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Nevada State Board of Pharmacy News

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Board Members

Changing Faces

In recent years, it seems as though with the coming of fall and the changing of leaves, there also comes a change to the Nevada State Board of Pharmacy. The year 2010 was no exception. Sadly, Board President Donald Fey, along with Board Members Chad Luebke and Mary Lau have concluded their respective terms on the Board. Board staff wishes to acknowledge the exemplary service that these three have contributed to the citizens of Nevada, and thank them accordingly. Serving on the Board is no easy task, many not appreciating the sacrifice, time, effort, pressures, and stress involved. Don, Chad, and Mary served with strength and respect, and the Board thanks them.

Board staff welcomes Governor Jim Gibbon's new appointees, Jody Lewis, PharmD, of Las Vegas, NV; Cheryl Blomstrom of Carson City, NV, public member; and Russell Smith, RPh, also of Carson City. Jody is a pharmacy supervisor for CVS, having received her PharmD from the University of Iowa in 1997, and is an avid golfer. Cheryl, who is the president of Blomstrom Consulting, Inc, comes with extensive experience in government relations and is a *huge* Giants fan, so she was quite enthralled with the recent World Series! Russ, who neither golfs nor plays baseball, is the pharmacy manager for Walgreens in Carson City and is an accomplished pilot who serves as mission pilot, instructor pilot, and check pilot for the Nevada Wing Civil Air Patrol. Board staff looks forward to working with all three!

Finally, with the end of President Fey's term, the Board has elected Beth Foster, RPh, to the office of Board president. Beth, last year's Bowl of Hygeia recipient, is not only a leader in her community, but is the chief of pharmacy service for the VA Sierra Nevada Health Care System. Beth has demonstrated a true commitment to her duties as a Board member, which will undoubtedly carry forward as she leads the Board into the future. Congratulations Beth!

The Role of Pharmacists in the Wake of Rising Rx and OTC Medication Misuse

Paul Oesterman, PharmD, Associate Professor Pharmacy Practice and Leila Taherkhani, PharmD Candidate, Class of 2011, University of Southern Nevada College of Pharmacy

The staggering increase in prescription and over-the-counter (OTC) abuse and misuse among people in all age and socioeconomic strata in America is problematic. We, as pharmacists, share in the responsibility and can help. All pharmacists should read a recent report released by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA is a public health agency within the Department of Health and Human Services and their mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA recently released a study showing that the number of all substance abuse treatment admissions of people aged 12 and older involving abuse of prescription drugs, especially pain relievers, rose by over 400% from 2.2% in 1998 to 9.8% in 2008. [1]

Misuse of prescription drugs to get high has become increasingly widespread among adolescents. Abuse of prescription painkillers now ranks second, only behind marijuana as the nation's most prevalent drug problem.[2] This dramatic rise is occurring among nearly all segments of the population regardless of age, gender, race, educational level, or employment status. SAMHSA released a similar study showing hospital emergency department visits involving the non-medical use of prescription pain relievers has more than doubled since 2004.[1]

As one reads these reports, it becomes evident that the abuse of prescription drugs is the fastest growing drug problem among people in our country. This cannot be ignored and requires immediate attention. In fact, reducing prescription drug abuse is a top priority of the President's National Drug Control Strategy, and as a result SAMHSA's 2010 National Drug Control Strategy calls for an all out effort to raise awareness of this risk. As pharmacists, it is our responsibility to take the initiative and help raise awareness of the tragic consequences of this phenomenon.

Educating patients about the proper use, storage, and disposition of all drugs, especially controlled substances is very important. When dispensing medications, pharmacists play a key role in teaching patients how to use them appropriately and describe potential side effects and/or drug interactions. Pharmacists should

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DEA Policy Statement on Role of Agents in Communicating CS Prescriptions

Drug Enforcement Administration (DEA) issued a statement of policy that clarifies the proper role of a duly authorized agent of a DEA-registered individual practitioner in communicating controlled substance (CS) prescription information to a pharmacy. The statement, published October 6, 2010, in the *Federal Register,* reminds health care providers that a prescription for a CS medication must be issued by a DEA-registered practitioner acting in the usual course of professional practice. Such a practitioner may authorize an agent to "perform a limited role in communicating such prescriptions to a pharmacy in order to make the prescription process more efficient," and the guidance emphasizes that medical determinations to prescribe CS medications may be made by the practitioner only.

