Atlas - closed

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Nevada State Board of Pharmacy

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* Chibueze work history

Search Results

Firm Name	Permit No.#
Atlas Medical Equipmen...	MP00358
ATLAS MENS HEALTH...	DS00203-...
ATLAS PHARMACEUTI...	OUT00002
ATLAS SPECIALTY PH...	PH03217
Atlas Wholesale	WH01346

Moditech 8/15-3/16
Spring Valley 3/16-2/17
Atlas 7/17-6/18
Aeva 2/19

Provider Details

Company Information | License | Application Data | Associate Information | Inspection | Compliance | Finance | Notes | DEA | Document Log | Compliance | Fingerprints

Associate Information

First Name : Last Name : License Number : Search Cancel

Current

First Name	Last Name	License Number	Start Date	Status	Managing Pharmacist	Action

Prior

First Name	Last Name	License Number	Start Date	End Date	Managing Pharmacist	Deassociate Date
NELSON	MUKUNA	16311	02/25/2015		☐	
Robinah	Nakimera	15544	08/19/2014	11/04/2015	☑	
Robinah	Nakimera	15544	08/19/2014	11/04/2015	☑	
Veronica	Walters	16099	11/04/2015		☑	
Robinah	Nakimera	15544	08/19/2014		☑	
Nga	Tran	14992	07/29/2015		☐	
Veronica	Walters	16099	11/04/2015	12/07/2015	☑	
Veronica	Walters	16099	11/04/2015	12/07/2015	☑	
Remi	Asindraza	09656	12/07/2015		☑	
Nga	Tran	14992	07/29/2015	07/13/2016	☐	
Nga	Tran	14992	07/29/2015	07/13/2016	☐	
Remi	Asindraza	09656	12/07/2015	06/17/2016	☑	
Remi	Asindraza	09656	12/07/2015	06/17/2016	☑	
NELSON	MUKUNA	16311	06/17/2016		☑	
NELSON	MUKUNA	16311	02/25/2015	07/13/2017	☐	
NELSON	MUKUNA	16311	02/25/2015	07/13/2017	☐	
MARTIN	CHIBUEZE	17555	07/13/2017		☐	
SORNAMBIKA	THARUMALINGAM	PT11927	07/13/2017		☐	
WILMA	GABISAN	PT06056	07/13/2017		☐	

ORIGINAL

FILED IN OPEN COURT
STEVEN D. GRIERSON
CLERK OF THE COURT
APR 10 2017
BY, Denise Husted
DENISE HUSTED, DEPUTY

GPA
STEVEN B. WOLFSON
Clark County District Attorney
Nevada Bar #001565
MICHELLE SUDANO
Deputy District Attorney
Nevada Bar #013260
200 Lewis Avenue
Las Vegas, NV 89155-2212
(702) 671-2500
Attorney for Plaintiff

DISTRICT COURT
CLARK COUNTY, NEVADA

THE STATE OF NEVADA,

Plaintiff,

-vs-

MARTIN CHIBUEZE,
#7028538,

Defendant.

CASE NO: C-16-314608-1

DEPT NO: XXV

suspended Jail sentence 1-3yrs; Sub. Abuse + mental health eval; no drags or alcohol, maintain FT employ, curfew, probation

GUILTY PLEA AGREEMENT

I hereby agree to plead guilty to: **COUNT 1 - ATTEMPT BATTERY BY STRANGULATION (Category D Felony/Gross Misdemeanor - NRS 200.481, 193.330 - NOC 54739/54741); COUNT 2 - COERCION (Category B Felony - NRS 207.190 - NOC 53159)** and **COUNT 3 - BATTERY CONSTITUTING DOMESTIC VIOLENCE (Misdemeanor - NRS 200.485(1)(A), 200.481(1)(A), 33.018 - NOC 50235)**, as more fully alleged in the charging document attached hereto as Exhibit "1".

My decision to plead guilty is based upon the plea agreement in this case which is as follows:

Both parties stipulate to jointly recommend Felony adjudication on Count 1. The State has no opposition to probation for a period not to exceed THREE (3) years. The State will retain the right to argue the terms and conditions of probation. If Defendant is honorably discharged from probation, he may withdraw his plea to Count 2 and, for Count 1, plead guilty to Attempt Battery By Strangulation, a Gross Misdemeanor, and receive credit for time served.

