



# Nevada State Board of Pharmacy

*Published to promote compliance of pharmacy and drug law*

431 W Plumb Lane • Reno, NV 89509 • Phone: 775/850-1440 • Fax: 775/850-1444  
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## **Veterinary Medications and the Pharmacist**

*By Leo Basch, Board Member*

A recent Gallup Poll finds that Americans rank the honesty and ethical standards of the pharmacist among the highest of all professions. One of the reasons for such sentiment is that pharmacists are the most accessible medical professionals available to the public and are counted upon to provide accurate drug information. While it is fairly easy to obtain drug information for human use, your patients might experience difficulty finding the same information as it relates to their pets. This is why it is important for pharmacists to have at least some knowledge of common pet medications and how they are used in different species.

Many pet owners erroneously believe that medications for their pets are dosed as they would be in a small child. This demonstrates the importance of an informed pharmacist who can relay accurate information and share that not only are pets **not** small children, but that many drugs are species-specific. A good example is acetaminophen, which may be used safely in dogs, rabbits, and rodents, however is absolutely contraindicated in cats.

Aspirin, benzodiazepines, and thyroid hormone offer further examples of differences in pharmacokinetics. While aspirin can be dosed every 12 hours in dogs, a dose should only be given every 2 to 3 **days** in cats. Benzodiazepines may be used in dogs, but the dose

most likely will be many times the human dose based on weight. Thyroid hormone is also dosed much higher in dogs than in humans. Antihistamines are often prescribed for dogs with allergies and the pet owner must be made aware that many preparations contain a decongestant like pseudoephedrine as well, which is toxic to dogs at only 5 mg/kg of body weight.

Food toxicity in pets is another issue that the pharmacist may share with his or her patients. For example, xylitol, an artificial sweetener found in some sugar-free products like cough drops, toothpaste, and Neuronin® Oral Solution, is highly toxic to dogs and could cause severe hypoglycemia and liver failure left untreated. Other food toxicities for dogs include onions (anemia), garlic, grapes, raisins, and macadamia nuts. Avocados can cause illness in horses. These examples illustrate the need to include a doctor of veterinary medicine (DVM) in the conversation when a patient asks the pharmacist about an animal eating something it should not have.

So what are the resources available to the pharmacist to help build drug information knowledge as it relates to pets? First and foremost is to build a relationship with a local DVM. DVMs obviously love animals and most likely will appreciate a pharmacist being concerned enough to call with a question. If the situation is urgent, as with xylitol ingestion, you may be instrumental in saving a pet's life.

Other resources include books, continuing education (CE), and the Internet. The *Merck Veterinary Manual* and *Plumb's Veterinary Drug Handbook* are both invaluable resources that you may want to keep in your pharmacy. The University of Wisconsin Veterinary Medical Teaching Hospital has developed a 10-lecture CE series that is Accreditation Council for Pharmacy Education accredited. Do not throw caution to the wind with the Internet. [www.veterinarypartner.com](http://www.veterinarypartner.com) has a comprehensive listing of drugs that might be used in animals. The site does not include dosing information, but explains why the drugs are effective in animals.


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## Changes to Fentanyl Pain Patch Warnings Required by FDA

To reduce the risk of accidental exposure, Food and Drug Administration (FDA) has announced new requirements that change the appearance of fentanyl pain patch warnings to make them more visible. The change also requires new language in the warning that emphasizes the risk of death from accidental exposure, particularly in children. The announcement coincided with a Consumer Update that stressed the potential danger of improperly discarded fentanyl patches to children and pets. FDA reminded consumers of the agency's previous advice for securely storing unused patches and disposing of used fentanyl patches by folding the sticky sides together and then flushing them down the toilet. The agency also advises patients to cover in-use patches with an adhesive film to keep them from coming loose, and to regularly check patches to ensure they are securely in place. FDA offers additional information for health care providers on the "Fentanyl Transdermal System (marketed as Duragesic) Information" page, available at [www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm114961.htm](http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm114961.htm). Consumer information about safe drug disposal methods is also available on the AWARE<sub>x</sub>E<sup>®</sup> Web site at [www.AWARERX.ORG](http://www.AWARERX.ORG).

## New: Free ISMP Medication Safety Alert! Newsletter for LTC Facilities

 This column was prepared by the Institute for Safe Medication Practices (ISMP). ISMP is an independent nonprofit agency and federally certified patient safety organization 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](http://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 an 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](http://www.ismp.org). ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: [ismpinfo@ismp.org](mailto:ismpinfo@ismp.org).

