



newsletter

National Association of Boards of Pharmacy®

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aid to government
the profession
the public
1904 to 2010

Pharmacists' H1N1 Vaccination Roles Expand Patient Care

With no change in the phase 6 pandemic alert set by the World Health Organization in June for the H1N1 influenza virus, governments and health care organizations continue to be concerned about rapid spread of the virus. Federal and state health agencies stepped up their prevention efforts beginning in June and including the fall distribution of over 65 million doses of H1N1 vaccine. This large influx of vaccines increased the need for additional vaccine providers, and pharmacists are a natural fit. By early October, Centers for Disease Control and Prevention (CDC) had documented cases of 2009 H1N1 influenza in 37 states, with death and hospitalization rates due to influenza higher than normal for that time of year; these statistics verified the need for careful H1N1 vaccination and

treatment planning, including pharmacy planning.

President Obama's declaration of a national emergency on October 25, 2009, made it easier for state governments to implement efficient state and local vaccination and treatment programs. Pharmacists in all states were authorized to administer at least some vaccines to certain age groups, and to address the impending 2009 H1N1 influenza situation, several state boards of pharmacy and health departments authorized emergency rules, adopted new statutes, or permanently updated existing statutes to expand the authority of pharmacists administering influenza vaccines. Along with state health departments and boards of pharmacy, CDC encouraged pharmacists to assist in administering the 2009 H1N1 vaccine, as well



as educate patients about the need for vaccination and the proper use of antiviral medications.

State Pharmacist Vaccination Policies Expand

Persons aged six months to 24 years were found to be among those most vulnerable to the 2009 H1N1 influenza virus and, thus, early on, CDC placed them on the list of persons recom-

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Upcoming Events

January 26-27, 2010
Committee on Law Enforcement/Legislation Meeting
Rosemont, IL

January 25 - February 5, 2010
PCOA Administrations

April 13, 2010
Committee on Constitution and Bylaws Meeting

April 19, 2010
FPGEE Administration

May 22-25, 2010
NABP 106th Annual Meeting
Hyatt Regency Orange County
Anaheim, CA

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Pharmacists' Roles

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mended to receive the initial administrations of the H1N1 vaccine. In response, boards of pharmacy in some states offered pharmacists the opportunity to vaccinate more people in this age group by modifying statutes or passing emergency statutes.

- In September 2009, Texas amended the Texas Pharmacy Act to allow pharmacists to administer the H1N1 influenza vaccination to patients over seven years of age; to become an influenza vaccinator, pharmacists in Texas must obtain required training and a written protocol from a physician.
- In Minnesota, the 2009 legislature clarified that pharmacists may administer influenza vaccines to all eligible patients 10 years of age or older through December 31, 2009, and after that date they remain authorized to administer influenza vaccines if they enroll in the Vaccines for Children program.
- The North Carolina Board of Pharmacy, as the result of discussions with the state health director and medical boards, passed an emergency amendment to the pharmacist vaccination rule in October 2009. This amendment authorizes pharmacists in North Carolina to administer seasonal and H1N1 influenza vaccines to patients age 14 and

older through July 2010. The emergency rule was directly related to the need for pediatric patients to receive the H1N1 vaccination and the need for pharmacists to aid in this vaccination effort.

- In June 2009, Maine became the 50th state to pass legislation allowing pharmacists to administer certain vaccinations. Maine law authorizes pharmacists to administer influenza vaccines to patients at least nine years old without a prescription, while certain other vaccines require a prescription. Thus, pharmacists in Maine were positioned appropriately to help protect many young people from 2009 H1N1 influenza.

Standing Orders

Some state health departments and boards of pharmacy made the vaccination process more efficient by authorizing pharmacists to administer the 2009 H1N1 vaccine to eligible patients under a "standing order" prescription process. In Louisiana, State Health Officer Jimmy Guidry allowed Louisiana Board of Pharmacy-certified pharmacists to administer the H1N1 influenza vaccine as long as they followed the established government protocol. This emergency order and protocol was extended on October 23, 2009, and remains effective through June 1, 2010.

Following the protocol detailed in a new collab-

orative drug therapy agreement (CDTA), pharmacists in Washington State will be authorized to prescribe antiviral medications if the local health officer determines this action necessary to respond to an influenza outbreak. The development of the CDTA was supported by CDC pandemic preparedness funds. If the protocol is put into effect, pharmacists will be authorized to evaluate patients using local public health guidelines to determine whether antivirals should be dispensed.

Various pharmacist associations, CDC, and the Association of State and Territorial Health Officials promoted the inclusion of pharmacies in states' 2009 H1N1 influenza immunization programs. At least 30 states included pharmacists in preregistration screening to become an H1N1 vaccine administrator according to a state-by-state list compiled jointly by the National Alliance of State Pharmacy Associations and Rx Response. As more vaccines were released and the demand for administering the vaccine grew, pharmacists were given an opportunity to increase patient access to the vaccine, thereby expanding their role in patient care.

States Take Action to Promote Efficiency

On October 29, 2009, New York Governor David Paterson issued an executive order declaring a state disaster emergency, an ac-

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Nominees Announced for Open Officer and Member Positions on 2010-2011 NABP Executive Committee

Elections for the 2010-2011 NABP Executive Committee officers and members will be held this May during the 106th Annual Meeting in Anaheim, CA. Open officer positions include president-elect and treasurer. The treasurer serves a one-year term, while the individual selected as president-elect makes a three-year commitment to the Association. Following one year as president-elect, he or she serves one year as the NABP president before assuming the responsibilities of chairperson of the Executive Committee for a final year.

Individuals interested in running for an open **officer** position must submit written notification including a letter of intent, the expiration date for their term on the active member board, and a resume or curriculum vitae to the NABP executive director/secretary at least 45 days prior to the Annual Meeting's First Business Session (**by April 8, 2010**). Currently, NABP has received the following nominations for the open officer positions.

President-elect (one-year term)

- Malcolm J. Broussard, RPh, Louisiana Board of Pharmacy

Treasurer (one-year term)

- Elizabeth Scott "Scotti" Russell, RPh, Virginia Board of Pharmacy

Nominations for open **member** positions on the NABP Executive Committee were accepted from NABP Districts 1, 2, and 5 subsequent to their respective district meetings this past fall.

In addition to the nominations made by the districts for the open district member positions, individuals may seek to become a candidate by providing written notice to the NABP executive director/secretary. The written notice must include a letter of intent, the expiration date for their term on the active member board, and a resume or curriculum vitae, and must be submitted after the relevant district meeting, but received no later than 45 days prior to the Annual Meeting's First Business Session (**by April 8, 2010**), as stated in Article IV, Section 3(c)(ii) of the NABP Constitution and Bylaws. Only those individuals who have been determined by NABP to meet all qualifications for the open member position will be placed on the ballot.

As of press time, the following nominations have been accepted for the three open Executive Committee member positions.

District 1 (three-year term)

- James T. DeVita, RPh, Massachusetts Board of Registration in Pharmacy
- Ronald L. Petrin, RPh, New Hampshire Board of Pharmacy

District 2 (three-year term)

- Edward G. McGinley, RPh, New Jersey Board of Pharmacy

District 5 (three-year term)

- Lloyd K. Jessen, RPh, JD, Iowa Board of Pharmacy

Qualifications and Voting Procedures

District member and officer nominees must meet the following criteria:

- The individual must be an affiliated member (chief administrative officer or board member) of the Association serving on a board of pharmacy of an active member state at the time of nomination and election.
- The individual must not, in addition to his or her board of pharmacy activities, currently serve as an officer, official, or board or staff member for any national or state pharmacy organization.
- The individual must not have a conflict of interest with the

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Executive Committee

Rich Palombo

Chairperson
One-year term

Gary A. Schnabel

President
One-year term

William T. Winsley

President-elect
One-year term

Malcolm J. Broussard

Treasurer
One-year term

Karen M. Ryle

Member, District 1
Serving third year of a three-year term

Elizabeth Scott "Scotti" Russell

Member, District 2
Serving third year of a three-year term

Michael A. Bursleson

Member, District 3
Serving second year of a three-year term

Gregory Braylock, Sr

Member, District 4
Serving second year of a three-year term

Lloyd K. Jessen

Member, District 5
Serving third year of a three-year term

Joseph L. "Joe" Adams

Member, District 6
Serving first year of a three-year term

Cathryn J. Lew

Member, District 7
Serving first year of a three-year term

Hal Wand

Member, District 8
Serving second year of a three-year term

NABP Executive Committee elections are held each year at the Association's Annual Meeting.

Who Knows What?

By Dale J. Atkinson, JD

While Internet pharmacy issues and criminal judicial opinions have been the recent subject of *NABP Newsletter* articles, the technological advancements and use of electronic and other means to participate in the chain of the distribution of prescription drugs dominate the regulatory landscape. Criminal, and for that matter civil, opinions may provide opportunities for boards of pharmacy to learn from and improve their mechanisms to license, renew, and discipline individuals who violate the practice act. Of course, concerted efforts between law enforcement and regulatory investigations remain critical to the successful public protection mission of pharmacy boards. Practice criteria of licensed pharmacists, as compared to technicians or others involved in pharmacy activities, may result in differing legal conclusions. Consider the following.

A husband and wife team opened a pharmacy (Red Mesa) in Wichita, KS in the fall of 2005. They pursued a business plan that involved securing customers exclusively through Web sites run by two companies: Safe Trust Processing based in Costa Rica and IntegraRx based in Seattle, WA. Through the Web-based business, customers received prescription drugs simply by filling out an online questionnaire. Physicians in the United States and Puerto Rico contracted with the

above two companies to electronically review customer questionnaires and either approve or disapprove the requested prescriptions.

