

# Oklahoma State Board of Pharmacy

Published to promote voluntary compliance of pharmacy and drug law.

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Oklahoma City, OK 73105-3488

## Board Meeting – June 14, 2006

### Disciplinary Action

**Kadarien Williams, Tech #9272 – Case 789:** Charges: Theft of controlled dangerous substances (CDS); possession of a CDS without a valid prescription; theft of merchandise; abusing alcohol or drugs, using an illegal CDS substance, and/or testing positive for such substance or its metabolite; and attempting diagnosis or treatment that is the legally constituted right or obligation of any practitioner of the healing arts. **Permit revoked.**

**Demitria Rice, Tech #7296 – Case 790:** Charges: Theft of CDS; possession of a CDS without a valid prescription; and theft of merchandise. **Permit revoked.**

The Board took action in two (2) impaired cases:

**Case 744 – DPh #12715,** respondent's pharmacist license was placed on probation for the remaining period of her suspension. She shall maintain her contract with Oklahoma Pharmacists Helping Pharmacists (OPHP).

**Case 770 – DPh #10013,** on March 8, 2006, respondent was given sixty (60) days to become compliant with his OPHP contract. Respondent may go back to work after the successful completion of the OPHP requirement of a back-to-work evaluation. He shall maintain his contract with OPHP.

## Board Meeting – July 19, 2006

### Disciplinary Action

**Rita L. Jones, Tech #5115 – Case 791:** Charges: Possession of a CDS without a valid prescription and abusing alcohol or drugs, using an illegal CDS substance, and/or testing positive for such substance or its metabolite. **Permit revoked.**

**Tiffany L. Taylor, Tech #7221 – Case 794:** Charges: Possession of a CDS without a valid prescription and theft of merchandise. **Permit revoked.**

The Board took action in three (3) impaired cases:

**Case 589 – DPh #12564,** the suspension and probation of respondent's pharmacist license have been removed, provided that respondent successfully completes the recommendations of the OPHP transition program.

**Case 758 – DPh #11391,** respondent's pharmacist license was placed on probation provided that he successfully completes a "fitness for duty" evaluation by OPHP. He is required to have an on-site monitor at his workplace and shall continue his contract with OPHP.

**Case 795 – DPh #13230,** respondent's pharmacist license was suspended for ten (10) years until July 19, 2016. He must enter into and abide by a ten (10)-year contract with OPHP. He may appear before the Board to request probation after he has completed a

period of eighteen (18) months in continued compliance of his OPHP contract.

## Board Meeting – August 16, 2006

### Disciplinary Action

**Heath E. Eaves, Tech #9412 – Case 797:** Charges: Possession of a CDS without a valid prescription; knowingly or intentionally distributing a CDS; acquiring or obtaining possession of a CDS by misrepresentation, fraud, forgery, deception, or subterfuge; and theft of merchandise. **Permit revoked.**

**Kevin Yeats, Tech #8719 – Case 798:** Charges: Theft of merchandise. **Permit revoked.**

**Walgreen's No. 3018, #2-3827 – Case 796:** Charges: Receiving two or more warning notices within a twelve-month period. **\$1,000 Fine and must provide "In-Service Type" review of Oklahoma pharmacy law regarding technician, intern, and substitution laws to pharmacists and technicians. Attendance must be documented.**

The Board took action in one (1) impaired case:

**Case 792 – DPh #11408,** respondent's pharmacist license was suspended for a period of twenty (20) years until August 16, 2026. He must enter into and abide by a contract with OPHP and must complete one (1) year of sobriety and compliance with his OPHP contract before OPHP can initiate a request to the Board for probation. If probation is granted, respondent will be required to license and work as an intern for a period of not less than six (6) months after passing the Oklahoma Law Exam.

### From the Inspectors

◆ **Pseudoephedrine (PSE) Training:** As of September 30, 2006, retailers must train their employees on the new PSE restrictions using Drug Enforcement Administration (DEA) materials. Go to [www.dea diversion.usdoj.gov/meth/trg\\_retail\\_081106.pdf](http://www.dea diversion.usdoj.gov/meth/trg_retail_081106.pdf).

