines are available at www.pharmacy.ok.gov, technician training manuals are available from www.opha.com.)
2. Keep verification of all training in each technician's file.
3. Observe and supervise properly.
4. Have them read the technician rules and ask questions if there is something they do not understand.
5. Have them read the Board *Newsletter*.
6. Encourage them to take continuing education (CE) courses and possibly become certified.
7. Encourage them to ask questions if they do not understand something in the filling process.
8. Do not become complacent with your process in the pharmacy.
9. Be observant at all times.

As pharmacies fill more and more prescriptions, there is a need for "good" pharmacy technicians. It is the pharmacist's responsibility to see that the technicians:

- ◆ are well trained;
- ◆ know what is expected of them;
- ◆ understand what they can and cannot do;
- ◆ are supervised properly; and
- ◆ have a current permit posted with the proper picture identification attached.

Training Area and Preceptor Permit Renewals for 2006, 2007, and 2008

The first week of November, the Board will mail renewal applications for Training Area and Preceptor permits expiring December 31, 2005. If, for any reason you do not receive your renewal application, it is your responsibility to obtain one.

Any renewal postmarked after January 15, 2006, is subject to the penalty fee whether or not an application was received. Renewal forms will be available from the Board's Web site at www.pharmacy.ok.gov. Permits not renewed are subject to cancellation thirty (30) days after expiration.

Reminder

Board rules require that all registrants (pharmacists, technicians, and interns) notify the Board in writing within ten (10) days of a change of address or employment. Also, pharmacist licenses and technician permits are now renewed according to birth month. If you do not receive a renewal prior to expiration, it is your responsibility to contact the Board. It is crucial that we have your current correct address on file at the Board.

Oklahoma Pharmacists Helping Pharmacists

If you or a pharmacist you care about is suffering from chemical dependency, there is a solution. OPHP is readily available to 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.

Let Us Hear From You

The Board welcomes your comments and questions. You may mail them to the Oklahoma State Board of Pharmacy, 4545 Lincoln Blvd, Ste 112, Oklahoma City, OK 73105, fax us at 405/521-3758, or e-mail us at:

Board e-mail: pharmacy@pharmacy.ok.gov

Board Web site: www.pharmacy.ok.gov

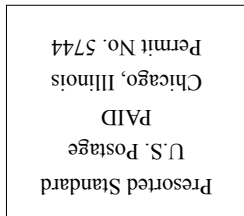
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The *Oklahoma State Board of Pharmacy News* is published by the Oklahoma State Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, to promote voluntary compliance of pharmacy and drug law. The opinions and views expressed 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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