



Arizona State Board of Pharmacy
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**THE ARIZONA STATE BOARD OF PHARMACY
HELD A REGULAR MEETING JUNE 25, 2014
MINUTES FOR REGULAR MEETING**

AGENDA ITEM 1 – Call to Order – June 25, 2014

President Foy convened the meeting at 9:00 A.M. and welcomed the audience to the meeting.

The following Board Members were present: President Jim Foy, Vice President Dennis McAllister, William Francis, Darren Kennedy, Kyra Locnikar, Reuben Minkus, John Musil, Nona Rosas, and Tom Van Hassel. The following staff members were present: Compliance Officers Steve Haiber, Tom Petersen, Sandra Sutcliffe, Dennis Waggoner, and Karol Hess, Drug Inspectors Melanie Thayer and Cesar Ramirez, Executive Director Hal Wand, Deputy Director Cheryl Frush, and Assistant Attorney General Monty Lee.

AGENDA ITEM 2– Declaration of Conflicts of Interest

Due to having a “substantial interest” in the matter, Dr. Foy recused himself from participating under Arizona’s conflict of interest laws in the review, discussion, and proposed actions concerning Agenda Item 3, Schedule A, Special Request for Alani Vaioleti.

Due to having a “substantial interest” in the matter, Dr. Foy recused himself from participating under Arizona’s conflict of interest laws in the review, discussion, and proposed actions concerning Agenda Item 4, Schedule B, Conferences for Complaint #4271, Complaint #4300, Complaint #4313, Complaint #4305, Complaint #4308, Complaint #4291, and Complaint #4290.

Due to having a “substantial interest” in the matter, Mr. Kennedy recused himself from participating under Arizona’s conflict of interest laws in the review, discussion, and proposed actions concerning Agenda Item 4, Schedule B, Conference for Complaint #4283.

Due to having a “substantial interest” in the matter, Mr. McAllister recused himself from participating under Arizona’s conflict of interest laws in the review, discussion, and proposed actions concerning Agenda Item 6, Express Scripts Proposed Donation Program.

AGENDA ITEM 3 - Special Requests- Schedule A

#1 Olufemi Omodara

Olufemi Omodara appeared on her own behalf to request that the probation imposed on her Pharmacist license per Board Order 13-0005-PHR be terminated.

President Foy opened the discussion by asking Ms. Omodara why she was appearing in front of the Board. Ms. Omodara stated that she is requesting that the Board terminate her probation.

Dr. Foy asked Ms. Omodara what she has learned during this probation period. Ms. Omodara stated that she was the Pharmacist in Charge at two pharmacies and she learned that it was her duty to pay attention to the activities that were happening at both pharmacies. Ms. Omodara stated that she closed the pharmacy that was also listed on the Consent Agreement.

Mr. Van Hassel asked about the discrepancies within the inventories. Ms. Omodara stated that she did the inventory on April 30th and did not record the inventory correctly. Ms. Omodara stated that she completed the inventory in the perpetual inventory books.

Dr. Foy asked Ms. Omodara why she stored the bottle of Cocaine in her car. Ms. Omodara stated that when she moved the store the Cocaine was left in the safe. Ms. Omodara stated that she did not want to leave the Cocaine in the store because of trust issues. Ms. Omodara stated that she had asked the Compliance Officer about the Cocaine in her car and was written up for storing it in her car. Ms. Omodara stated that she did not know what to do with the Cocaine.

Dr. Foy asked Ms. Omodara what she did with the bottle of Cocaine. Ms. Omodara stated that she returned the Cocaine to the company that accepts returns. Ms. Omodara stated that the Compliance Officer had weighed the Cocaine and there was no Cocaine missing.

On motion by Mr. Van Hassel and seconded by Mr. Francis, the Board unanimously agreed to terminate the probation of Ms. Omodara's pharmacist license per Board Order 13-0005-PHR.

#2 Alani Vaiioletti

Dr. Foy was recused due to a conflict of interest.

Alani Vaiioletti appeared on his own behalf to request to renew his Intern license and take the the NAPLEX exam for the fourth time.

Bert Plemmons, Pharmacy Supervisor for CVS, was also present to support Mr. Vaiioletti's request.

Vice President McAllister opened the discussion by asking Mr. Vaiioletti why he was appearing in front of the Board.

Mr. Vaiioletti stated that after he graduated from pharmacy school he took and passed the

MPJE exam. Mr. Vaiioletti stated that he has taken the NAPLEX exam three times and is requesting the opportunity to take the NAPLEX exam for the fourth time.

Mr. Vaiioletti stated that he has studied for the NAPLEX exam but did not invest in study materials. Mr. Vaiioletti stated that he studied his school notes and borrowed some old materials from a colleague. Mr. Vaiioletti stated that he has realized that it is necessary to invest in good study materials. Mr. Vaiioletti stated that he has signed up for a review course. Mr. Vaiioletti stated that it is a robust program which helps him identify his weaknesses and helps him address those weaknesses. Mr. Vaiioletti stated that he has changed his study habits. Mr. Vaiioletti stated that he works at CVS as an Intern.

Mr. McAllister asked Mr. Vaiioletti about his knowledge deficiencies. Mr. Vaiioletti stated that the areas where he has deficiencies are in the areas of drug interactions and side effects. Mr. Vaiioletti stated that he is focusing on cancer and HIV questions because he has difficulty with those two areas.

Mr. McAllister asked Mr. Vaiioletti how he preparing to take the exam. Mr. Vaiioletti stated that he has waited three months to take the exams and studied. Mr. Vaiioletti stated that this time he is taking the review course.

Dr. Musil asked Mr. Vaiioletti why he does not enroll in a course that requires him to be present. Mr. Vaiioletti stated that the cost to attend the course is prohibitive for him. Mr. Vaiioletti stated that he is also studying with a group of recent graduates. Mr. Vaiioletti stated that the Interns ask each other questions at work.

Mr. McAllister asked Mr. Vaiioletti if he attended the review course at Midwestern this year. Mr. Vaiioletti stated that he did not attend the course this year. Mr. Vaiioletti stated that he attended the course last year and still had the book from last year.