The contracted physicians did not examine their "patients," nor did they verify any of the personal information provided in the questionnaire. Indeed, the physicians "did not have any dealings at all with the subjects of their prescriptions." Regardless, the physicians approved the vast majority of requested prescriptions.

Upon approval, Safe Trust and IntegraRx placed the approved prescriptions online for access by participating pharmacies, including Red Mesa. Customers used credit card payments online and Red Mesa received \$7 for each order filled. In the eight-month period of operations during late 2005 and into 2006, Red Mesa received \$706,611 for its efforts in this relationship.

Red Mesa was run by the husband, who managed the inventory and chose which prescriptions were filled, and wife, who served as the day-to-day operations manager. Red Mesa employed a pharmacist (licensee) and a computer technician (technician), who was responsible for printing out labels. The "technician" was not registered with the Kansas State Board of Pharmacy. During its first few months of operations, Red Mesa carried a Drug Enforcement Administration (DEA) certificate permitting it to distribute substances subject to the Controlled Substances Act (CSA). During this short period, Red Mesa filled a total of 9,256 prescriptions for controlled substances, more than for non-controlled substances by a factor of 9 to 1. These controlled substances consisted largely of diet and sleep aid pills, while the non-controlled substances included lifestyle drugs, like Viagra®.

A previous pharmacist employed by Red Mesa complained to a state board of pharmacy investigator that Red Mesa was filling prescriptions issued by physicians who did not reside in the same state as their patients. The investigator reported the allegations to the state board and DEA. Thereafter, the investigator visited the pharmacy and issued a number of citations, including violations of Kansas law limiting customers to a 30-day supply of diet pills. DEA executed a search warrant resulting in the surrender of the pharmacy's DEA controlled substances registration. The pharmacy continued to distribute non-controlled substances until its state license was revoked in June 2006.

Eventually, the federal government brought charges against the husband and wife (pharmacy owners) and the licensee (pharmacist) and technician alleging violations of the CSA. The husband pled guilty to conspiracy charges and the allegations against the wife were dropped. The licensee and technician were tried jointly and each was convicted of one count of conspiracy to distribute controlled substances and three counts of conspiracy (aiding and abetting). Both the licensee and technician appealed.

On appeal, the licensee sought reversal arguing

that there was not enough evidence to support a conviction in light of the fact that there is no law that a prescription received via the Internet is illegal. In rejecting this "red herring" argument, the court stated that the government has disclaimed any interest in trying to prove that using the Internet to transmit a lawful prescription is unlawful under the CSA. But, the issuance of a prescription based solely on an online questionnaire, without more, "falls outside the usual course of contemporary medical practice."

The licensee argued that under *Gonzales v Oregon*, the federal government "has no business trying to define what practices are and are not within the usual course of professional medical practice." However, the appellate court held that *Gonzales* did not apply to the current matter because that case addressed an interpretative rule issued by the United States Attorney General's office (which was struck down by the US Supreme Court), while the current case addressed a practice alleged to have no legitimate medical purpose. In this case, both parties presented witnesses and documentary evidence focused on the "contemporary norms of the medical profession." As referenced by the court, the defendants were not foreclosed by rule from disagreeing. Instead,

they were free to present contrary proof that their behavior in filling prescriptions was in conformance with professional practice.

The licensee also argued that the government presented insufficient evidence to support its claims that prescriptions based solely on online questionnaires, without more, are inconsistent with contemporary medical practice. In rejecting this argument, the court focused on the licensee's own testimony. As a pharmacist of almost 45 years, the licensee admitted that a prescription issued by a prescriber acting in the course of legitimate professional practice will be one which the prescriber might normally have seen in the office or elsewhere. Additional testimony also supported this conclusion, including that of the executive director of the Kansas State Board of Pharmacy, certain board inspectors, as well as a DEA inspector.

The licensee also argued that the pharmacists who testified are not physicians. Rejecting this notion, the court held that the regulations implementing the CSA expressly place a duty on pharmacists "not to knowingly fill prescriptions issued outside the ordinary course of medical practice." The court noted that given this legal duty, "it does not strain the imagination to think that some pharma-

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Legal Briefs

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cists might know and be qualified to speak about what it means for a prescription to be consistent or inconsistent with the usual course of medical practice.” Indeed, the licensee offered his own testimony on that very subject.

The court also rejected arguments of the licensee related to expert witnesses, unconstitutional vagueness of the CSA, and entrapment and upheld the conviction of the licensee for conspiracy and aiding and abetting.

Turning its attention to the computer technician, the court had a very different approach and legal

expectation of a high school dropout hired to perform menial tasks, including logging onto the Safe Trust and IntegraRx Web sites, and accessing a page that listed what prescriptions were available, checking the box next to the prescriptions the pharmacy would fill, and printing the label for the chosen prescriptions. The technician did not interact with customers, did not see the patient profiles, did not communicate with the physicians, and did not identify which particular prescriptions the pharmacy filled.

The court noted the absence of an apparent link between the facts the government relies upon, including that the techni-

cian knew the prescriptions filled by Red Mesa were issued by Safe Trust and IntegraRx physicians, acting outside the usual course of professional medical practice or without a legitimate medical purpose. The court held that the facts presented did not support the inference that the technician knew the boundaries of legitimate medical practice and emphasized that the CSA prohibits the “knowing” distribution of prescriptions issued without a legitimate medical purpose or outside the usual course of professional practice. Because the technician had no previous pharmaceutical knowledge or training, and was brought on to assist

with computer tasks and data entry, the court held his conviction cannot be sustained.

Once again, the criminal courts are enforcing the CSA by interpreting the meaning of contemporary medical practice and requiring pharmacists to understand and interpret such practice as part of their professional responsibilities. If evidence exists to criminally convict a licensed pharmacist under a burden of beyond a reasonable doubt, administrative discipline under a preponderance or clear and convincing burden is in order.

United States v Lovorn, 2009 WL 2871538 (10th Cir. 2009) ①

Nominees Announced

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purpose, mission statement, and operation of NABP.

During the First Business Session of the Annual Meeting on Sunday, May 23, NABP President Gary A. Schnabel, RN, RPh, will announce the open Executive Committee officer and member positions. The president will also announce the names of the candidates who have submitted the required materials to run for office by the specified deadlines and have been qualified by

NABP. The final ballot for the Executive Committee election will include those individuals nominated at the district meetings, as well as those nominated outside the district meeting nomination process, and qualified by NABP.

During the Annual Meeting, time will be designated for candidate speeches and/or speeches given on the candidates’ behalf. Individuals giving candidate speeches must be affiliated members of NABP, and a maximum of two speeches may be given for each candidate, including the candidate’s own speech. Individuals giving speeches must

limit their remarks to two minutes.

Voting will take place during the Final Business Session on Tuesday, May 25. Candidates, whether running opposed or unopposed, must receive a majority of the delegate votes present in order to be elected to office. If more than two candidates are slated for a single office and none receives a majority of the vote, the candidate(s) receiving the fewest votes will be eliminated from subsequent ballots. The results of the election will be announced immediately and an installation ceremony will be conducted for the

new officers and members of the 2010-2011 Executive Committee. Terms commence immediately following the Annual Meeting.

More information about the procedures for nominating and electing Executive Committee officers and members is available in Article IV, Section 3(b) and 3(c) of the NABP Constitution and Bylaws. Updates to the list of nominees will be posted on the NABP Web site at www.nabp.net. More information on the 106th Annual Meeting is available on pages 15-16. ①

States Respond Regarding the Practice of Utilizing Timing Systems in Pharmacy Dispensing Processes

Concerns about medication dispensing errors due to stressors in the pharmacy work environment have been increasing over the past two decades. With changes in health care and the economy, many pharmacists have the pressure of filling a higher volume of prescriptions than in the past, and without additional staff. Some pharmacists believe that the use of timer systems in pharmacies that track how long a pharmacist takes to dispense individual prescriptions adds to the stress, and possibly increases the risk for error. Pharmacy operators, on the other hand, have stated that timer systems are used to improve pharmacy efficiency in the interest of meeting patients' medication needs.

State boards of pharmacy recently had the opportunity to voice whether or not licensees in their states held concerns about the use of timer systems in pharmacies in a survey administered by NABP on behalf of the Delaware State Board of Pharmacy in September 2009.

State boards were asked (1) if there were any concerns regarding the use of timers in pharmacies for their state and (2) how the board has addressed this issue of using timers in pharmacies (eg, through legislation, regulation, newsletters).

Of the 31 state boards of pharmacy that responded to the survey, 15, or 48%, indicated that there is concern regarding the use of timers in pharmacies. Three of these states have taken action in response to the issue.

The North Carolina Board of Pharmacy reported that it has investigated two complaints concerning the use of timers. In both instances, the Board expressed its view that the use of such timers could amount to negligence in the practice of pharmacy and that it would take strong disciplinary action if necessary. The North Carolina Board of Pharmacy believes the use of timers in pharmacies may send the message that prescription dispensing speed should be prioritized over patient safety.

As reported in the survey, in New Mexico, if

an error occurs and a patient is harmed, the New Mexico Board of Pharmacy will proceed under rule 16.19.27, a dishonorable conduct rule that was adopted in 2003 and updated in March 2004 to include language regarding mis-filled prescriptions related to work conditions. Under the rule, the New Mexico Board may take action if it determines "failure of the business owner or authorized representative to provide an appropriate environment, (staffing and physical environment) that can provide pharmaceutical care in a way that does not endanger the public."