The specific circumstances in which an agent may assist in communicating prescription information to a pharmacy are detailed and include:

- An authorized agent may prepare the prescription, based on the instructions of the prescribing practitioner, for the signature of that DEA-registered practitioner.
- For a Schedule III-V drug, an authorized agent may transmit a practitioner-signed prescription to a pharmacy via facsimile, or may communicate the prescription orally to a pharmacy on behalf of the practitioner.
- An authorized agent may transmit by facsimile a practitioner-signed Schedule II prescription for a patient in a hospice or long-term care facility (LTCF) on behalf of the practitioner.

The guidance also makes clear that generally, Schedule II prescriptions may not be transmitted by facsimile and that hospice and LTCFs are exceptions. Further, Schedule II prescriptions may only be communicated orally by the DEA-registered practitioner and only in emergency situations. DEA stresses that the practitioner should decide who may act as his or her authorized agent and advises that such designation be established in writing. An example written agreement is included in the policy statement, along with additional guidance related to designating an authorized agent. DEA also notes that as electronic prescribing for CS is implemented and its use increases, the role of the agent in communicating CS prescriptions will likely be reduced over time. The DEA policy statement is available on the *Federal Register* Web site at *www.federalregister.gov/articles/2010/10/06/2010-25136/role-of-authorized-agents-in-communicating-controlled-substance-prescriptions-to-pharmacies.*

FDA and NABP Partner to Help Prevent Acetaminophen Toxicity

In partnership with the National Association of Boards of Pharmacy® (NABP®), and as part of its Safe Use Initiative, Food and Drug Administration (FDA) encourages pharmacies to stop using the abbreviation APAP and to spell out the drug name, acetaminophen, in effort to help patients avoid acetaminophen toxicity. As explained in an FDA drug safety notice, liver injury due to acetaminophen overdose is a serious public health problem, and by spelling out the drug name on prescription labels, pharmacies are enabling patients to know when their medication contains the drug. Patients can then compare their prescription and over-the-counter medications to determine whether both contain acetaminophen and avoid taking two medicines containing the drug. The FDA drug safety notice provides more information and is available at *www.fda.gov/Drugs/DrugSafety/ucm230396.htm.*

In July 2010, NABP recommended that the state boards of pharmacy prohibit the use of the abbreviation APAP on prescription labels, and require that acetaminophen be spelled out. In situations where the board is unable to mandate such a provision, NABP recommended that the boards strongly encourage practitioners to follow this guideline. More information is available on the NABP Web site at *www.nabp.net/news/nabp-recommends-boards-of-pharmacy-prohibit-use-of-acetaminophen-abbreviation/.*

The ISMP Ambulatory Care Action Agenda: Learn from Others' Mistakes

This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations. To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory Care Edition by visiting www.ismp.org. *ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also a FDA MedWatch partner. Call 1-800-FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at* www.ismp.org. *ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: ismpinfo@ismp.org.*

No news is **not** good news when it comes to patient safety. Each organization needs to accurately assess how susceptible its systems are to the errors that have happened in other organizations, and acknowledge that the absence of similar errors is not evidence of safety. Personal experience is a powerful teacher, but the price is too high to learn all we need to know from firsthand experiences. Learning from the mistakes of others is imperative.

A great way to utilize the ISMP Medication Safety Alert!® Community/Ambulatory Care Edition is by using the Ambulatory Care Action Agenda*. Three times a year, selected items are prepared for you and your staff to stimulate discussion and collaborative action to reduce the risk of medication errors previously reported to the ISMP Medication Errors Reporting Program (MERP). The agenda topics appeared in the ISMP Medication Safety Alert! Community/Ambulatory Care Edition during the preceding four

months. Each item includes a brief description of the medication safety problem, recommendations to reduce the risk of errors, and the issue number to locate additional information as desired.