Mr. Kennedy asked Mr. Vaiioletti about the renewal of his Intern license. Mr. Vaiioletti stated that he would like his license renewed until at least September so that he could continue working until he takes the exam again. Mr. Vaiioletti stated that he cannot take the test until August.

Mr. Van Hassel asked Mr. Plemmons about Mr. Vaiioletti's work abilities. Mr. Plemmons stated that Mr. Vaiioletti has the ability to perform the tasks required of a pharmacist. Mr. Plemmons stated that Mr. Vaiioletti is able to communicate with patients and store personnel. Mr. Plemmons stated that he is comfortable with Mr. Vaiioletti's abilities.

On motion by Mr. Van Hassel and seconded by Mr. Minkus, the Board unanimously agreed to renew Mr. Vaiioletti's Intern license through September of 2014 and allow him to take the NAPLEX exam for the fourth time.

AGENDA ITEM 4 - Conferences- Schedule B

Conference 1 – Complaint #4265

The following individual was present to discuss the complaint:

1. Kelly Downing

President Foy asked Mr. Waggoner to give a brief overview of the complaint. Mr. Waggoner stated that a hospital director reported that a pharmacy technician was terminated due to diversion of a controlled substance. Mr. Waggoner stated that he reviewed the video of the technician with the hospital pharmacy director. Mr. Waggoner stated that the video showed the technician compounding midazolam cassettes. Mr. Waggoner stated that the midazolam was removed from 19 vials each containing 2 mls. Mr. Waggoner stated that a 60 cc syringe was used to remove the liquid from 16 vials and a separate 6 cc syringe was used for the remaining 3 vials. The technician subsequently placed the 6 cc syringe containing 6 ml of midazolam into his pocket and then the technician left the compounding room.

President Foy asked Mr. Downing to discuss the complaint. Mr. Downing stated that he had recently suffered two concussions. Mr. Downing stated that he was involved in a car accident and had received a concussion. Mr. Downing stated that while at the park playing with his nephew he hit his head on a pole and suffered another concussion. Mr. Downing stated that as a result of the concussions he has suffered seizures for which he was given medication. Mr. Downing stated that the taking of the midazolam is not something he would usually do. Mr. Downing stated that he has had drug tests since that time. Mr. Downing stated that the combination of the concussions and seizure medications affected his thought processes. Mr. Downing stated that at the time he did not realize that he was not competent and should not have been at work. Mr. Downing stated that after being terminated that he took six weeks off to himself and realized at that time he should not have been working.

Dr. Foy asked Mr. Downing what happened to the syringe. Mr. Downing stated that he took the syringe.

Dr. Foy asked Mr. Downing if he used the contents of the syringe. Mr. Downing replied that he used it in hopes that it would help him sleep at night.

Mr. Minkus asked Mr. Downing why he did not go a doctor and get diagnosed. Mr. Downing stated that he was not in the right frame of mind. Mr. Downing stated that after the incident he did seek help.

Dr. Foy asked Mr. Downing when he used the contents of the syringe. Mr. Downing stated that he used the contents that evening.

Dr. Foy asked Mr. Downing if he had taken anything else that day. Mr. Downing stated that the only medication he took that day was the Keppra that the doctor prescribed for his seizures. Mr. Downing stated that he experienced side effects from the Keppra.

Mr. Van Hassel asked Mr. Downing if he had every taken any opiates. Mr. Downing stated that he had taken opiates prior to this incident. Mr. Downing stated that he had valid prescriptions for the opiates that he had taken.

Mr. Francis asked Mr. Downing about smoking cannabis. Mr. Downing stated that he obtained a medical marijuana card because his doctor thought that the cannabis would help with his seizures and headaches. Mr. Downing stated he has lost the card and has not renewed the card.

Mr. Van Hassel asked Mr. Downing what he has been doing since that time. Mr. Downing stated that he had taken 6 weeks off. Mr. Downing stated that he still has headaches and the drugs do not help. Mr. Downing stated that he has gone to church and is committed to the church. Mr. Downing stated that he is working at Scottsdale Healthcare as a pharmacy technician.

Mr. McAllister asked if Scottsdale Healthcare questioned his termination. Mr. Downing stated that he told them that he was terminated due to a stolen drug investigation.

Dr. Foy asked about the lost marijuana card. Mr. Downing stated that he did have a medical marijuana card but lost the card. Mr. Downing stated that the dispensary takes your picture at your first visit and he did not have to present the card on his subsequent visits. Mr. Downing stated that the dispensary is now closed.

Dr. Foy asked Mr. Downing how many times he had visited the dispensary. Mr. Downing stated that he visited the dispensary three times.

Mr. Minkus asked Mr. Downing when his card expired. Mr. Downing stated that the card expired in October.

Dr. Foy asked Mr. Downing if Scottsdale Healthcare knew that Mr. Downing was present at the meeting today. Mr. Downing replied yes.

Mr. McAllister asked Mr. Downing if he had a pre-employment urine screen. Mr. Downing replied yes.

On motion by Mr. McAllister and seconded by Mr. Kennedy, the Board agreed to offer Mr. Downing a consent agreement with the following terms:

1. Probation for one year
2. Submit to monthly random urine screens for drugs of abuse with the results submitted to the Board.
3. Respondent shall not have a urine screen that is positive for drugs of abuse
4. Appear before the board to terminate probation.

There was one nay vote by Mr. Van Hassel.

Conference 2- Complaint #4265

The following individual was present to discuss the complaint:

1. Greg Mowers

Dr. Julian Pickens, PAPA counselor, was also present to speak on behalf of Mr. Mowers.

Dr. Foy stated that a pharmacy director had reported to the Board that Mr. Mowers was terminated because he was viewed on video taking medications from the pharmacy. Mr. Mowers is in violation of current Consent Agreement.