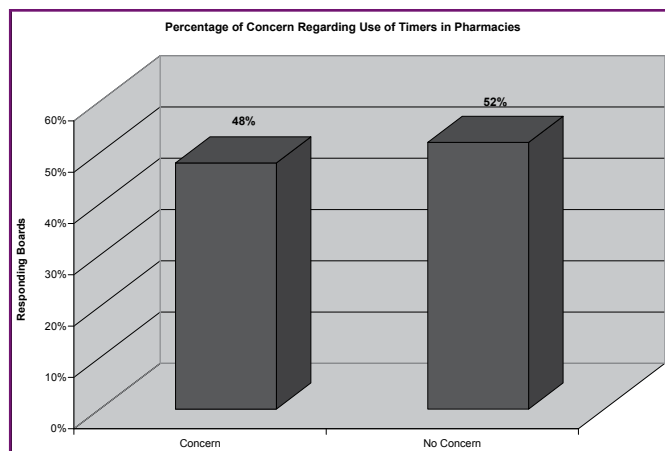
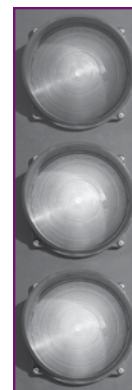
The New York State Board of Pharmacy has acted through motions and comments at Board meetings, warning that, should errors occur, the use of timers will be a factor in determining

disciplinary penalties. Further, the New York Board has warned pharmacists that not only will this factor not be mitigating in their favor, but more likely it would lead to harsher penalties.

Twelve of the 15 state boards of pharmacy reporting concerns regarding the use of timers, to date, have not addressed the issue, but several of these boards provided comments that suggest the need for further examination of this issue. The Hawaii State Board of Pharmacy expressed concerns that timers could distract pharmacists from fulfilling their duties and responsibilities. Similarly, the Ohio State Board of Pharmacy has no records of errors due to the use of timers, but does monitor for this activity. The Texas State Board of Pharmacy has also recently become aware that a chain pharmacy operating in its state does use timers.

Of the 31 state boards of pharmacy responding to the survey, 16, or 52%, indicated that there are no concerns regarding the use of timers in pharmacies in their state. The South

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Of the 31 state boards of pharmacy that responded to the survey, 15, or 48%, indicated that there is concern regarding the use of timers in pharmacies and 16, or 52%, indicated there was no concern.

Risks Increase for Patients Seeking Medications Online: Be Wary of Pharm Spam, Phishing Attacks, and Identity Theft Scams

The use of “pharm spam,” spam promoting pharmaceutical products, and the unauthorized use of trusted pharmaceutical brand names to market fraudulent products through Web sites continues to grow. Through targeted, high volume spam; fraudulent Internet advertisements; sophisticated Web site and message design; and silent malware, scammers continue finding new ways to victimize computer users who are lured by promises of discount, brand-name drugs, and the convenience and anonymity of not visiting a physician. Still peddling fake, counterfeit, and otherwise illegal drugs under false pretenses and often from distant locations such as India, Ukraine, and Turkey, many of these rogue Internet drug outlets complement their illegal drug trafficking with a host of other cybercrimes such as credit card fraud and identity theft. In a worst-case scenario, users may receive dangerous counterfeit drugs, have their money and identity stolen, and have their computer taken over by a cybercriminal who uses it to spam the users’ friends, family, and the owners of any e-mail addresses stored on their computer, and to access their passwords to various other online accounts.

Deceptive Practices Lead Users to Malicious Web Sites

Cybercriminals blast out spam e-mail messages in hopes of luring users to Web sites with various malicious intents. Spam messages

attempt to fool or confuse users with deceptive content and some link to Web sites claiming to sell pharmaceuticals, or actually marketing and distributing certain illegal products, including fraudulent, unapproved, or counterfeit medications.

Furthermore, some of the Web sites linked to these spam e-mails impersonate legitimate businesses as part of phishing scams that attempt to trick users into providing personal identifying information such as usernames, passwords, credit card numbers, mother’s maiden name, and Social Security number.

“Pharm spam,” which advertises discount drugs and includes links to questionable Internet drug outlets, accounted for the majority of global spam volume in September 2009 according to the *October 2009 Spam Report* from McAfee, Inc, an Internet and network security provider. McAfee concludes that 70% of the global spam volume in September advertised and included links to supposedly “Canadian” online pharmacies. These spammers hope to take advantage of consumer trust in authentic Canadian pharmacies and prey upon their desire for discount drugs.

Brandjacking and Cybersquatting Help Create Ruse Leading to Malicious Sites

Scammers may use brandjacking tactics or cybersquatting to lure spam recipients to their Web sites where these users may be preyed upon. Brandjacking, according to brand protec-

tion company MarkMonitor, involves hijacking “a brand to deceive or divert attention” and it is “often used in abusive or fraudulent activities devised for gain.” A good example of brandjacking involves Liberty Medical Supply, Inc, a legitimate company that built good will with consumers through its television advertisements. According to the McAfee *October 2009 Spam Report*, questionable drug vendors used the name Liberty Medical in spam messages, to make it appear to consumers that the company endorsed the vendors’ drugs. Some scammers may use brandjacking tactics such as these in spam that leads to malicious Web sites.

In another instance, a network of potentially thousands of Internet drug outlets was found by NABP to impersonate a well-known pharmacy chain, display a fake VIPPS® (Verified Internet Pharmacy Practice Sites™) Seal on its affiliate Web sites, and claim to be licensed by the Minnesota Board of Pharmacy. Further, as of October 26, 2009, NABP had found 71 instances of name fraud in which Internet drug outlets used the NABP name in the URL or link description.

Some scammers also use a practice that exploits a brand name by using it

in keyword content and metatag coding on their fraudulent Web sites. The content then serves to make their drug outlet sites rank higher in search engine results when the user enters the drug brand name as a search term.

According to MarkMonitor, cybersquatting is the “practice of abusing trademarks within the domain name system.” In other words, scammers may exploit brand names by incorporating them into domain names to fool users into believing they are accessing the authentic online business. For example, BrandnameUS.com, Brandname-USA.com, or Brandnameonline.com may appear to be legitimate sites for a known brand name when in fact the rightful owner only uses Brandname.com. The practice of pharmaceutical cybersquatting increased 9% from the previous year according to a 2009 MarkMonitor study that followed six drug brands. More than 19,000 sites are cybersquatting on these six pharmaceutical brand names alone. Sites misusing lifestyle drug brand names made up 75% of this misuse, while sleep aids, anti-anxiety medications, anti-cholesterol medications, digestive aids, and anti-flu medications comprised the other drug types whose brand names are exploited.

Malware Attacks

Of growing concern, some malicious Web sites, through malware and phishing pages, attempt to steal a computer user’s personal data, possibly leading to identity theft. In fact, “The Crimeware Landscape,” authored by the United States Department of Homeland Security, SRI International Identity Theft Technology Council, and the Anti-Phishing Working Group, reports that “[o]nline identity theft, in which confidential information is illicitly obtained through a computer network and used for profit, is a rapidly growing enterprise. Credible estimates of the direct financial losses due to ‘phishing’ alone exceed a billion dollars per year.” According to MarkMonitor, “Brand attacks are the new form of eCrime, and they’re being launched with new and rapidly evolving exploits, including phishing and – most recently – malware.”

Whereas many phishing scams will not work without user actions such as clicking on a link or entering data on a phishing Web page, the combination of drive-by downloads and malware gives the cybercriminal almost complete control, with little action required from the computer user. In a drive-by download, when users click on the link that takes them to a Web site, the site automatically installs malware. Malware, according

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Internet Risks

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to MarkMonitor, is “any type of software that is deployed to cause damage to devices or to collect confidential data from users.” Recent malware is insidious, working unknown to the computer user; whereas in the past, the hacker’s activity would bog down the computer, making common applications run slow enough to prompt the user to detect and eliminate the virus or malware if possible.

Some malware is used to further propagate spam. This type of malware installs a program on the computer that leaves the computer Internet port open. Hackers then scan the Internet for computers with the open ports, and install the bot that allows them to send commands initiating spam

distribution and phishing schemes. These compromised computers are referred to as “zombies” because the spammer can wake them up and use them at any time.

Some of the current malware, dubbed crimeware by some security experts, works by keylogging everything the user types, making it possible to steal any personal data available on their computer. Hackers can then sell the data to criminals who use it to perpetrate identity theft.

Further, Web sites that actually take orders for drugs – whether or not they intend to send a product – may also facilitate identity theft. Web site owners illegally selling counterfeit or prescription drugs, and processing payments using the victim’s credit card information, may have no qualms about selling the

victim’s data or using the data themselves to commit identity theft. Such activities are facilitated by online credit card processing and merchant account companies that make it possible for anyone to accept payment through a credit card without completing the registration process used by a bank.

Further, as reported in *Digital Journal* and *ITbusiness.ca*, criminals advertise their products for sale, including stolen credit and debit card numbers, personal identification information, and government IDs, on Internet chat rooms.

Current Phishing Scams

In contrast to the unattractive, error-laden spam content of a decade ago, unscrupulous operators of phishing schemes now craft

highly sophisticated spam messages that impersonate and can appear as professional as authentic e-mail correspondence from legitimate businesses. The graphics, design, and content closely mimic messages sent by legitimate merchant services and well-known financial institutions and attempt to trick users into believing that they need to update account passwords, payment information, or other private data. Even the “from” address can be faked. In addition, the practice of cybersquatting can make links appear legitimate and they often lead to phishing Web pages that appear to be legitimate as well.