The Action Agenda is presented in a format that allows community practice sites to document their medication safety activities, which is important for internal quality improvement efforts but also important for any external accrediting or regulatory organizations. Each pharmacy practice site should convene a staff meeting to discuss each item in the Action Agenda. The staff should ask themselves, "Can this error occur at our site?" If the answer is "yes," the ISMP recommendations for prevention should be reviewed for applicability at that specific site. If the recommendations are germane to the practice site, the columns on the Action Agenda indicating "Organization Assessment" and "Action required/Assignment" should be completed and a reasonable time set for completion. The staff should reconvene in three months time to determine if the proposed recommendation strategies have been implemented, if they are still pertinent, and if other strategies have been offered or considered since the initial meeting.

According to the 2011 *Survey of Pharmacy Law,* published by NABP, at least 19 states regulate, require, or recommend a continuous quality improvement (CQI) program to monitor and prevent quality related events. The purpose of the CQI program is to detect, document, and assess prescription errors in order to determine the cause, develop an appropriate response, and prevent future errors. Utilization of the Action Agenda to review externally reported errors combined with review and analysis of internally reported events constitutes a feasible and effective CQI program.

*The Action Agenda is available at no charge on the ISMP Web site, *www.ismp.org/Tools/communitySafetyProgram.asp.*

Iowa Tracks Group Using Fraudulent CS Prescriptions

The Iowa Department of Public Safety seeks assistance in tracking a group of individuals using fraudulent prescriptions to obtain CS. Specifically, four unidentified individuals have obtained oxycodone using fraudulent prescriptions at a number of pharmacies in Iowa. Similar cases have occurred in Missouri, and it is believed that the same group of people is involved. The subjects are reported to have used multiple aliases, to be in their 20s or 30s, and to have paid in cash. They have also been reported to use crutches when dropping off and picking up prescriptions. The fraudulent prescriptions were on legitimate prescription paper with valid prescriber names, but the addresses on them had been computer generated. Similar cases or relevant information can be reported to Criminal Intelligence Analyst Crystal Munson at the Mid-Iowa Narcotics Enforcement Task Force by calling 515/270-8233, extension 119, or by e-mailing crystal.munson@polkcountyiowa.gov.

Stolen Carbatrol, Adderall XR Surfacing in Supply Chain

Shire, along with FDA, alerts pharmacists and distributors that certain lots of Carbatrol® that were stolen on October 17, 2008, have been found in the supply chain as expired returns. The stolen shipment also contained Adderall XR®. The manufacturer warns that more stolen product may still be on the market and that stolen Carbatrol and Adderall XR should not be used or sold because the safety and effectiveness of the product could have been compromised by improper storage and handling or tampering while outside of the legitimate supply chain. The following products and lot numbers are affected:

- Adderall XR 15 mg, Lot No: A38146A, Expiration Date: 02/29/2012
- Carbatrol 200 mg, Lot No: A40918A, Expiration Date: 04/30/2010
- Carbatrol 200 mg, Lot No: A40919A, Expiration Date: 04/30/2010
- Carbatrol 200 mg, Lot No: A41575A, Expiration Date: 05/31/2010

These lots of Carbatrol and Adderall XR were stolen while in transit from Shire's manufacturing facility in North Carolina to Shire Distribution Center in Kentucky. FDA seeks assistance and asks that any information regarding the stolen Carbatrol or Adderall XR, including suspicious or unsolicited offers for these products, be reported by contacting FDA's Office of Criminal Investigations (OCI) at 800/551-3989, or by visiting the OCI Web site at *www.accessdata.fda.gov/scripts/email/oc/oci/contact.cfm.*

Survey of Pharmacy Law's 60th Edition Now Available!

Celebrating its 60th edition as a convenient reference source for individuals seeking an overview of the state laws and regulations that govern pharmacy practice, the updated 2011 *Survey of Pharmacy Law* is now available.

The *Survey,* produced in a CD format, consists of four sections including a state-by-state overview of organizational law, licensing law, drug law, and census data. Newly added this year, a question in Section 18, Drug Control Regulations, asks whether or not states have CS or drugs of concern scheduled differently than the federal Controlled Substances Act.