Dr. Foy asked Mr. Mowers to address the complaint. Mr. Mowers stated that he took the medications from his work place. Mr. Mowers stated that he had been in a stressful situation. Mr. Mowers stated that during this time he was in the process of getting a divorce and his wife received a large divorce settlement. Mr. Mowers indicated that he was asked to step down at work and not be a pharmacist in charge but he wanted to stay in that position. Mr. Mowers stated that he was terminated because he had taken medications from the pharmacy. Mr. Mowers stated that he has been in the PAPA program for 10 years. Mr. Mowers stated that 5 years was of his own choice. Mr. Mowers stated that he has completed a 30 day relapse prevention program. Mr. Mowers stated that he now has a new sponsor and they are going through the 12 steps from the beginning. Mr. Mowers stated that he is attending more meetings and is attending a PA (Pills Anonymous) meeting. Mr. Mowers stated that he is paying restitution to the company.

Dr. Foy stated that the medications were not controlled substances and asked Mr. Mowers why he took the medications. Mr. Mowers explained that due to issues at the doctor's office he was unable to see a doctor for about 1½ weeks. Mr. Mowers stated that he was out of medication and was in pain and that is why he took the medications.

Dr. Foy asked Mr. Mowers if he had taken medications for the last 11 months. Mr. Mowers indicated that there were only three instances where he had taken medication from the pharmacy. Mr. Mowers indicated that he has not worked for the last three months.

Dr. Pickens stated that he supports Mr. Mowers. Dr. Pickens stated that Mr. Mowers is an active member of his PAPA group. Dr. Pickens stated that Mr. Mowers had been in counseling due to his divorce and dysfunctional family life. Dr. Pickens stated that this was a stressful time in Mr. Mower's life. Dr. Pickens stated that the stressors affected Mr. Mowers thinking and rationalization and led to him making these mistakes.

Dr. Foy asked Mr. Mowers if he had taken any controlled substances. Mr. Mowers stated that he did not take any controlled substances and he is drug tested twice monthly.

Dr. Musil asked Mr. Mowers if the PAPA program has been effective in helping him handle stressful situations. Mr. Mowers stated that he discussed his issues in group. Mr. Mowers stated that the group members did know about his issues.

Dr. Musil asked about Mr. Mowers current consent agreement and why he has not asked for the probation to be terminated. Ms. Frush stated that Mr. Mowers signed his original consent agreement in 2004 but he has not completed his community service hours because he wants to remain in the program. Ms. Frush stated that he did appear before the Board in June of 2012 and asked the Board to amend his consent agreement to allow him to be a pharmacist in charge. Ms. Frush stated that the Board agreed to amend his consent to allow him to be a pharmacist in charge but the rest of his consent agreement was not changed.

Dr. Pickens stated that individuals in recovery often rationalize their situation and then justify their behavior.

Ms. Locnikar stated that that this is not an addiction issue but an issue involving theft.

Dr. Pickens stated that Mr. Mowers experienced errors in thinking. Dr. Pickens stated that this is not a relapse but more of a relapse in thinking. Dr. Pickens stated that often the lapses in thinking lead back to taking the drug of choice.

Mr. McAllister asked Mr. Mowers if pharmacy is the right career for him. Mr. Mowers replied yes.

On motion by Mr. McAllister and seconded by Mr. Van Hassel, the Board unanimously agreed to offer a consent agreement to Mr. Mowers with the following terms:

1. His current Consent Agreement would be canceled
2. He would be required to sign a new consent agreement continuing his probation for 5 years and participate in the PAPA program during his probationary period
3. He cannot be a preceptor or pharmacist in charge
4. He cannot work in any pharmacy setting as a pharmacist without another licensed pharmacist being present during his entire shift

Conference 3- Complaint #4238

The following individual was present to discuss the complaint:

1. Todd John – Store Manager representing the permit holder

President Foy asked Mr. Petersen to give a brief overview of the complaint. Mr. Petersen stated that the Board requested a complaint be opened against the permit holder based on allegations made by the Pharmacist in Charge in response to his complaints. Mr. Petersen stated that the pharmacist alleged that the technician provided counseling to customers. Mr. Petersen stated that the pharmacist alleged that store staff or store staff family members entered the pharmacy after the pharmacy was closed and with no pharmacist present. Mr. Petersen stated that the Pharmacist in Charge stated that the lead technician was in charge of “running” the pharmacy.

Mr. Petersen stated that since the original filing of this complaint he spoke to the pharmacist in charge that preceded the pharmacist in charge that made the allegations. The pharmacist stated that he did not witness any of the incidents that the pharmacist alleged. The pharmacist stated that no one entered the pharmacy when the pharmacy was closed.

Mr. Petersen stated that the pharmacist that made the allegations did not witness anyone enter the pharmacy but was told that someone had entered the pharmacy.

Dr. Foy asked if the lead technician was present. Ms. Frush stated that she has moved and is available by phone. Mr. John stated that the technician no longer works at the store and is now living in New York.

Mr. McAllister stated that there is no supporting evidence of the allegations that the pharmacist made against the technician. Mr. John indicated that there was a personality conflict between the pharmacist and the technicians working in the store.

Dr. Foy asked Mr. John about the access to the pharmacy. Mr. John stated that there is an emergency key to the pharmacy that is kept in the locked safe in the office that is monitored by door sensors and monitors. Mr. John stated that the pharmacy closes at 6:00 P.M. and the store remains open until 10:00 P.M. Mr. John stated that if there was an emergency the police department would be called.

Dr. Foy asked if the pharmacists have their own keys. Mr. John stated that the regular pharmacist has their own set of keys. Mr. John stated that a relief pharmacist would use the key in the safe.

Dr. Foy asked Mr. Petersen if he collected any keys while he was at the pharmacy. Mr. Petersen stated that he did not collect any keys. Mr. Petersen stated that everyone was arguing in the pharmacy and Mr. John brought the keys from the lock box to show Mr. Petersen.

Dr. Musil asked if the pharmacy is monitored on a separate system or is it monitored by the store system. Mr. John stated that the pharmacy door is monitored and is alarmed. Mr. John stated that if the door was opened the alarm would sound.

On motion by Mr. Francis and seconded by Dr. Musil, the Board unanimously agreed to dismiss the complaint and take no further action.

Conference #4 – Complaint #4271

Dr. Foy was recused due to a conflict of interest.