Once on the phishing Web page, if users enter their usernames and passwords, cybercriminals may

Internet Risks Glossary

Bot

Short for robot, a software program that operates as an agent for a user or another program, or simulates human activity. A malicious bot may be installed by a hacker and used to control the victim’s computer.

Botnet

A network of bot-infected computers working at the command of a hacker to facilitate malicious Internet acts.

Brandjacking

Unauthorized use of a brand name often for

the purpose of facilitating fraudulent activities devised for gain.

Crimeware

Malware that enables computer crime, such as keylogging programs that track the victim’s keystrokes and report the data to a remote hacker who may use the information for identity theft.

Cybersquatting

Bad faith use of others’ trademarks, usually for profit, by registering and/or incorporating the marks into domain names of Web sites that do not offer bona fide goods or services or that seek to damage or exploit the trademark. Often practiced

by hacking into the Web site servers of legitimate domain name owners without their knowledge.

Drive-by Download

By simply visiting a Web site, malicious software may be downloaded to the victim’s computer without the consent, knowledge, or any action on the part of the victim.

Malware

Software deployed to cause damage to devices or to collect confidential data from the user.

Pharm Spam

Spam promoting pharmaceutical products, typically advertising discount drugs

and including links to questionable Internet drug outlets.

Phishing Scams

Spam e-mail messages lure users to click on links to Web pages that request the victim to enter personal data such as account usernames, passwords, payment information, Social Security numbers, and/or mother’s maiden name.

Spam

High volume, unsolicited e-mail messages prompting recipients to click on links to Web sites or open malicious attachments. ⓘ

have access to their credit card and bank account data, as well as enough personal information to drain bank accounts and ruin users' credit. In other words, phishers can use the data they obtain to steal identities.

Example Attacks: Storm Botnet and Swine Flu Spam


While early hackers, who were at times classified as vandals of the Internet, committed crimes to show off and gain notoriety, today's cybercriminals who deceive victims through misrepresentation and other types of fraud are motivated by financial gain. In a study conducted in spring 2008 by University of California, San Diego and University of California, Berkeley researchers concluded that pharmaceuti-

cal spam from one botnet, a network of bot-infected computers sending out spam at the behest of the spammer, could produce \$3.5 million of revenue a year. The team infiltrated the Storm worm botnet, at one time reportedly responsible for an estimated 20% of all spam, by impersonating a small percentage of its alleged spam and directing it to their own dummy pharmaceutical Web sites and servers. Out of 350 million e-mails promoting their dummy site, 28 \$100 would-be sales resulted over 26 days. Extrapolating from their data, which accounted for roughly 1.5% of the botnet, the researchers concluded that a botnet as pervasive as Storm would probably generate \$7,000 to \$9,500 per day, enough sales to keep cybercriminals highly motivated. In fact, an-

other portion of their study determined that about 10% of people clicking on links in pharm spam end up running and installing the malware that propagates more spam through their machine, continuing the opportunity for the criminals to profit. The trade of botnets is itself a lucrative form of organized crime. Security experts report that botnet attacks cost between \$500 and \$1,500 or that they are sometimes priced per compromised computer at \$1 to \$40 each.

Most recently, spammers have latched on to public fears over the spread of the 2009 H1N1 influenza virus, continuing to use the fear-evoking term "swine flu." US-Computer Emergency Readiness Team, a government agency that monitors computer-related security issues, reported

in April 2009 that scammers were using e-mails with messages about swine flu. The e-mail messages contained links leading to phishing Web sites or links that downloaded malicious code. In one scam, users were sent a PDF document purporting to answer frequently asked questions about swine flu. Instead, if the user tried to open the document, the file uploaded the malicious Infostealer, a Trojan horse that has the ability to steal sensitive information from the victim's computer.

Look for part 2 of this article in next month's *NABP Newsletter*: What actions are federal agencies, state boards of pharmacy, and NABP taking to combat cybercrime and unauthorized use of pharmaceutical brand names? 

Practice of Timing

(continued from page 7)

Dakota State Board of Pharmacy, however, indicated that as the issue has been raised, inspections will now monitor for the activity. Of the 16 state boards responding that there are no concerns, seven indicated that the board had not addressed or discussed the issue, five indicated that they had no reports of the practice being used in their state, and four indicated that there were no concerns regarding the issue in their state.

Pharmacists' Workload Addressed in Past Decade

The North Carolina Board of Pharmacy addressed the related issue of pharmacists' daily workload in 1996 by adopting the guideline that 150 prescriptions per pharmacist per day should be used as a threshold. The North Carolina Board can use the threshold guideline when investigating reports of dispensing errors under rule 1811, which states, "Pharmacists shall not dispense and permit holders shall not allow a pharmacist to dispense

prescription drugs at such a rate per hour or per day as to pose a danger to the public health or safety." The Board stresses that their policy is not intended to be used as a limit or quota that triggers a pharmacist to stop filling prescriptions; rather, it can signal the need for management to reexamine a situation as workloads increase.

Investigative reporters working a decade later found that some pharmacies were pushing for volume as high as 500 prescriptions per day, per pharmacist. Specifically, in November and Decem-

ber 2006, two reporters investigated the practice of timing pharmacists' dispensing process and the correlation to medication dispensing errors.

Pharmacy operators have noted that automated dispensing tools, such as robotic fill centers, and e-prescribing help pharmacists to increase the number of prescriptions dispensed per day without adding to their workload, and while ensuring patient safety. Computerized work-flow systems also assist pharmacists in dispensing a higher

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Pharmacists' Roles

(continued from page 2)

tion that allowed additional personnel and flexibility to local governments implementing the statewide 2009 H1N1 influenza vaccination campaign. Under the state's existing law, only physicians, certified nurse practitioners, and nurses were authorized to administer vaccinations. Pharmacists and other health care professionals who chose to assist in the vaccine administration were required to complete training and worked under the direction of state and county health departments. The executive order authorized additional health care professionals, including pharmacists, to administer the 2009 H1N1 vaccine. Approximately 10 million New Yorkers fell into CDC's 2009 H1N1 vaccination priority groups, and the additional authorized vaccinators helped to meet the state's vaccination goals.

Other state boards of pharmacy also recently updated policies to increase efficiency in procedures enabling pharmacists to administer vaccines. In September 2009, the New Hampshire Board of Pharmacy adopted a new statute providing clear guidelines for regulating pharmacists' administration of influenza vaccines; by adopting clear guidelines for regulation, the Board aims to make vaccinations more easily accessible and to provide immunity to a larger patient population.

Specifically in response to the approaching influenza season and the threat posed by the H1N1 pandemic, the District of Columbia adopted an emergency rule aimed to eliminate the requirement for multiple protocols, thus, increasing the number of pharmacies participating in the vaccination efforts. Effective August 18 through December 18, 2009, the rule permitted District of Columbia Board of Pharmacy certified-pharmacists to administer immunizations and vaccinations, including the H1N1 vaccine, to people 18 years of age and older pursuant to one written protocol and standing order with one DC-licensed physician.

H1N1 Training for Pharmacists

All states require appropriate training for pharmacists wishing to administer vaccines, and in 2009 several states created additional pharmacist training specific to the 2009 H1N1 influenza pandemic. In October 2009, the state of Maryland provided a free course, "Influenza Pandemic Training for Pharmacists," through the University of Maryland School of Pharmacy, in conjunction with Montgomery County Department of Health and Human Services, Public Health Services, and the Public Health Emergency Preparedness and Response Program. The Massachusetts Department of Public Health offered

free training for vaccine administrators, including pharmacists, throughout October. Training included information on initial target groups to receive H1N1 vaccine, screening, and immunization administration for children and adults.

Helping Pharmacists to Educate the Public

Just as state boards, health departments, and universities provided H1N1-related training to pharmacists, pharmacists were encouraged to become even more active in their role to educate the public.

Pharmacists in California, through the coordinated efforts of Federal Emergency Management Agency (FEMA) and the California Pharmacists Association (CPhA), were called upon to provide H1N1 information to patients as well as participate in the administration of vaccines, as their part in the Ready America campaign. The Ready America campaign urges the public to prepare emergency kits and make plans to cope with emergency disasters, and a CPhA press release notes that California "[p]armacists and pharmacies [were] uniquely positioned at the center of the H1N1 crisis" expected in the fall, and that pharmacists were "swiftly preparing to participate in state-wide vaccination and dissemination of information."

Studies confirm the efficacy of pharmacists'

educational efforts. For example, a study published in the *International Journal of Pharmacy Practice* by Grabenstein and colleagues in 1993 concluded that unvaccinated people encouraged by pharmacist mailings were 74% more likely to get vaccinated. Another study published in *Pharmacotherapy* in 2001, analyzed the results of 655 patients at high risk for influenza who were mailed educational materials and discovered that vaccination rates increased by 24% from the previous year when no mailings were sent.