In July, ISMP began publishing *Long-Term Care Advise-ERR*, a new *ISMP Medication Safety Alert!* newsletter for nurses and administrators in long-term care (LTC) facilities. ISMP receives error reports that have occurred in LTC facilities. The newsletter is provided free to LTC facilities in the United States thanks in part to corporate sponsorship from Lilly and for a nominal sub-

scription fee for pharmacies that service LTC facilities and others. Please visit ISMP's Web site at [www.ismp.org/Newsletters/longtermcare](http://www.ismp.org/Newsletters/longtermcare) for more information, and let your LTC facilities know about this free offer.

Here are a few excerpts from a recent issue.

### Immediate Vs Extended Release Error

A physician called a LTC facility to change a resident's oxycodone order from an extended-release formulation to an immediate release formulation at the same dose and frequency. The nurse receiving the verbal order transcribed it as "Discontinue OxyContin 10 mg BID, Start OxyContin 10 mg IR BID," with "IR" meant to represent immediate release. Although OxyContin<sup>®</sup> is a brand of oxycodone, it is only available as an extended-release tablet. The pharmacy had previously been dispensing OxyContin for the resident, so the nurse thought she could communicate the prescriber's order by discontinuing the current OxyContin order and then ordering OxyContin as an immediate-release product. The pharmacy continued dispensing OxyContin. The differences between these products and formulations were brought to the attention of nursing staff via an in-service. To minimize the risk of confusion, do not attach modifiers such as "IR" for immediate-release or "RS" for regular strength unless it is part of the official drug name.

### Errors Occur During Transitions of Care

A pharmacist reported the following hazardous situation that can occur during a hospital to LTC transfer. Residents are often admitted to a LTC facility with a list of medications printed from the hospital pharmacy computer. On these printouts, doses are expressed along with the number of tablets. For example, the printout may list hydrochlorothiazide 50 mg/2 tablets daily for an order in which the total dose was 50 mg because the hospital only stocks the 25 mg tablets. During hospitalization the patient required two tablets for each dose; however, the LTC nurse may misinterpret the order to mean two 50 mg tablets, making the total dose 100 mg, or two times more than prescribed. This issue arises every time the resident's total dose in the hospital requires more than one tablet or capsule. Discharge medication summaries and transfer orders should only list the total dose in mg or mcg and other directions for use (ie, frequency, route, drug name) to avoid misinterpretation.

### 2013 USP Chapter <797> Compliance Survey Shows Compliance Trends Unchanged From 2012

The 2013 United States Pharmacopoeia (USP) Chapter <797> Compliance Survey, the third annual report released since 2011, shows that the overall compliance rate of 77.2% remains nearly unchanged from the 2012 rate. Budgetary restrictions and physical plant limitations were among the top challenges to compliance by survey respondents. The report also details the



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

survey's findings on what types of facilities are participating in compounding, and compliance in specific domain areas such as environmental sampling and gloved fingertip sampling. Of the survey's 1,045 participants, 97% of the survey's respondents said that USP Chapter <797> "has had a positive influence on patient safety." The report notes National Association of Boards of Pharmacy® (NABP®) efforts to assist state boards of pharmacy in evaluating pharmacy compliance with USP Chapter <797> requirements for sterile compounding in their states. The report also noted that those who participated in the 2011 survey had a higher compliance score than those who did not. The survey's authors encouraged pharmacy owners with multiple areas of noncompliance to target one or two areas to improve. They also encouraged organizations that participated in the survey to make use of the free Action Plan – generated upon completion of the survey – and other free resources to "reshape" their sterile compounding practices. The full report on the survey's results is available in the October 2013 issue of *Pharmacy Purchasing & Products Magazine* and on the magazine's Web site at [www.pppmag.com/article/1403](http://www.pppmag.com/article/1403).

## **FDA Recommends Schedule II Classification for Hydrocodone Combination Products**

FDA planned to submit a formal recommendation to reclassify hydrocodone combination products as Schedule II controlled substances to the Department of Health and Human Services by early December 2013. FDA expects the National Institute on Drug Abuse to concur with the recommendation, indicates a statement on the FDA Web site. FDA also indicates that while "the value of and access to these drugs has been a consistent source of public debate," the agency has "been challenged with determining how to balance the need to ensure continued access to those patients who rely on continuous pain relief while addressing the ongoing concerns about abuse and misuse." Drug Enforcement Administration makes the final decision about the appropriate scheduling of these drugs. In January 2013, FDA's Drug Safety and Risk Management Advisory Committee made a recommendation that hydrocodone combination products be classified as Schedule II drugs following a 19-to-10 vote that concluded a two-day meeting during which members discussed the potential for abuse and misuse of the medications and the potential impact of rescheduling the drug products. FDA's statement on the recommendation is available at [www.fda.gov/Drugs/DrugSafety/ucm372089.htm](http://www.fda.gov/Drugs/DrugSafety/ucm372089.htm).