The following respondent was not present:

1. John Tomkins

Ms. Frush informed the Board that Mr. Tomkins had called that morning and stated that his mother was in the hospital and he would not be able to appear. Ms. Frush informed Mr. Tomkins that it would be the Board's decision if they wanted to continue the conference in his absence.

Ms. Frush stated that she has provided the Board Members with additional information. Ms. Frush stated that CVS submitted the form that the respondent signed indicating that he had taken the medication from the pharmacy. Ms. Frush stated that she has also provided the court document indicating that the respondent had been charged with theft.

Vice President McAllister asked the Board Members if they would like to continue with the conference or table until the conference until the next meeting.

On motion by Mr. Francis and seconded by Mr. Van Hassel, the Board Members unanimously agreed to move forward with the conference.

Dr. Musil asked Ms. Frush if Mr. Tomkins had reported his charges to the Board. Ms. Frush stated that Mr. Tomkins did not report his charges. Ms. Frush stated that Mr. Tomkins had indicated on his initial complaint response that he was going to court in May. Ms. Frush stated that she printed the results of the case from the court site.

On motion by Dr. Musil and seconded by Mr. Van Hassel, the Board unanimously agreed to offer Mr. Tomkins a Consent Agreement with the following terms: Revocation of his Pharmacy Technician Trainee license. If the Consent Agreement is not signed, the case will proceed to Hearing.

Conference #5 – Complaint #4300, Complaint #4313, Complaint #4305

Dr. Foy was recused due to a conflict of interest.

The following individuals were present to discuss the complaint:

1. Mark Placek – Pharmacist - Respondent
2. Jennifer Vucson – Pharmacy Supervisor – Witness
3. Roger Morris – Legal Counsel for Mr. Placek and CVS

Vice President McAllister asked Ms. Sutcliffe to give a brief overview of the complaints.

Complaint #4300

Ms. Sutcliffe stated that the complainant stated that his doctor phoned in a prescription for Promethazine with Codeine. Ms. Sutcliffe stated that the label read to “Take 1 to 2 mls twice daily. Ms. Sutcliffe stated that the complaint contacted his doctor and was told that the he should take 1 to 2 teaspoonfuls twice daily. Ms. Sutcliffe stated that the pharmacist stated that when he reduced the prescription to writing he used the symbol for teaspoon and the pharmacy technician interpreted the teaspoon symbol as milliliters. Ms. Sutcliffe stated that the error was not caught during verification. Ms. Sutcliffe stated that the pharmacy technician stated that when entering the prescription she came across a symbol she did not recognize and asked the pharmacist if it was milliliters or teaspoons. The pharmacy technician heard the pharmacist say milliliters. There was no documentation of counseling. The pharmacist stated that counseling was offered by the pharmacist but was declined.

Complaint #4305

Ms. Sutcliffe stated that the complainant stated that the directions on her son’s Carbamazepine prescription were entered as one tablet every morning and one tablet at night and directions should have been one tablet every morning and two tablets at night. Ms. Sutcliffe stated that the pharmacist in charge stated that the prescription was received electronically and was typed by the technician on 12/17/2013 and then stored for later use because the patient had plenty of medication. The prescription was filled on 2/21/2014 and the incorrect directions were not caught on the final verification by the pharmacist. Ms. Sutcliffe stated that no documentation of counseling was found in the record. Ms. Sutcliffe stated that the pharmacist in charge stated that counseling was offered but the offer was declined.

Complaint #4313

Ms. Sutcliffe stated that the complainant stated that his prescription for Duloxetine (Cymbalta) 30mg was entered and dispensed as Duloxetine 60mg. The pharmacist stated that the prescription was entered and data verified by a different pharmacist on 3/13/14. The pharmacist stated that when the patient arrived on 3/14/14 to pick up the medication, an insurance update was required. The pharmacist stated that on final verification he failed to catch the data entry error made the previous day. The complainant did not take any of the incorrect medication.

Vice President McAllister asked Mr. Placek to address the complaints.

Complaint #4300

Mr. Placek stated that the error was due to confusion on the part of the technician. Mr. Placek stated that he thought the technician was trained on basic nomenclature. Mr. Placek stated that he assumed that the technician knew the symbol for teaspoonful. Mr. Placek stated that he has brought the error to the attention of the technician.

Mr. Placek stated that he is slowing down and spending more time reviewing his work. Mr. Placek stated that he has completed a CE course on nomenclature issues. Mr. Placek stated that he is reading the prescription from left to right. Mr. Placek stated that he is looking more closely at medications that have different strengths. Mr. Placek indicated that he is looking at medication markings by opening the bottle. Mr. Placek stated that he is sending errors back to the technician to retype.

Complaint #4305

Mr. Placek stated that he assumed the prescription was typed correctly and reviewed. Mr. Placek indicated that there is no review process by the pharmacist prior to placing the prescription on hold. Mr. Placek stated that the prescription was typed prior to his arrival at the store and he assumed it was done correctly. Mr. Placek stated that he assumed it was typed and verified correctly.

Mr. Placek stated that he is reviewing the prescription again if it was reviewed before and placed on hold.

Complaint #4313

Mr. Placek stated that the prescription was processed by another pharmacist. Mr. Placek stated that the prescription was a rebill. Mr. Placek stated that he assumed that the pharmacist and technician did everything correctly.

Mr. Placek stated that he is now looking at the medication. Mr. Placek stated that he is not assuming that everything was done correctly. Mr. Placek stated that he is making a greater effort to counsel patients. Mr. Placek stated that if counseling is required he has told the technician to call him over to the window. Mr. Placek stated that he is asking the patient if they have any questions about their medication.

Mr. Morris indicated that the patient for complaint #4300 and #4313 was the same patient.

Mr. Morris indicated that the patient had stated that he had not spoken with the supervisor. Mr. Morris stated that the supervisor had contacted the patient.

Mr. McAllister asked Mr. Placek when he graduated from school. Mr. Placek stated that he graduated 30 years ago.