Updates for the 2011 *Survey* were graciously provided by the state boards of pharmacy. In addition to the boards' support, NABP requested data from relevant health care associations for the *Survey's* prescribing authority and dispensing authority laws in Sections 24 and 25, and laws pertaining to the possession of non-controlled legend drugs and possession of CS in Sections 26 and 27.

The *Survey* can be purchased online for $195 by visiting the Publications section of the NABP Web site at *www.nabp.net/publications.*

All final-year pharmacy students receive the *Survey* free of charge through the generous grant of Purdue Pharma L.P.

For more information on the *Survey,* please contact Customer Service via phone at 847/391-4406 or via e-mail at custserv@nabp.net.

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also warn patients of the risks of drug misuse and abuse and offer patients tips on how to safeguard their medications. Patients should be encouraged to carefully monitor their prescription and OTC medications, especially if they have an adolescent living in or visiting their home.

Furthermore, patients should also be educated how to safely dispose of unwanted, unused, or expired medications. Pharmacies can offer information on proper ways to discard these medications. One example is to provide instructions on how unwanted medications can be mixed with undesirable products (coffee grounds, kitty litter) and some liquid, placed in sealable, impermeable nondescript containers (empty can, sealable bag), and discarded in the household trash.[3] This will ensure these products are not diverted. A second measure includes the provision of a list of medications that are most safely disposed of by flushing them down the toilet. These lists are available from a number of resources.[4]

Patients need to be encouraged to take advantage of community pharmacy take-back programs like the successful Nevada Rx Round-up or Operation Medicine Cabinet drop off events. These events allow people to anonymously drop off unwanted, unused, or expired medications at a central location for proper disposal. [5,6]

Pharmacists can also help prevent prescription drug abuse by monitoring prescriptions for falsification or alteration and being aware of patient "doctor shopping."[7] Pharmacists must be the first line of defense in recognizing prescription drug abuse. In addition to the Controlled Substance Abuse and Prevention Task Force monitoring, all pharmacies should develop hotlines to alert other pharmacies in the region when a fraudulent prescription is detected.

Patients should always have access to a center where they can seek treatment for themselves or a family member who is misusing prescription or OTC medications. In fact, SAMHSA's Substance Abuse Treatment Facility Locator is a national directory of drug abuse and alcoholism treatment programs. This directory can be searched to locate a program that meets a patient's specific search specification.

Lastly, pharmacists should take every possible opportunity to spread the word that prescription and OTC drugs are dangerous when misused or abused. We need to saturate our communities with educational materials, offer training sessions, and never assume that our mission is complete – the proper use of medications to achieve a desired outcome, and above all do no harm.

References

1 *www.samhsa.gov/newsroom/advisories/1007140544.aspx*

2 *www.theantidrug.com/pdfs/TEENS_AND_PRESCRIPTION_DRUGS.pdf*

3 *www.ncjrs.gov/ondcppubs/publications/pdf/prescrip_disposal.pdf*

4 *www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm*

5 *www.jtnn.org/projects/prescriptiondrug.html*

6 *www.operationmedicinecabinet.blogspot.com/*

7 *www.nida.nih.gov/researchreports/prescription/prescription6.html*

Continuing Education

NRS 639.2174 states "The Board shall **not** renew the certificate of any registered pharmacist until the applicant has submitted proof to the Board of the receipt of the required number of continuing education units, obtained through the satisfactory completion of an accredited program of continuing professional education during the period for which the certificate was issued." Would it then not be prudent for the Board, upon discovering that a pharmacist's continuing education (CE) for the renewal period is not complete, to suspend that registration until the CE requirement is met? The statute seems clear.

Pharmacists have until October 31, 2011, to complete their CE for this biennium, including the one hour of law CE. Best not to wait!

The *Nevada State Board of Pharmacy News* is published by the Nevada State Board of Pharmacy and the National Association of Boards of Pharmacy Foundation, Inc, to promote compliance of pharmacy and drug law. The opinions and views expressed in this publication do not necessarily reflect the official views, opinions, or policies of the Foundation or the Board unless expressly so stated.

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