08/07/2017 Adult Adjudication ▾

1	ATTEMPT BATTERY BY STRANGULATION	Adult Adjudication

Sentenced to Nevada Dept of Corrections

Term: Minimum: 12 Months Maximum: 36 Months

Suspended-Period of Probation: Indeterminate, Not To Exceed 3 Years

08/07/2017 Adult Adjudication ▾

2	COERCION	Adult Adjudication

Sentenced to Nevada Dept of Corrections

Term: Minimum: 12 Months Maximum: 36 Months

Concurrent: Charge 1

Suspended-Period of Probation: Indeterminate, Not To Exceed 3 Years

Comment

Comment (08/07/17 - See Court Minutes for Standard Conditions. Special Conditions as Follows)

Condition

sentence

1. Substance Abuse Evaluation, and any recommended counseling or case plan

2. Mental Health Evaluation, and any recommeded counseling or case plan

3. Abstain From Use, Possession, Control of Alcohol, and drugs, including marijuana for the term of probation

4. Maintain Full-Time Employment

5. Comply With Curfew Imposed By Probation Officer

6. Comply with orders and directives of Family Court, contact with the victim is only allowed for the exchange of their mutual children if permitted by Family Court.

7. Report to P&P after Sentencing PO Assignment

Fee Totals

* discharged from probation 6/2019

NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway – Suite 206 • Reno, NV 89521
(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444
• Web Page: bop.nv.gov

AGENDA ITEM 26

December 11, 2019

VIA CERTIFIED U.S. MAIL

Tuan Dinh, RPh
Deeflat Pharmacy
2580 HWY 95 – Suite 106
Bullhead City, AZ 86442

Re: ***CITATION: Unregistered Operation of Pharmacy***

Dear Mr. Dinh:

In the course of an investigation by the Nevada State Board of Pharmacy (Board), you admitted to Board investigators that Deeflat Pharmacy engaged in unlicensed operation in Nevada by delivering drug prescriptions to patients in the State from May - August 2019.

This letter shall serve as a CITATION pursuant to NRS 639.2895(2), for your unlicensed operation of a pharmacy. The Board has assessed you an administrative fine of five thousand dollars ($5,000.00) pursuant to NRS 639.2895(3).

You must pay this administrative fine within 30 days of receipt of this citation, or otherwise contact Board staff to request an alternative payment plan. Payment must be by *cashier's check, certified check* or *money order* made payable to "State of Nevada, Office of the Treasurer," to be received at the Board's Reno office, located at 985 Damonte Ranch Parkway – Suite 206, Reno, NV 89521.

You have the right to appeal this citation by submitting a written request for a hearing to the Board at the Board's Reno office no later than 30 days after receipt of this letter. *See* NRS 639.2895(2).

Please be aware that the forgoing does not preclude a formal investigation or filing of an accusation pursuant to NRS 639.241. If you have any questions, please do not hesitate to contact me at 775-850-1440 or bkandt@pharmacy.nv.gov.

Best regards,

Brett Kandt
General Counsel
Nevada State Board of Pharmacy

December 20, 2019

To: Nevada State Board of Pharmacy

Re: Citation Unregistered Operation of Pharmacy

We would like to appeal the citation pursuant to NRS 639.2895.

Our background: My name is Tuan Dinh and Michelle Vo, husband and wife, Pharm.D. graduated from Roseman University School of Pharmacy in Henderson class of 2013. In May, we opened our pharmacy, licensed in Arizona on the border of Nevada and Arizona, in Bullhead City. Our delivery service is free of charge and has benefited the low income and disabled populations in the area that don't have transportation. We offer free home delivery out of good hearts in hope to improve patient adherence and health overall. Our delivery service has been a great resource to the local clients, and we are glad we were able to help.

Situation: In the same town, there is another Arizona independent pharmacy that had been delivering to Nevada residents for over 2 years and as we checked with them, they were not aware that they also needed NV license to deliver to Nevada residents neither.

Two months after we opened, there was a disabled patient that had no mean of transportation a dental office had reached out to us for help. We delivered to the client in Nevada for a total of 5 prescriptions at no charge. The pharmacy had made $12 profit out of the transactions of antibiotics, ibuprofen and alprazolam.

Once we get the notification from the board in August 8th, we immediately stopped delivering to Nevada and applied for the license that got approved on 12/19/2019.

We would like to ask board members to consider waiving the fine since we have complied with the law and got our Nevada Pharmacy license. We would love to continue providing delivery service at no charge to Nevada residents since there is no pharmacy in Laughlin now.

Please do not hesitate to contact us at or

Best regards,

Michelle Thu Vo, RPH, Pharm.D.

Tuan Dinh, RPH, Pharm.D

Proposed Regulation of the Nevada State Board of Pharmacy

Workshop

January 16, 2020

Explanation – Language in ***blue italics*** is new; language in ***red text*** [~~***omitted material***~~] is language to be omitted, and language in ***green text*** indicates prior Board-approved amendments that are in the process of being codified.