Mr. McAllister asked Mr. Placek why he used the symbol for teaspoonful. Mr. Placek stated he learned the symbol in school and assumed that the technician also knew the symbol for teaspoonful.

Mr. McAllister stated that ISMP lists the symbol for teaspoonful as a common source for errors and does not recommend using the symbol when transcribing prescriptions.

Dr. Musil asked if the filled prescriptions run for cash are backed out of the system when the patient presents with an insurance card. Mr. Placek stated that the number is retained and not reassigned.

Dr. Musil asked if the billing process reassigns a new number. Mr. Placek stated that he did delete the prescription and restarted the prescription again. Mr. Placek stated that the image was rescanned and a new prescription was created.

Ms. Sutcliffe clarified by stating that the prescription for Complaint #4313 which was filled for the wrong strength was assigned a new number when it was corrected.

Mr. Kennedy stated that these three mistakes were made in a relatively short period of time. Mr. Kennedy indicated that Mr. Placek was notified quickly by the patient after each error occurred. Mr. Kennedy asked Mr. Placek if he made any changes prior to getting additional errors.

Mr. Placek stated that he did not anticipate that there were additional errors. Mr. Placek stated that he was not thinking that there was more than the one incident. Mr. Placek stated that he is still finding situations that could generate errors. Mr. Placek stated that this is a learning process. Mr. Placek stated that he looking individually at each prescription. Mr. Placek stated that he brings up the image. Mr. Placek stated that he looks to see if the medication is a time released product.

Mr. McAllister asked Ms. Vucson if there was an internal quality assurance program. Ms. Vucson replied that the company does have a quality assurance program. Ms. Vucson stated that all errors must be reported within 24 hours. Ms. Vucson stated that Mr. Placek has made other errors. Ms. Vucson stated that Mr. Placek has been placed in a program to help improve his performance. Ms. Vucson stated that Mr. Placek is required to complete CE on errors. Ms. Vucson stated that Mr. Placek is required to review the quality assurance program and be sure the quality assurance program is being followed at his store. Ms. Vucson stated that the company is having Mr. Placek shadow with a precepting pharmacist to improve his verification skills.

Mr. Van Hassel told Mr. Placek that when he described his mistakes he made the comment several times that he assumed everyone else had done their job. Mr. Van Hassel told Mr. Placek that the role of the verification pharmacist is to check the prescription.

Dr. Musil asked Mr. Placek about counseling. Mr. Placek stated that the technician would notify the patient that the pharmacist needs to talk to them about their prescriptions. Mr. Placek stated that counseling is recorded in the system. Mr. Placek stated that he tears off the tag from the prescription and the number is typed into the system.

Dr. Musil asked if there is a report showing if counseling did or did not occur. Ms. Vucson stated that there is not a report.

Mr. McAllister stated that as pharmacist in charge, Mr. Placek failed to control the activities of the pharmacy.

On motion by Mr. McAllister and seconded by Ms. Rosas, the Board unanimously agreed to offer Mr. Placek a Consent Agreement with the following terms:

1. One year probation
2. \$500 fine for each error (Total of \$1,500)
3. 16 hours of Continuing Education on patient safety

Fine and CE are to be completed within 6 months. If the Consent Agreement is not signed, the case would proceed to Hearing.

Conference #6 – Complaint #4308

Dr. Foy was recused due to a conflict of interest.

The following individuals were present to discuss the complaint:

1. Mary Ellen Marshall – Pharmacist – Respondent
2. Janay Jones – Pharmacy Technician - Respondent
2. Bert Plemmons – Pharmacy Supervisor – Witness
3. Roger Morris – Legal Counsel for the Respondents and CVS

Vice President McAllister asked Mr. Waggoner to give a brief overview of the complaint.

Mr. Waggoner stated that the complainant indicated that her prescription for Hydrochlorothiazide was filled incorrectly. The complainant stated that when she picked up her prescription she noticed the tablets were a different color but thought they were a different brand. The complainant stated that she took the tablets for 10 days and experienced side effects. The complainant stated that her doctor told her to skip the water pill and she began to feel better. The complainant stated that she looked the tablets up on a pill identifier and discovered that the tablets inside her bottle were Lisinopril. The pharmacy response indicated that the technician placed the medication in the incorrect bottle. The pharmacist stated that the pharmacy technician does not follow company policy when she scans the bottles and labels to verify the correct medication is pulled and counted. The pharmacist stated that she does not believe that she

opened the bottle to view the medication because it would not have corresponded to the image on the screen.

Vice President McAllister asked the respondents to address the complaint.

Ms. Marshall stated that she learned about the error when the doctor called the pharmacy. Ms. Marshall stated that the patient called the doctor and then the doctor called the pharmacy stating that an error was made. Ms. Marshall stated that the doctor told her the patient would show her the medication that she received when she returned the medication to the pharmacy. Ms. Marshall stated that she apologized to the patient and said she was sorry. Ms. Marshall stated that she gave the patient the correct medication and a gift card.

Ms. Marshall stated that she discussed the error with the technician right away. Ms. Marshall stated that she told the technician that she should only fill one prescription at a time.

Ms. Jones stated that it was an error on her part. Ms. Jones stated that she probably was not paying attention. Ms. Jones stated that she was probably distracted and when she came back to fill the prescription she picked up the wrong bottle. Ms. Jones stated that she would pull two batches at a time and scanned everything first and then placed the bottles with the prescriptions. Ms. Jones stated that this is a busy store and she thought this method was faster. Ms. Jones stated that she cares about her job and she has now slowed down and is not rushing through the prescriptions.

Mr. McAllister asked if scanning is an option. Ms. Jones replied that scanning is required.

Mr. Kennedy asked if there are any scan alerts. Ms. Marshall stated that the only alert is if the product is not scanned. Ms. Marshall stated that it would not allow you to proceed if it is not scanned correctly.

Mr. Van Hassel asked if under the quality program for CVS if batches are allowed to be pulled for scanning. Ms. Marshall stated that the program matches the scanned bottle with the person's credentials. Ms. Marshall stated that the bottle and label are both scanned.

Mr. Plemmons stated that the correct process is to scan one bottle and one person with the stock bottle placed in the basket for that patient.