## **New FDA Drug Info Rounds Training Videos Available**

FDA Drug Info Rounds, a series of online videos, provides important and timely drug information to practicing clinical and

community pharmacists so they can help patients make better medication decisions. In the latest two Drug Info Rounds videos, pharmacists discuss the review and approval of new drug names and the review of marketing and advertising materials for new drugs. The videos can be viewed at [www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm368620.htm](http://www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm368620.htm) and [www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm371785.htm](http://www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm371785.htm), respectively. Drug Info Rounds is developed with contributions from pharmacists in FDA's Center for Drug Evaluation and Research, Office of Communications, and Division of Drug Information.

## **CPPA Developing Specialty Pharmacy Accreditation Program**

The Center for Pharmacy Practice Accreditation® (CPPA) has announced the development of a new accreditation program for specialty pharmacy practices. CPPA Executive Director Lynnae Mahaney, MBA, RPh, FASHP, VHA-CM, indicates that "CPPA will be able to develop the new specialty pharmacy standards quickly and efficiently with the existing standards development methodology, infrastructure, and network of specialty pharmacy expertise."

CPPA is a partnership between the American Pharmacists Association, the American Society of Health-System Pharmacists, and NABP. CPPA develops and implements comprehensive programs of pharmacy practice site accreditation, including the promotion, development, and maintenance of principles, policies, and standards. CPPA offers the general public and users of pharmacy services a means of identifying those pharmacies that satisfy the accreditation criteria and are focused on advancing patient care, safety, and quality.

More information may be found in the press release, available at [www.pharmacypracticeaccredit.org/news/2013/10/cppa-to-develop-specialty-pharmacy-accreditation-program](http://www.pharmacypracticeaccredit.org/news/2013/10/cppa-to-develop-specialty-pharmacy-accreditation-program).



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When providing consultation to a pet owner, the pharmacist can make no assumptions and should check with the prescribing DVM if questions on a prescription arise. Live up to that Gallup Poll!

### **The 14-Day Rule**

The infamous “14-Day Rule,” which seems to be unique to Nevada, often causes confusion, not only to practitioners, but to Nevada State Board of Pharmacy staff as well. See the statute NRS 453.431 and regulation NAC 453.450. The statute states that “A pharmacist shall not fill a prescription for a controlled substance classified in schedule II unless it has been tendered on or before the 14<sup>th</sup> day after the **date of issue**” (emphasis added). So what is the “date of issue” when it comes to a Schedule II prescription that was written on one date but has a “do not fill until” date? The regulation NAC 453.450 states that the date indicated by the practitioner is the date of issue for the purposes of Subsection 4 of NRS 453.431, which then seems to move the date of issue to the “do not fill until” date, hence the confusion.

Board staff asked the full Board to interpret the laws, the result of which is the following.

A Schedule II prescription with a “do not fill until” date must be tendered on or before the 14<sup>th</sup> day after the **do not fill until** date. Bottom line: a patient may carry around a previously written Schedule II prescription until up to 14 days after that “do not fill until” date.

### **AB 408**

AB 408, a bill that the Nevada Legislature passed during the 2013 Legislative Session, requires state agencies, including the Board, to determine whether a proposed regulation is likely to impose a direct and significant economic burden upon small businesses, or restrict the formation, operation, or expansion of small businesses. The statute defines “small business” as a for-profit business that employs fewer than 150 full-time or part-time employees.

To come into compliance with AB 408 (NRS Chapter 233B), the Board will post on its Web site (<http://bop.nv.gov>) information regarding any regulation coming up for workshop or public hearing before the Board. The Board invites the officers and owners of small businesses to review the information posted and to submit to the Board feedback regarding the impact, if any, a proposed regulation or amendment will have on small businesses. Your comments may be e-mailed to the Board at [pharmacy@pharmacy.nv.gov](mailto:pharmacy@pharmacy.nv.gov) or mailed to 431 W Plumb Lane, Reno, NV 89509.

### **Thank You to Our Pharmacists**

The Board wrapped up another successful pharmacist renewal cycle at the end of October 2013. We at the Board would like to thank everyone for renewing their license and especially those who chose to use the online option, allowing staff to address the public’s needs as well as the needs of its licensees.

The Board realizes not everyone is eligible to use the online option and appreciates those pharmacists who accurately used the paper form option. Board renewal staff is limited, but staff was able to process paper renewals swiftly upon receipt, within two business days. As pharmacists know, attention to detail is paramount to accuracy.

This cycle was by far the smoothest it has ever been, with minimal issues. Every year the Board looks to improve its process and will be using changes made this year to implement with future renewal cycles.