The pharmacist's role as educator was lauded in an October 2009 CDC press release covering the 2009 Get Smart About Antibiotics Week. CDC stressed that pharmacists can help emphasize to patients that influenza viruses do not respond to antibiotic treatments, helping promote correct treatment of viral infections, as well as helping to curb the rate of antibiotic resistance. In the press release, CDC medical director for the Get Smart program emphasizes the important role of pharmacies in the promotion of appropriate antibiotic use, citing the pharmacists' knowledge and ability to have a positive influence on public health. CDC's ample information and updates for pharmacists, as well as its Web site and educational materials for

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Panelists Convene to Review and Set NAPLEX Standards; Blueprint Revision to be Released in Early 2010

In November 2009, a group of specially selected panelists convened at NABP Headquarters to review and set standards for the North American Pharmacist Licensure Examination® (NAPLEX®). In adherence to testing industry standards, this standard setting meeting was scheduled as a follow-up to the NAPLEX practice analysis survey distributed by NABP during the second quarter of this year, which resulted in a recommendation to review the current passing score for the NAPLEX.

Review of Competency Statements

The practice analysis survey was developed after a subcommittee of the NAPLEX Review Committee conducted extensive research focusing on the current practice responsibilities of pharmacists and the knowledge, skills, and abilities required to carry out those responsibilities with respect to the protection of the public health and patient care outcomes. The subcommittee worked to determine necessary changes to the NAPLEX competency statements, which define the important knowledge, skills, and abilities examinees are expected to demonstrate as entry-level pharmacists and guide the development of NAPLEX items. After meticulously reviewing the

competency statements, the subcommittee recommended that pharmacoeconomics be addressed in the statements. Utilizing their research results, the subcommittee subsequently revised the appropriate competency statements to adequately reflect the influence pharmacoeconomics has on the practice of pharmacy today with respect to patient care outcomes.

Upon review and approval by the NAPLEX Review Committee, the Advisory Committee on Examinations, and the NABP Executive Committee, these proposed revisions were transformed into the format of a practice analysis survey, which was then administered to a comprehensive group of United States- and Canada-based pharmacists in all practice areas. The individuals surveyed were asked to rate the three areas of competency statements based on two factors: criticality (how serious the consequences are if the items described in the competency are not performed properly) and frequency (how often an entry-level pharmacist must perform a task that requires knowledge of this item). After receiving responses and feedback from the survey, NABP conducted an in-depth statistical analysis of the results to analyze any necessary shifts in the competency statements among the major competency areas.

The results garnered from the survey were also used to further evaluate and validate the possible updates to the NAPLEX Blueprint (see October 2009 *NABP Newsletter* article “Results of Pharmacy Practice Analysis Survey to Assist NABP in 2010 NAPLEX Blueprint Revision”).

Who Sets the Standards

Following the review of the practice analysis survey results, invitations to participate in a NAPLEX standard setting meeting were sent to a vast array of pharmacy practitioners and NAPLEX Review Committee members. From the responses received, NABP carefully selected a demographically diverse group of subject matter experts and practicing pharmacists to participate in the November meeting. These panelists represented a balanced group of individuals from all areas of practice with experience in the field ranging from two years to more than 35 years.


After receiving extensive training by an experienced psychometrician, the panelists were asked to rate a representative sample of items in the NAPLEX operational pool. Specifically, the panelists were instructed to evaluate the items by estimating the proportion of sufficiently knowledgeable, entry-level pharmacists that *would* be able to answer each



question correctly. As in the past, the modified Angoff standard setting method was used as a model.

How Does this Affect the Blueprint?

The entire process from start to finish adheres strictly to the testing industry standards and utilizes an established methodical procedure to support all aspects of the process. The resulting updated Blueprint, which will be effective on March 1, 2010, will directly reflect the shift in weight of the content areas. The proportion of items represented in the NAPLEX is anticipated to increase in Area 1, which covers pharmacotherapy and therapeutic outcomes, decrease in Area 2, which covers preparation and dispensing of medications, and remain the same in Area 3, which covers patient counseling and the promotion of public health. The NAPLEX will be revised to reflect any updates to the Blueprint and will be released March 1, 2010.

To view the current or new Blueprint and for more information on the NAPLEX, visit the Examinations section of the NABP Web site, www.nabp.net, or contact custserv@nabp.net. 

nabp newsletter

NAPLEX, MPJE, and ELTP Fees to Increase

In 2010, NABP will be implementing fee increases for its examination and licensure transfer programs in order to continue to protect the integrity and security of the programs. The new application fees for the Electronic Licensure Transfer Program® (ELTP®), the North American Pharmacist Licensure Examination® (NAPLEX®), and the Multistate Pharmacy Jurisprudence Examination® (MPJE®) will be effective May 10, 2010.

In recent years, the state boards of pharmacy and

NABP have faced a number of challenging issues involving the security and integrity of the examination and licensure processes. These challenges continue and the development of secure and valid competence assessment examinations and litigation activities taken to protect copyrighted examination content incur significant expenses for NABP. The same is true in regard to NABP's Licensure Transfer Program, which provides for uniformity across the states and vital information for the

state boards of pharmacy to evaluate when considering the eligibility of pharmacists seeking licenses through licensure transfer.

NABP has not adjusted ELTP application fees since 2001. During that time NABP invested in the development of an online application that has reduced application status inquiries to board of pharmacy staff as well as reduced processing time due to application features that help decrease the likelihood of incomplete or incorrect applications. Future enhancements to the ELTP application are planned for 2011 and are expected to further streamline the license transfer process for board staff and applicants.

The NAPLEX and MPJE fees were last

amended in January 2006 due to increases in vendor fees. In addition to vendor fees, the NAPLEX and MPJE fees offset and support costs for examination development and registrations, and help support non-revenue member services including the NABP Clearinghouse.

Fee information has been updated in the NAPLEX/MPJE Registration Bulletin, which is available in a PDF format on the NABP Web site at www.nabp.net. ELTP fee information can be found in the Licensure Programs section of the Web site.

For more information, contact NABP via e-mail at custserv@nabp.net or via phone at 847/391-4406. ☎

Fee Adjustments Effective May 10, 2010

Program	Current Fee	New Fee
ELTP	\$300	\$350
NAPLEX	\$465	\$485
MPJE	\$185	\$200



Task Force Convenes to Discuss E-Prescribing Software

On September 15-16, 2009, the Task Force on Electronic Prescribing Software Standards and Data Storage met in Northbrook, IL. Back row from left to right: Donald Casar, RPh, member, Ohio State Board of Pharmacy; Karen M. Ryle, MS, RPh, Executive Committee liaison; Frank Whitchurch, RPh, member, Kansas State Board of Pharmacy; Larry Hadley, RPh, member, Kentucky Board of Pharmacy; Suzanne Neuber, RPh, assistant compliance officer, Omnicare, Inc; and Elvy Paiva, RPh, member, New Jersey Board of Pharmacy. Front row from left to right: Alice Mendoza, RPh, member, Texas State Board of Pharmacy; Lydia Main, RPh, member, West Virginia Board of Pharmacy; David Kozera, RPh, member, Virginia Board of Pharmacy; Jeannine Dickerhofe, MS, RPh, member, Colorado State Board of Pharmacy; and Joann Predina, MBA, RPh, compliance specialist, Ohio State Board of Pharmacy. ☎

Anaheim Provides Family-Oriented Entertainment and Modern Amenities for 106th Annual Meeting

With easy access to exciting entertainment, Anaheim – the largest and most populated city in Orange County, CA – provides an engaging and relaxing setting for the NABP 106th Annual Meeting, to be held May 22-25, 2010, at the Hyatt Regency Orange County. After participating in important business sessions and timely continuing pharmacy education (CPE) sessions, attendees can enjoy with ease all that Orange County offers.

Now known as the home of Disneyland and Angel Stadium, the city of Anaheim was founded by German settlers in 1857 as a tightly knit agricultural community producing primarily wine vineyards. When disease wiped out the vineyards in the 1870s, Anaheim made a name for itself as one of the primary producers of oranges in the county named for the fruit. While the population grew and events such as the annual Anaheim Halloween Parade attracted up to 150,000 spectators, Anaheim remained a rural, agricultural community into the 1950s.

Entrepreneurship and innovative industry spurred tremendous economic and population growth in Anaheim throughout each decade of the last half of the twentieth century. The post-World War II industrial boom brought new jobs,

new residents from the east, and the construction of new homes, buildings, highways, and roads.

During this era of southern California's growth and prosperity, Walt Disney began to imagine a park that would offer families fun and fantasy. After several revisions to plans, meetings with city councils, and fund-raising efforts, Disney chose Anaheim as the site of his theme park and construction began in 1954. Disneyland's opening day was July 17, 1955, and while the Magic Kingdom had a rough beginning, planning, persistence, and a partnership with ABC television helped bring 1 million guests through the Disneyland gates within seven weeks. Disneyland's success brought more jobs, additional industries, and a seasonal stream of tourists to Anaheim. The city annexed additional land and by 1955 was four times the size it had been in 1953.

With the aim of bringing in tourists and visitors year round, business leaders in the 1960s organized to plan the Anaheim Convention Center, marketing the facility to attract the family-oriented conventioner. The center opened in 1967 and was booked to capacity year after year, continuing Anaheim's growth and prosperity. In 1966, the opening of Anaheim Stadium brought sports fans to the city as the Angels baseball team

decided to make Anaheim home. Throughout the 1960s and 1970s, the stadium hosted motor sports and rock concerts, in addition to baseball, and was hailed as a modern, well-managed facility. This reputation helped bring the Los Angeles Rams to call Anaheim Stadium home in 1978. Following renovations completed in the late 1990s, the stadium was renamed Angel Stadium of Anaheim in 2003.