Mr. Plemmons stated that if a patient has more than one prescription each prescription is done separately with the bottle and label being scanned for each prescription. Mr. Plemmons stated that the bottles are placed in a basket for verification.

Mr. Plemmons stated at verification the pharmacist sees an image of the hard copy and the information the technician entered. Mr. Plemmons stated that there is also a colored image of the medication that should be in the bottle and the markings that should be on the tablets.

Ms. Marshall stated that she did not look in the bottle to view the contents.

Mr. Van Hassel asked Mr. Plemmons where the error occurred. Mr. Plemmons stated that the issue was that the labels and bottles were scanned and placed on the counter instead of being placed in a basket. Mr. Plemmon believes that the medication was counted and placed in the bottle and the bottle was labeled incorrectly. Mr. Plemmons stated that all the bottles were scanned and not bypassed, but were not placed in the baskets to separate the different patients.

Ms. Marshall stated that the technician has corrected the problem with scanning batches of labels and then filling the prescriptions.

Mr. Van Hassel asked Ms. Marshall if she had talked to the technician about this issue prior to the error occurring. Ms. Marshall stated that she talked to the technician prior to and after the incident.

On motion by Mr. Van Hassel and seconded by Mr. Kennedy, the Board unanimously agreed to issue a non-disciplinary letter to the pharmacy technician requesting that she complete 6 hours of CE on the prevention of medication errors or patient safety.

On motion by Mr. Van Hassel and seconded by Mr. Kennedy, the Board unanimously agreed to issue a non-disciplinary letter to the pharmacist requesting that she complete 9 hours of CE on the prevention of medication errors or patient safety.

Conference #7 – Complaint #4315

President Foy asked if Ms. Leon was present because she did not come forth when her name was called. Ms. Leon was not present.

Dr. Foy asked Ms. Frush how Ms. Leon was notified. Ms. Frush stated that a letter was sent to Ms. Leon at the address on file and an e-mail copy of the letter was also sent to Ms. Leon. Ms. Frush stated that the letter requests that the respondent notify her that they received the letter. Ms. Frush indicated that she did not receive any communication from Ms. Leon.

The Board Members agreed to move forward with the conference.

Dr. Foy stated that Ms. Leon had been charged with possession of drug paraphernalia and had not disclosed the charges on her application.

On motion by Ms. Rosas and seconded by Mr. Kennedy, the Board unanimously agreed to offer Ms. Leon a Consent Agreement with the following terms: Revocation of her Pharmacy Technician Trainee license. If the Consent Agreement is not signed, the case will proceed to Hearing.

Conference #8 – Complaint #4291

Dr. Foy was recused due to a conflict of interest.

The following individuals were present to discuss the complaint:

1. Stacie Guthrie – Pharmacist – Respondent
2. Francisca Juarez – Pharmacist - Respondent
3. Bruce Beckwith – Pharmacy Supervisor – Witness
4. Roger Morris – Legal Counsel for the Respondents and CVS

Vice President McAllister asked Mr. Petersen to give a brief overview of the complaint. Mr. Petersen stated that the complainant stated that her brother, who lives in a group home, was given a prescription for Clarithromycin on 11/27/2013. The complainant stated that her brother has had his prescriptions filled at the pharmacy and the pharmacy has a list of medications that her brother was taking. The complainant stated that the Clarithromycin was dispensed even though it was contraindicated with his seizure medications. The complainant stated that her brother subsequently suffered Tegretol toxicity due to this error. The pharmacy response indicated that the a prescription for carbamazepine was transferred to the pharmacy on 9/27/2014 and the prescription was placed in a hold file and was not entered into the computer system. A prescription for Clarithromycin was dispensed on 11/27/2013. A DUR interaction did not appear on the screen because the Tegretol was not entered into the computer. On 12/1/2013, the patient fell and was taken to the hospital and was discharged with high blood levels of carbamazepine. The pharmacy entered the carbamazepine prescription on 12/4/2013 and a severe interaction with clarithromycin appeared on the DUR screen. The pharmacist stated that she would normally call the prescriber but it was 6:00 in the evening when she filled the prescription and her normal practice would have been to place a note on the bag about the interaction. Mr. Petersen stated that there were no annotations on the prescription or in the computer regarding the interaction.

Mr. McAllister asked the respondents to address the complaint.

Ms. Juarez stated that the carbamazepine was a transferred prescription and was placed in a hold file and not entered into the computer. Ms. Juarez stated that the prescription was too soon to fill because the other pharmacy had just filled the prescription. Ms. Juarez stated that since the prescription was not entered into the computer there was no DUR flag with the Clarithromycin.

Ms. Guthrie stated that she was a fill in pharmacist at the store. Ms. Guthrie stated that she was not familiar with the pharmacy or the patient. Ms. Guthrie stated that she believes that a DUR alert appeared on the screen and she did not call the doctor because it was after hours for the doctor. Ms. Guthrie stated that she would have placed a note on the prescription bag to discuss the DUR with the patient at pickup.

Mr. McAllister asked the respondents to describe the DUR screen. Ms. Guthrie stated that the DUR screen would list the level of interaction. Ms. Guthrie stated that the interaction was severe. Ms. Guthrie stated that the screen would list the two drugs and the date filled. Ms. Guthrie stated that the screen would also list the prescriber's name and phone number.

Mr. McAllister asked about the process if a DUR occurs. Ms. Guthrie stated that she cannot recall the prescription but her normal process would be to place a note on the bag and the screen. Ms. Guthrie noted that the Clarithromycin should have been completed when the Carbamazepine prescription was filled.

Mr. McAllister stated that there seems to be an issue when the prescription was not entered into the hold queue on the computer.

Dr. Musil asked about the discrepancy in filling the prescription. Dr. Musil stated that the verification screen indicates that the carbamazepine prescription was verified on 12/4/2013 but the patient prescription record indicates the carbamazepine prescription was filled on 11/30/2013.

Ms. Juarez stated that the home called in on 11/30/2013 requesting that the Carbamazepine be filled. Ms. Juarez stated that at that time they did not have the full quantity and had to order the medication.