◆ **Reporting PSE sales:** Reporting PSE sales via the Oklahoma Bureau of Narcotics (OBN) Web site goes into effect October 1, 2006. If you are unable to comply with this requirement, please contact OBN. Please report the total number of grams sold (not milligrams).

◆ **PSE Inventory:** OBN has notified us that pharmacies **must** inventory over-the-counter PSE products when they conduct their annual CDS inventory.

◆ **Generic substitution:** Generic substitution must be approved by the prescriber or the purchaser.

◆ **Hospice Nurses:** Hospice nurses are not agents of the physician. If a hospice nurse phones in a prescription, that prescription needs to be verified with the doctor.

*Continued on page 4*



## **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](http://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](mailto: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](http://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](mailto: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**<sup>®</sup>, **Micalcin**<sup>®</sup>) 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**<sup>®</sup>), sumatriptan (**Imitrex**<sup>®</sup>), and zolmitriptan (**Zomig**<sup>®</sup>).

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](http://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](http://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](http://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<sup>™</sup> 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](http://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](mailto:custserv@nabp.net).

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- ◆ **Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNP):** PAs and ARNPs must be licensed in Oklahoma and supervised by a physician licensed in Oklahoma. Pharmacies located in border towns particularly need to take note of this. Prescribing limits for PAs and ARNPs can be found in Appendix E of your *Oklahoma Pharmacy Law Book*.
- ◆ **Prescription Monitoring Program (PMP):** Regarding the submission of CII, and CIII-V, OBN has asked us to remind pharmacies that they must have a letter from the OBN director granting permission to file in paper format. Identification numbers must be submitted with CII prescriptions, but the identification number is not being enforced for CIII-V prescriptions at this time. If you are already obtaining this information, continue to do so because it will be enforced at a later date. Also, please report the number of tablets or milliliters (if liquid) for the "quantity dispensed" field.
- ◆ **Inspection deficiencies:** The most commonly found deficiencies during inspections are lack of technician training documentation and failure to **sign** logbooks or nightly logs on a **daily** basis.

### **Big Change In Pharmacy Renewal Forms Coming!**

Beginning December 1, 2006, the Board will require pharmacies renewing for the 2007-2008 period to complete a new comprehensive renewal application that will replace the current one-page renewal form. The new form is several pages long and will require the notarized signature of an owner or managing officer. After the 2007-2008 renewal period, the Board will return to a simpler, condensed renewal form.

### **Pharmacy Change of Ownership**

OAC 535:25-3-7 requires that the new owner of a pharmacy obtain a new pharmacy license if a pharmacy changes ownership. A change of ownership occurs when:

- ◆ the original owner(s) transfers 20% or more of the ownership of the pharmacy to another owner;
- ◆ a change of 20% or more of the ownership of the business entity owning the pharmacy occurs (for example, when the corporation owning the pharmacy sells 20% or more of the stock); or
- ◆ a change of ownership form occurs (for example, from a sole proprietor ownership to a partnership, limited liability company, or corporation).

Any ownership change not reported as a change of ownership because it involves a transfer of less than 20% of the ownership of the pharmacy must be reported at the next renewal of the pharmacy's license.

**Note:** For publicly traded corporations, a routine sale of stock is not a change of ownership.

### **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 for help. Pharmacists in Oklahoma, Texas, and Louisiana may call the OPHP Help Line at 1-800/260-7574 ext 5. All calls are confidential.

### **Let Us Hear From You**

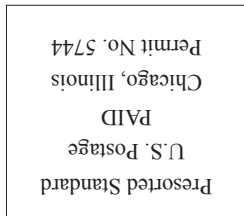
The Board welcomes your comments and questions. You may mail them to the Oklahoma State Board of Pharmacy, 4545 Lincoln Blvd, Suite 112, Oklahoma City, OK 73105; fax us at 405/521-3758; or e-mail us at [pharmacy@pharmacy.ok.gov](mailto:pharmacy@pharmacy.ok.gov). Visit our Web site at [www.pharmacy.ok.gov](http://www.pharmacy.ok.gov).

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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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