Local Attractions

Located at the crux of southern California's major freeways, Anaheim provides easy access to additional Orange County attractions. Anaheim sits less than 15 miles from the most popular beaches of Orange County, including Seal Beach, Huntington Beach, and Corona Del Mar. Outdoor adventures range from tide pool exploration to whale watching excursions. Well-known area shopping malls, South Coast Plaza and Fashion Island, are also located within 20 miles, in Costa Mesa and Newport Beach, respectively. The latter is one of the most successful outdoor shopping malls in the country.

Optional Tour

Attendees of the Annual Meeting will have the opportunity to explore the beautiful beaches and unique shops running down

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Anaheim Attractions

Additional information on the Anaheim area sites and attractions mentioned in this article is available at the following Web sites and phone numbers.

Disneyland Park and Disney's California Adventure Park

<http://disneyland.disney.go.com>
714/781-4565

Disneyland theme park tickets specially priced for Annual Meeting attendees may be purchased using the link in the Meetings section of the NABP Web site. Tickets must be purchased online by 9 PM PST on May 14, 2010. Buses leave the hotel every 30 minutes.

Angel Stadium, Ballpark Tours

http://losangeles.angels.mlb.com/ana/ballpark/ballpark_tours.jsp
714/940-2070

Anaheim/Orange County Visitor and Convention Bureau

www.anaheimoc.org
714/765-8888

Laguna Beach

www.lagunabeachcity.net
www.lagunabeachinfo.com
949/497-3311

Newport Beach, Newport Harbor

www.newportbeachca.gov/index.aspx?page=6
www.visitnewportbeach.com
800/94-COAST

New Registration Fees Set for 106th Annual Meeting

Registration is now available for the 106th Annual Meeting, held May 22-25, 2010, at the Hyatt Regency Orange County in Anaheim, CA, with new registration fees now in effect. This is the first fee change since 2002.

While the board group-member rate is no longer being offered, the individual member rate has been reduced by \$25. Fees for spouses and guests have risen by \$25, while student registration rates have increased by \$100.

Online registration will be available in the Meetings section of the NABP Web site at www.nabp.net in February 2010. A printable registration form is available now for download.

Both types of registration offer attendees three payment options:

1. Mailing in the payment
2. Using a credit card (American Express, MasterCard, or Visa)
3. Paying in Anaheim

Attendees are encouraged to register early to receive the early registration rates. In order to receive the early registration rates, attendees must register **on or before April 12, 2010**.

Hotel and Transportation

For your convenience, NABP has confirmed a special meeting rate at the Hyatt Regency Orange County of \$169 single/double occupancy plus 13% state and local tax and \$0.10 California State Assessment Fee. Rooms may be reserved online by visiting the Meetings section of the NABP Web site and clicking on the link for the hotel special group page rate, or attendees may make their reservations by calling the hotel directly at 714/750-1234, and mentioning that they will be

attending the NABP 106th Annual Meeting. To ensure accommodations at the special rate, reservations must be received by the Hyatt Regency Orange County no later than **Friday, April 23**.

You may contact NABP's official travel agency, Options Travel, at 1-800/544-8785 for airfare and car rental rates. When calling Options Travel, mention the NABP meeting code number, NABP106.

Please note, the last event of the 106th Annual Meeting is the Annual Awards Dinner, which takes place from 7 - 11 PM on Tuesday, May 25. Please make your travel arrangements accordingly.

For more information about the 106th Annual Meeting, visit the Meetings section of the NABP Web site at www.nabp.net. ☺

New Meeting Registration Fees

Registrant Type	Early Registration (On or before 4/12/10)	Registration (After 4/12/10 or on site)
NABP Member	\$375	\$400
Non-NABP Member	\$550	\$575
Spouse/Guest	\$125	\$150
Student	\$125	\$150

Anaheim

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the coast of Orange County during the optional tour, Southern California Experience, which will take place Monday, May 24 from 1:30 - 6 PM for \$49 per person. Guests will be greeted aboard an air conditioned motor coach for an informative and scenic drive to Laguna Beach where free time is allotted for browsing the art galleries and shops, or taking a stroll on the beach walk. The drive north through the hills of Laguna will afford guests remarkable views of the Pacific

Ocean, as they are transported to Newport Harbor where a cruise boat awaits. The Newport Harbor Cruise includes a narrated tour of the area's celebrity homes, and allots time for shopping and enjoying the view from the dock. Advanced registration is required.

Transportation

With easy access from local airports, the Hyatt Regency Orange County is located near Anaheim's landmarks: Angel Stadium and Disneyland. The hotel provides a free shuttle to and from the Disneyland Resort.

A variety of transportation options are available from both the John Wayne Orange County Airport (a 20 minute drive to the Hyatt) and the Los Angeles International Airport (a 50 minute drive to the Hyatt). From the John Wayne Airport to the Hyatt Regency Orange County, the Super Shuttle rate is \$10 per person. Town cars or SUVs may be pre-arranged through the concierge for \$45. From the Los Angeles International Airport to the Hyatt Regency Orange County, the Super Shuttle rate is \$16 per person. Town cars or SUVs may be

prearranged through the concierge for \$95. For guests choosing to rent a vehicle, the Hyatt offers self parking for \$15 and valet for \$19. Hyatt's guest services also includes a transportation desk that can arrange shuttle service and access to other transportation.

Area taxis are available at a rate of \$4.90 for the first mile and \$2.60 for each additional mile.

Additional information about the 106th Annual Meeting is available in the Meetings section of the NABP Web site at www.nabp.net. ☺

Date Set for Advanced Distribution of Proposed Resolutions

Proposed resolutions received at NABP Headquarters by Thursday, March 18, 2010, will be distributed to state boards of pharmacy on the following Thursday, March 25, 2010, for review prior to the 106th Annual Meeting, where the resolutions will be presented and voted upon. This mailing will constitute the only preconference distribution of proposed resolutions. Resolutions will be presented to the voting delegates during the An-


nual Meeting on Monday, May 24, 2009, by the chair of the Committee on Resolutions.

To be considered during the Annual Meeting, resolutions must adhere to the requirements of Article IV, Section 6 (d) of the NABP Constitution and Bylaws, which states the following:

(d) Any active member board, District, or committee of the Association may submit resolutions to the Association.

Except as otherwise provided in subparagraph (c) of this section, all resolutions submitted in writing to the Association at least twenty (20) days prior to the date of the Annual Meeting shall be presented at the Annual Meeting for consideration. Resolutions not presented within such time limitations may be

presented during the Annual Meeting and will be considered for adoption by the Association upon the affirmative vote of three-fourths (3/4) of those Association members present and constituting a quorum.

Questions regarding resolution procedures should be directed to NABP Executive Office via e-mail at exec-office@nabp.net. 

NABP Accepting Travel Grant Applications for Qualified Voting Delegates to Attend 106th Annual Meeting


In an effort to defray the costs for qualified voting delegates, NABP is now accepting travel grant applications for the 106th Annual Meeting held May 22-25, 2010, at the Hyatt Regency Orange County in Anaheim, CA. The Association established the grant to assist boards in sending voting delegates to the Annual Meeting so they may participate in important business including discussing and voting upon resolutions, electing NABP Executive Committee members and officers, and attending educational ses-

sions regarding current issues facing pharmacy regulators.

The NABP Annual Meeting travel grant program lessens the costs for designated state board of pharmacy voting delegates by providing funds for travel expenses, including airfare, hotel rooms, meals, taxis, parking, and tips. Qualified voting delegates will have the opportunity to receive up to \$1,500 in grant monies to attend the NABP 106th Annual Meeting. The grant does not include Annual Meeting registration fees.

Last year, NABP provided 28 state boards of pharmacy with

grants to attend the NABP 105th Annual Meeting. Grant applications may be obtained from NABP upon the direct requests of executive officers of the state boards of pharmacy. NABP requests that applications be submitted to NABP Headquarters prior to the Annual Meeting. All applicants will be informed of whether or not they have qualified for the grant.

For more information on the Annual Meeting Travel Grant, contact the NABP Executive Office at exec-office@nabp.net. 

nabp newsletter

FDA and ISMP Alerts Regarding Tamiflu for Oral Suspension

Food and Drug Administration (FDA) issued a Public Health Alert regarding potential dosing errors with Tamiflu® (oseltamivir) for oral suspension. While United States prescriptions for liquid medicines are generally written in milliliters or teaspoons, Tamiflu is dosed in milligrams and packaged with a dispenser marked in milligram dosages. Errors where dosing instructions for the patient do not match the dosing dispenser have been reported to FDA. FDA advises that providers should write doses in milligrams if the dosing dispenser with the drug is in milligrams. Pharmacists should ensure that prescription instructions and the dosing device use the same unit of measure. More information can be accessed at www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm183714.htm.

The Institute for Safe Medication Practices (ISMP) issued an alert to all health care professionals regarding a risk of dosing errors related to the concentration of pharmacy-compounded Tamiflu (oseltamivir phosphate) oral suspension being dispensed due to shortages of the manufacturer's oral suspension. The base concentration for the commercially manufactured Tamiflu oral suspension is

12 mg/mL. The directions for emergency compounding of Tamiflu oral suspension from Tamiflu powder capsules result in a 15 mg/mL oseltamivir base concentration. Incidents have occurred resulting in too large of a dose being dispensed to children. ISMP advises that prescribers communicate suspension doses in milligrams rather than by volume, and that, if experiencing shortages of commercial Tamiflu oral suspension, pharmacists communicate with area medical practices to advise them of the shortage and steps being taken regarding the dosage error risk. More information may be found at the ISMP Web site at www.ismp.org/safetyalerts/20091015-Tamiflu.asp.