Dr. Musil asked if there was a DUR history for the Carbamazepine. Ms. Guthrie stated that the DUR appeared on 12/4/2013.

Dr. Musil asked the Pharmacy Supervisor to discuss the DUR policy when a DUR occurs after hours.

Mr. Beckwith stated that the pharmacist would be advised to not fill the prescription until they contact the physician.

Mr. Kennedy noted that the Clarithromycin should have been completed when the pharmacy filled the Carbamazepine prescription.

On motion by Mr. Kennedy and seconded by Ms. Rosas, the Board unanimously agreed to dismiss the complaint and take no further action on the complaint.

Conference #9 – Complaint Number #4290

Dr. Foy was recused due to a conflict of interest.

The following individuals were present to discuss the complaint:

1. Donald Tartaglio – Pharmacist – Respondent
2. Bert Plemmons – Pharmacy Supervisor – Witness
3. Roger Morris – Legal Counsel for the Respondents and CVS

Vice President McAllister asked Mr. Waggoner to give a brief overview of the complaint. Mr. Waggoner stated that the complaint was filed by the patient's attorney. The complaint stated that the patient picked up a refill prescription for Effexor ER 75 mg capsules on June 6, 2012 at the pharmacy. The prescription was filled incorrectly with Zonisamide 100mg capsules. Effexor is used to treat depression and Zonisamide is used to treat seizures. The patient took the incorrect medication for 3 days. It is not known if the patient questioned the appearance of the medication. The pharmacy stated that the original prescription was filled correctly with Venlafaxine 75mg ER capsules. The prescription refill was incorrectly filled with Zonisamide. The pharmacist stated that during the filling process they used a return to stock bottle. The bottle was scanned to verify the correct medication was dispensed. The pharmacist who did the

verification believes that he did not open the bottle to view the medication or he would have noticed that the medication was different. The pharmacist stated that the patient called several days later to question the color of the medication. The pharmacist told the patient she had the wrong medication and asked the patient to return the medication and the correct medication was dispensed. The pharmacist called the patient's physician. It was determined that the return to stock bottle contained the wrong medication. The pharmacist noted that the return to stock procedure was changed.

Mr. McAllister asked Mr. Tartaglio to address the complaint. Mr. Tartaglio stated that the medication was scanned to verify the product. Mr. Tartaglio stated that there had been a break down in the return to stock procedure in 2012. Mr. Tartaglio stated that this allowed the wrong product to be in the wrong bottle. Mr. Tartaglio stated that he did not look in the bottle to verify the drug. Mr. Tartaglio stated that the other incorrect bottle was located and the medication was destroyed. Mr. Tartaglio stated that the return to stock procedure has been changed.

Ms. Rosas asked Mr. Tartaglio to describe the return to stock process. Mr. Tartaglio stated that once filled the prescriptions are placed in bins waiting for the patient to pick up the prescription. Mr. Tartaglio stated that after 14 days, they would batch the labels and place the bottles in a basket. Mr. Tartaglio stated that somewhere in the process the wrong label was placed on the wrong bottle.

Ms. Rosas asked if the bottles and labels were bar-coded. Mr. Tartaglio stated that they were not bar coded at that time. Mr. Tartaglio stated that they now scan one return bottle at a time and do not scan all the products at one time.

On motion by Dr. Musil and seconded by Mr. Minkus, the Board unanimously agreed to issue a non-disciplinary letter to the pharmacist requesting that he complete 9 hours of CE on the prevention of medication errors or patient safety.

The Board Members requested that a letter be sent to CVS corporate office concerning the following of company policies.

Conference #10 – Complaint Number #4283

Mr. Kennedy was recused due to a conflict of interest.

The following individuals were present to discuss the complaint:

1. Matthew Hines – Pharmacist – Respondent
2. Joy Reese – Pharmacy Supervisor – Witness
3. Christine Casseta – Legal Counsel for the Respondent and Walgreens

President Foy asked Mr. Waggoner to give a brief overview of the complaint. Mr. Waggoner stated that the complainant stated that she suffered from an overdose of a medication because of a pharmacy error. The patient presented a prescription to the pharmacy for MSIR 15mg tablets and received Morphine Sulfate 15mg ER tablets. The pharmacist stated that the prescription was entered by a pharmacy technician at their site in Florida. The error was not detected by the

verification pharmacist. The patient took four tablets daily for 27 days resulting in a visit to the Emergency Room. The patient stated that she received an IV at the hospital and was told that her kidney function had decreased. The patient stated that she did not question the prescription due to the difference in appearance because she stated that she has received previous prescriptions where the manufacturer had changed.

Dr. Foy asked Mr. Hines to address the complaint. Mr. Hines stated that the complainant dropped off the prescription early. Mr. Hines stated that the prescription was entered by a technician at a remote site on the date indicated by the doctor. Mr. Hines stated that the technician entered the prescription for Morphine 15mg Extended Release instead of the Immediate Release formulation. Mr. Hines indicated that he did not catch the error when he verified the prescription.

Dr. Foy asked Mr. Hines what factors contributed to the error. Mr. Hines indicated that he dispenses more Morphine Extended Release than Morphine Immediate Release.

Dr. Foy asked if the patient was on the medication previously. Mr. Hines replied yes.

Dr. Foy asked if there were any drug interactions that occurred when he verified the prescription. Mr. Hines replied no.

Dr. Musil asked when Mr. Hines became aware of the error. Mr. Hines stated about a month after the prescription was filled.

Ms. Cassetta stated that they are not aware that the patient was hospitalized. Ms. Cassetta stated the pharmacy was notified by the physician.

Mr. Hines stated that he has made several changes when verifying prescriptions. Mr. Hines indicated that he makes sure that his attention is focused on the task. Mr. Hines stated that he eliminates any disruptions or interruptions.

Mr. Hines stated that when he checks a CII prescription he has asked the technicians not to place the sticker on the back of the prescription. Mr. Hines stated that he does a side by side comparison between the sticker and the hard copy.

Mr. Hines indicated that he double and triple checks high risk prescriptions. Mr. Hines stated that he has completed 6.5 CE hours on medication errors.