FDA Authorization for Outdated Tamiflu Products in Effect Until April 2010

On October 30, 2009, FDA issued an Emergency Use Authorization (EUA) allowing pharmacists to dispense certain lots of expired Tamiflu for oral suspension as part of the federal government's response to the 2009 H1N1 influenza public health emergency. The declaration of emergency justifying the EUA remains in effect until April 26, 2010, unless it is terminated earlier, or extended. The authorized lots of Tamiflu for oral suspension, which were tested through the

Life Extension Program, are part of the Strategic National Stockpile and are listed on the FDA Web site at www.fda.gov/NewsEvents/PublicHealthFocus/ucm154962.htm. Additional information for health care professionals and the EUA letter are also available on the FDA Web site. Boards of pharmacy are encouraged to reassure the pharmacists in their jurisdictions that they are authorized to dispense these products.

FDA Comment Period for Certain Opioid Drug REMS Open Until October 2010

On October 19, 2009, FDA reopened the comment period to solicit input on developing Risk Evaluation and Mitigation Strategies (REMS) for certain opioid drugs, including those formulated with the active ingredients fentanyl, hydromorphone, methadone, morphine, oxycodone, and oxymorphone. FDA emphasizes that “[a] REMS that will adequately manage the risks of these products without unduly burdening the health care system or reducing patient access to these medications must be carefully designed.” Thus, the comment period will remain open until October 19, 2010, and interested parties can submit written or electronic comments to FDA through www.regulations.gov using docket number FDA-2009-N-0143.

USP Standards for Heparin Products May Require Dosage Adjustments

Heparin products using new standards began shipping on October 8, 2009, and may require that dosages are adjusted to achieve consistent potency, according to a FDA alert. New manufacturing controls issued by the United States Pharmacopeia (USP) were adopted for heparin to guard against potential contamination. Included in the new controls were changes in the unit dose, making heparin about 10% less potent than the former unit used. More information can be found at www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm184674.htm.

FDA Issues Alert on Stolen Tylenol Arthritis Pain and Tylenol PM Caplets

FDA has issued an alert regarding stolen Tylenol® Arthritis Pain and Tylenol PM products. Pharmacists should be wary of the following Tylenol products:

- Tylenol Arthritis Pain Caplet 150 count bottles with the following identifying information: UPC number 30300450838155, code number 8381500, and lot number 09XMC112.
- Tylenol PM 2-caplet packets with the following identifying information: UPC number 30300450482304, code

number 4823000, and lot number 09XMC110.

The theft took place at a cargo terminal at the Jacksonville Port Authority in Jacksonville, FL on September 25, 2009.

FDA seeks assistance in tracking this theft and is asking pharmaceutical drug distributors and pharmacies that may receive offers for the stolen drug products, or that may have been sold stolen product, to contact FDA's Office of Criminal Investigations (OCI) by phone at 800/551-3989 or on the OCI Web site at www.fda.gov/ICECI/CriminalInvestigations/

[ucm123025.htm](http://www.fda.gov/ICECI/CriminalInvestigations/ucm123025.htm). Boards of pharmacy are urged to share this information with their licensees and to encourage distributors and pharmacies to verify pedigrees they receive with any wholesale drug purchases. News regarding the alert can be found at www.fda.gov/ICECI/CriminalInvestigations/ucm186269.htm.


FDA Warning: Stop Marketing Unapproved Codeine Sulfate Tablets

On October 13, 2009, FDA warned four compa-

nies to stop marketing unapproved codeine sulfate tablets. The manufacturers and distributors that received warning letters are as follows:


- Lehigh Valley Technologies Inc in Allentown, PA
- Cerovene, Inc in Valley Cottage, NY
- Dava International Inc in Fort Lee, NJ
- Glenmark Generics Inc USA in Mahwah, NJ

FDA regulations allowed the companies 15 days to provide the agency with a plan to discontinue marketing the unapproved drugs. Manufacturers have

90 days to cease manufacturing of new product, and distributors have 180 days to cease further shipment of existing products. Previously manufactured unapproved products may still be found on pharmacy shelves for a period of time. FDA advises that Roxane Laboratories markets FDA-approved codeine sulfate tablets and is able to meet the demand for the drug. For additional information about the warning letters, visit www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm186418.htm. 



Task Force Members Review Prescription Monitoring Program Standards

On October 28-29, 2009, the Task Force on Prescription Monitoring Program Standards convened in Northbrook, IL. Back row from left to right: Ex Officio Member Cathy Gallagher, associate section chief, liaison and policy section, Drug Enforcement Administration; Gay Dodson, RPh, executive director/secretary, Texas State Board of Pharmacy; Gregory Braylock, Sr, RPh, Executive Committee liaison; Edward McGinley, RPh, member, New Jersey Board of Pharmacy; Allan Dulwick, RPh, pharmacy supervisor, Kaiser Permanente; and William Prather, RPh, member, Georgia State Board of Pharmacy. Front row from left to right: Elizabeth Gregg, RPh, member, Ohio State Board of Pharmacy; Danna Droz, RPh, JD, prescription drug monitoring program administrator, Ohio State Board of Pharmacy; Ex Officio Member Jennifer Fan, PharmD, JD, CDR, United States Public Health Service, Public Health Advisor, Substance Abuse and Mental Health Services Administration; John Dorvee, Jr, PharmD, former member, Vermont Board of Pharmacy; Frederick Karsten, RPh, director, Georgia Drugs and Narcotics Agency; William Fitzpatrick, RPh, NABP Past Honorary President; Lawrence "Larry" Mokhiber, MS, RPh, executive secretary, New York State Board of Pharmacy; and Richard K. "Mick" Markuson, RPh, former executive director, Idaho State Board of Pharmacy. 

nabp newsletter

Louisiana Board Reports Its PMP Results

The Louisiana Board of Pharmacy initiated the implementation of its Prescription Monitoring Program (PMP) in September 2008, by notifying dispensers of controlled substances of the reporting obligation. During the implementation process, the Board monitored the reporting status of all pharmacies and reported that all pharmacies had filed their reports. This consistency, the Board states, provides some degree of assurance of the comprehensive nature of the information in the database. The Board will continue to monitor the reporting status of all pharmacies, as well as other dispensers of controlled substances.

The Board's first annual report for the program describes the operations and results for the fiscal year ending June 30, 2009. A copy can be accessed on the Board's Web site at www.labp.com. Highlights from the report are listed below:

- Approximately 11.2 million prescription transactions, representing controlled substance prescriptions dispensed to Louisiana residents since June 1, 2008, are in the database.
- 1,040 prescribers (from a total of 17,968 licensed) completed the training program and acquired authorized user status.

- 603 pharmacists (from a total of 6,890 licensed) completed the training program and acquired authorized user status.
- Of the 160,119 queries received during the first six months, 76% originated from prescribers, 23% from pharmacists, and the remainder in response to authorized requests from law enforcement agencies and licensing agencies.
- Comparing the numbers for certain drugs for the months of December 2008 and May 2009, the Board made the following observations:
 - Hydrocodone/APAP: 4% decrease in the number of prescriptions and 6.9% fewer doses.
 - Alprazolam: 3.4% decrease in the number of prescriptions and 2.2% fewer doses.
 - Methadone: 13% decrease in the number of prescriptions and the number of doses.
 - Oxycodone: 17% decrease in the number of prescriptions and 12% fewer doses.

After six months of operation, the program has assisted in reducing the diversion of controlled substances in an efficient and cost-effective manner, which is the goal of the program, as well as the intent of the legislature in authorizing the development and implementation of the program. The

Board is working with other states to develop the technical capacity and legal permissions to share program data with prescribers, dispensers, and law enforcement agencies from other states.

Minnesota Implements Amended Prescription Monitoring Program

In May 2009, the Minnesota Legislature amended its PMP to include Schedule IV controlled substances and to allow the Minnesota Board of Pharmacy to contract with a vendor to assist in both the implementation and administration of the program. The new program will require all dispensers, including nonresidential pharmacies that ship or mail prescriptions into the state, to report certain information concerning Schedule II, III, and IV prescriptions to the Board. Prescribers and pharmacists will be able to enroll in the PMP as users, allowing them to access controlled substance profiles for patients who are currently under their care. The purpose of the program is to help prescribers and pharmacists identify patients who may be engaged in "doctor shopping."

The implementation deadline is January 4, 2010. Additional information about the PMP will be made available on the Board's Web site and on its new Web site dedicated to the PMP at www.phcybrd.state.mn.us/Main-PMP.htm.

Nevada Board Addresses False DEA Numbers, Unauthorized Profile Access

The Nevada State Board of Pharmacy has expressed concerns regarding two issues with potential detrimental consequences. The first issue pertains to pharmacists using inaccurate Drug Enforcement Administration (DEA) numbers for prescribers simply to expedite the process of getting the prescriptions adjudicated by the insurance company, not realizing that they are adding that prescription to the profile of the holder of that incorrect DEA number, as well as adding that physician to the patient's profile within the task force. This activity results in physicians being questioned for prescribing medication for patients they have never seen and patients who may be falsely accused of "doctor shopping." The Board stresses that pharmacists must use the correct DEA number of the practitioner actually prescribing the medication.

The second issue the task force has identified is practitioners and pharmacies attempting to access drug profiles of individuals who were never a patient of either the practitioner or the pharmacy. By law, practitioners may access only the profiles of their patients.