On motion by Mr. Van Hassel and seconded by Dr. Musil, the Board unanimously agreed to dismiss the complaint and take no further action on the complaint.

AGENDA ITEM 5 – Hearing – Schedule C
#1 – Dorian Lange

President Foy stated that this is the date, time, and place where the matter dealing with the Notice of Hearing on License Denial for Dorian Lange is scheduled to be heard by the Arizona State Board of Pharmacy.

The subject of the hearing is set forth in the Notice of Hearing. This is a formal Administrative Hearing to determine whether to grant or deny Mr. Lange's licensure.

The following Board Members were present for the Hearing: Kyra Locnikar, William Francis, John Musil, Reuben Minkus, Tom Van Hassel, Dennis McAllister, Darren Kennedy, Nona Rosas, and Jim Foy.

Dr. Foy stated let the record show that the Board Members have been furnished with copies of the Notice of Hearing and all pleadings of record.

Dr. Foy asked the parties to identify themselves.

Monty Lee, Assistant Attorney General, was present representing the State.

Mr. Lange was not present. Ms. Frush told the Board Members that she received an e-mail from Mr. Lange stating that he was sick and would not be able to attend the Hearing today. Ms. Frush stated that Mr. Lange is asking for a continuance.

Mr. Munns, Solicitor General, stated that the Board could proceed with the hearing or grant a continuance.

On motion by Mr. Musil and seconded by Mr. Francis, the Board unanimously agreed to proceed with the hearing.

Mr. Lee asked that his prepared exhibits be passed out to the Board Members.

The witnesses were sworn by the court reporter.

Mr. Lee waived the presentation of an opening statement.

The evidence was presented.

A closing statement was made by Mr. Lee.

On motion by Mr. Francis and seconded by Dr. Musil, the Board unanimously agreed to affirm the denial of Mr. Lange's license and incorporate the factual conclusions and legal conclusions of the denial letter.

The Hearing was concluded.

AGENDA ITEM 6 – Express Scripts Donation Program to Mission of Mercy

Mr. McAllister was recused due to a conflict of interest.

The following individuals were present to discuss the proposed program:

1. Dennis McAllister – Express Scripts
2. Gianna Sullivan – Pharmacist with Mission of Mercy
3. Bradley Smith – Physician with Mission of Mercy
4. Henry Konerko – CEO of Mission of Mercy

President Foy asked Mr. McAllister to open the discussion. Mr. McAllister stated that Express Scripts would like to donate medications to the Mission of Mercy program.

Mr. McAllister asked Mr. Konerko to describe the services offered by Mission of Mercy. A short video was played. Mr. Konerko stated that the Mission of Mercy offers a wide range of services to their patients, such as medical treatment, dental treatment, and pharmaceutical services. Mr. Konerko stated that most services are provided by volunteers.

Dr. Sullivan addressed the pharmaceutical services provided. Dr. Sullivan stated that the Mission of Mercy provides free ongoing prescriptions to their patients at their patient visit. Dr. Sullivan stated that the medications are donated or purchased. Dr. Sullivan stated that all products are labeled in accordance to regulations. Dr. Sullivan stated that they do not have temperature sensitive medications.

Mr. McAllister stated that Express Scripts would like to donate medications to the Mission of Mercy. Mr. McAllister is asking the Board to approve a pilot program where Express Scripts would donate medications that are returned to the pharmacy in the original Express Scripts packaging. Mr. McAllister stated that the medications are packages that are returned because they have been sent to the wrong address or the patient did not accept the package. Mr. McAllister stated that the medications are currently destroyed when there is nothing wrong with the medications.

Mr. McAllister stated that the packages are in vials in tamper proof packaging. Mr. McAllister stated that the lot number and expiration date are not on the prescription label but are maintained by the software at Express Scripts.

Mr. McAllister stated that Express Scripts is asking for a waiver to donate the medications to Mission of Mercy based on technology and experimentation.

Dr. Smith stated that the donations from Express Scripts would provide more flexibility in treating conditions such as congestive heart failure, diabetes, asthma, and respiratory conditions.

Dr. Foy asked about their formulary. Dr. Sullivan stated that the products are purchased or donated. Dr. Sullivan stated that the inventory is generic products and products are prescribed based on therapeutic classes.

Dr. Foy asked what would happen if the packages are returned open. Mr. McAllister stated that if the packages are opened they would not be accepted.

Mr. Van Hassel asked if the medications would be donated from a Phoenix facility. Mr. McAllister stated that the medications would be donated from the Hardy facility.

Dr. Sullivan stated that the medications donated initially would be inhalers and topical medications.

Dr. Foy asked Mr. McAllister to describe what happens when a package is returned. Mr. McAllister stated that the package is sent to returns. Mr. McAllister stated that the package is logged into the system. The package currently is not used and is sent to destruction. Mr. McAllister stated that the drug name, strength, and beyond use date is tracked. Mr. McAllister stated that the lot number is not in the system.

Mr. Kennedy asked Dr. Sullivan what would occur at the Mission of Mercy if a recall occurred and they were not able to identify the lot number. Dr. Sullivan stated that they would not use the medication if there was a recall and they could not identify the lot number.

Dr. Musil asked if they are asking for a waiver for R4-23-1202. Mr. McAllister stated that they are asking for a waiver based on technology that will allow them to trace the product in their system.

On motion by Mr. Van Hassel and seconded by Dr. Foy, the Board unanimously agreed to allow Express Scripts to deviate from R4-23-1202 based on technology and experimentation. The Board asked that Express Scripts report back to the Board in the next year. The report will include what medications were donated and if there were any issues. Also, the Board noted that no controlled substances or refrigerated products could be donated.

AGENDA ITEM 7– Call to the Public

President Foy announced that interested parties have the opportunity at this time to address issues of concern to the Board; however the Board may not discuss or resolve any issues because the issues were not posted on the meeting agenda.

No one came forth.

AGENDA ITEM 8– Adjournment

There being no further business to come before the Board, President Foy adjourned the meeting at 3:15 P.M.