Washington Board Adds Carisoprodol to Schedule IV CS

At its September 17, 2009 meeting, the Washington State Board of Pharmacy changed rules to add the drug carisoprodol to Schedule IV controlled substances. After considering evidence and testimony at the public rules hearing, the Board determined that the potential for abuse and risk to public safety warranted the change. The rule goes into effect 31 days after it is filed with the Washington State Code Reviser's Office. More information is available on the Board's Web site at www.doh.wa.gov/hsqa/Professions/Pharmacy/default.htm.

Minnesota Enacts Changes Affecting the Practice of Pharmacy

During its past legislative session, Minnesota enacted several bills related to the practice of pharmacy or to pharmaceutical manufacturers. Descriptions of some of the provisions that were enacted into law follow.

Changes in Definition of Practice of Pharmacy

Pharmacists were allowed to administer influenza vaccines to children 10 years of age and older until December 31, 2009. After that date, pharmacists must enroll in the Minnesota Vaccines for Children Program administered by the Minnesota Department of Health in order to continue administering influenza vaccines to children.

Additionally, pharmacists may now sign legally valid prescriptions working under protocol with certain practitioners. The relevant new language is as follows:

A licensed practitioner may prescribe a legend drug, without reference to a specific patient, by directing a nurse, pursuant to section 148.235, subdivisions 8 and 9, physician assistant, or medical student or resident, or pharmacist according to section 151.01, subdivision 27, to adhere to a particular practice guideline or protocol when treating patients whose condition falls within such guideline or protocol, and when such guideline or protocol specifies the circumstances under which the legend drug is to be prescribed and administered.

The Board adopted the following guideline at its June 10, 2009 meeting:

If a pharmacist working per a protocol (as authorized in Minnesota Statutes 151.01, Subd. 27) uses a prescription form, a faxed prescription, or an electronic prescription, the pharmacist should indicate the name of the authorized prescriber who developed the protocol, the name of the pharmacist who is implementing the protocol, and indicate that the prescription is generated per protocol.

The guideline advises pharmacists to not fill prescriptions signed by a pharmacist unless there is an indication on the prescription that the pharmacist signing

the prescription is authorized to do so per protocol. As with all prescriptions, pharmacists are encouraged to verify any prescription if there is a question as to its validity.

Medication Therapy Management Provision

Legislation was passed that requires a pharmacy benefit manager to "make available medication therapy management services for enrollees taking four or more prescriptions to treat or prevent two or more chronic medical conditions." The legislation further defines "medication therapy management" to mean the provision of certain pharmaceutical care services by, or under the supervision of, a licensed pharmacist. The Board interprets the "or under the supervision of" clause to refer only to registered pharmacy interns and that other individuals working under the supervision of a pharmacist may not provide medication therapy management services.

New Jersey Board Implements New Labeling Requirement for Generic Drugs

Senate Bill 906, which addresses new labeling requirements for generic drugs, was signed into law on July 31, 2009, in the state of New Jersey, and becomes effective January 27, 2010. Section 10 of P.L.1977, c.240 (C.24:6E-9) was amended to read as follows:

If a nonbrand name drug product is dispensed, the pharmacist shall include

on the label of such drug product pursuant to a prescription the name of the brand drug and the name of the generic drug. The information required pursuant to this section shall be in the following form, with the generic name and brand name inserted as appropriate: _____ Generic for _____.

Around the Association

Board Member Appointments

- **Susan DelMonico, RPh, JD**, has been appointed a member of the Rhode Island Board of Pharmacy. DelMonico's appointment will expire on November 30, 2011.

Board Officer Changes

The Illinois Board of Pharmacy has elected the following officers to the Board:

- **Sudhir Manek, RPh**, Chairperson
- **Robert Anselmo, RPh**, Vice Chairperson

The Oklahoma State Board of Pharmacy officer changes were erroneously listed in the October 2009 issue of the *NABP Newsletter*. The current officers elected to the Board are as follows:

- **James Spoon, DPh**, President
- **William Osborn, DPh**, Vice President

Pharmacists' Roles

(continued from page 12)


the public, continue to assist pharmacists in these efforts.

Additionally, boards of pharmacy in Missouri, Nebraska, New Jersey, Maryland, and other states assist pharmacists by providing educational materials and external links on their board of pharmacy Web sites.

Pharmacists' Opportunity to Expand Patient Care

The opportunity for pharmacists to assist in the 2009 H1N1 vaccination campaign is one example of pharmacists beginning to realize the future vision of pharmacy practice that emphasizes patient care outlined in the Joint Commission of Pharmacy Practitioners

Future Vision statement. In late September 2009, CDC declared, "The current [H1N1 influenza] situation will likely impact the nation's pharmacies as a greater number of people than usual seek to fill prescriptions for influenza antiviral drugs or antibiotics to treat secondary infections, in addition to seeking advice on over-the-counter flu medications." As the end of flu

season approaches, pharmacists are expected to see continued opportunities for increasing patient care. State boards of pharmacy and health department efforts to update vaccination policies and provide training and educational materials assist pharmacists in fulfilling their roles as vaccinator and patient educator, spurring the patient care movement forward. 

Practice of Timing

(continued from page 11)

number of prescriptions per day, and to prioritize their dispensing. For example, prescriptions for patients who wait in the pharmacy, or for patients who need medications more urgently than others, can be automatically prioritized.

Since workflow systems prioritize prescriptions for waiting customers over those with designated pick-up times, which are often arranged by phone, use of these systems may be helping pharmacy operators to meet customer expectations. According to Boehringer Ingelheim's 2008 Pharmacy Satisfaction Digest, of 34,454 patients surveyed by Wilson Health Information, LLC, 40% consider wait times very important, and


44% consider wait times important. 30% were highly satisfied and 56% were satisfied with pharmacy service in this area. The computer workflow system may be one tool that helped to generate these positive survey results. In fact, the same report also reveals that 63% of patients surveyed valued as very important the ability to call ahead in order to have prescriptions ready, and another 28% ranked this area as important. Further, in the same survey patients identified accurate and error-free prescription dispensing as one of their top concerns. The report indicates that 56% were highly satisfied and 41% were satisfied that their prescriptions were filled without errors.

In addition, workflow systems may assist pharmacies in meeting customer expectations regarding communication.

Boehringer Ingelheim's 2006 "10 Steps to Customer Satisfaction," also based on a Wilson Health Information survey, highlights communication as step two, and suggests that communication about wait times is a primary customer concern. While the pharmacy's ability to fill prescriptions on time is critical for customer satisfaction, one pharmacist surveyed emphasized that most patients do not mind waiting longer for a prescription, but they do want to know how much extra time is needed and why. Since computer timer systems alert pharmacists if the promised dispensing time is exceeded, some advocates may perceive timers as a tool to let the pharmacist know when and what information to communicate to the customer.

Some pharmacies do not use timers, but do

have a standard fill time in the interest of customer service and efficiency. Kaiser Permanente pharmacies, for example, have a standard of filling new prescriptions within 15 minutes, and expect that 80% of prescriptions meet that standard. The guideline can be used as a benchmark to alert Kaiser Permanente management of the need for improvements. For example, a pharmacy improvement team can work with management and staff to make recommendations for increasing efficiency, such as hiring more staff.

NABP will continue to monitor the issue and interested parties may submit relevant comments or information electronically to the NABP Executive Office at exec-office@nabp.net. 

Twenty-Two States Now Recognize VAWD Accreditation to Ensure Safe Distribution of Prescription Drugs

In an effort to secure the United States distribution systems from dangerous or counterfeit prescription drugs, 22 states recognize either third-party accreditation and/or NABP's Verified-Accredited Wholesale Distributors® (VAWD®) program.


Currently Indiana, North Dakota, and Wyoming require VAWD accreditation, while 19 states recognize either VAWD or some other form of third-party survey and wholesale distributor accreditation. The states that recognize VAWD or some other form of third-party survey of wholesalers are Colorado, Idaho, Iowa,

Kansas, Maryland, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Jersey, New Mexico, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Vermont, and Wisconsin.

Many of these states recognize VAWD as a means of implementing the licensing provisions of new laws, while mitigating the fiscal and operational impact on their board.

VAWD accreditation provides assurance that the wholesale distribution facility operates legitimately, is validly licensed in good standing, and employs security and best practices for safely distributing pre-

scription drugs from manufacturers to pharmacies and other institutions. In addition, VAWD provides a uniform set of standards that can alleviate inconsistencies between states. Applicants for VAWD accreditation undergo a criteria compliance review, licensure verification, on-site survey, background checks, and screening through the NABP Clearinghouse.

More than 390 facilities have obtained VAWD accreditation. A complete listing of VAWD-accredited facilities is available in the Accreditation Programs section of the NABP Web site at www.nabp.net. 



NEWLY ACCREDITED VAWD FACILITIES

The following facilities were accredited through the NABP Verified-Accredited Wholesale Distributors® (VAWD®) program:

Baxter Healthcare Corporation
Memphis, TN
Accredited October 16, 2009

Butler Animal Health Supply, LLC
Alsip, IL
Des Moines, IA
Accredited October 28, 2009

Indiana Blood Center
Indianapolis, IN
Accredited October 28, 2009


JM Smith Corporation
Paragould, AR
Accredited October 10, 2009

Kaiser Foundation Hospitals
Downey, CA
Oakland, CA
Accredited October 7, 2009

Merit Healthcare International, Inc dba Merit Pharmaceutical
Los Angeles, CA
Accredited October 7, 2009

PrePak Systems, Inc
Cookeville, TN
Accredited October 30, 2009

Prescription Supply, Inc
Northwood, OH
Accredited October 30, 2009

A full listing of more than 390 accredited VAWD facilities is available on the NABP Web site at www.nabp.net. 



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