AUTHORITY: §1, NRS 639.070

A REGULATION relating to the treatment of partners for a shared communicable disease upon the diagnosis of one of the partners.

Section 1. NAC 639.

A prescription ordered in accordance with the Center for Disease and Control (CDC) Sexually Transmitted Diseases Treatment Guidelines Expedited Partner Therapy (EPT) or Patient Delivered Partner Therapy (PDPT) is a valid prescription in the State of Nevada.

Technical Bulletin
Division of Public and Behavioral Health

October, 2019

Topic: **Expedited Partner Therapy**

Contact: **Elizabeth Kessler, STD & Adult Viral Hepatitis Program Manager**
Jennifer Somdahl, Syphilis Coordinator
Office of Public Health Investigations and Epidemiology

To: **Health Care Providers Treating Chlamydia or Gonorrhea**

Current Situation

Nationally since 2014, the number of reported chlamydia and gonorrhea cases has continued to rise. In 2018, Nevada ranked 14th in the United States for its chlamydia rate with a rate of 584.0 per 100,000 population, higher than the national average of 539.9 per 100,000 population[1]. Gonorrhea rates in 2018 ranked 12th in the nation with 216.0 cases per 100,000 higher than the national average of 179.1 cases per 100,000 population.[1] From 2017 to 2018 chlamydia rates increased by 7.7% and gonorrhea rates increased by 15.5%.[2]

Background

According to the 2015 Centers for Disease and Control (CDC) Sexually Transmitted Diseases Treatment Guidelines, Expedited Partner Therapy (EPT) or patient delivered partner therapy (PDPT), is the clinical practice of treating the sex partners of persons who receive a chlamydia or gonorrhea diagnosis through prescribed medications to the patient.[3] Under Nevada Administrative Code (NAC 441A.200(2)(f)), EPT is permissible in Nevada.[3] These laws include the use of the most current CDC Sexually Transmitted Treatment Guidelines, which include the use of EPT for patients with chlamydia and gonorrhea.

- **Recommendations** Nevada Division of Public and Behavioral Health (DPBH) considers the EPT standard of care based on the recommendations from the 2015 CDC STD Treatment guidelines.[4] Clinicians who treat patients for chlamydia or gonorrhea are strongly advised to review and comply with current CDC recommendations and be aware of the alarming increase in STD trends in Nevada.
- Symptomatic partners receiving EPT should be encouraged to seek medical attention through educational counseling of index cases with written materials.
- Health care providers and staff should work with their agency's pharmacy and therapeutics to ensure EPT medications are available.
- Providers who know of, or provide services to, a case or suspected case of gonorrhea or chlamydia are required by law (NAC 441A.230) to report the case or suspected case to their local health authority. Reporting forms can be found at: http://dpbh.nv.gov/Programs/OPHIE/Public_Health_Informatics_and_Epidemiology_-_Home/

Summary Guidance for the Use of EPT[4]

Eligible Patients: Persons with a clinical diagnosis of Chlamydia trachomatis or Neisseria gonorrhea, preferably confirmed with a laboratory test, particularly when other management strategies are unavailable and impractical, or unlikely to be successful.

Eligible Partners: Patients with sex partners treated for chlamydia and/or gonorrhea who were exposed within the previous 60 days (or most recent sex partner if none in the previous 60 days), and who are unable or unlikely to seek medical care.

- ***Not recommended***: gonorrhea and chlamydial infection in men who have sex with men, women with trichomoniasis, patients with infectious syphilis, and pregnant women.

First-choice Partner Management Strategy: Attempt to refer partners for complete clinical evaluation, STD/HIV testing, counseling, and treatment.

Recommended Drug Regimens for Sex Partners Receiving EPT: *

- ***Patients diagnosed with chlamydia, but not gonorrhea: ****
  - Azithromycin 1 gram orally in a single dose OR

- Doxycycline 100 mg orally BID for 7 days

- ***Patients diagnosed with gonorrhea but not chlamydia: *****
  - Ceftriaxone 250 mg IM in a single dose PLUS
  - Azithromycin 1 gram orally in a single dose
- ***Patients diagnosed with both gonorrhea and chlamydia: *****
  - Ceftriaxone 250 mg IM in a single dose PLUS
  - Azithromycin 1 gram orally in a single dose

Informational Materials: Health care professionals must provide patients participating in EPT with counseling and written materials to include:

- A warning about administering EPT to pregnant partners;
- Information about the antibiotic and dosage prescribed or provided;
- Information about the treatment and prevention of STDs;
- The requirement of abstinence until a period of time after treatment;
- Notification of the importance of sex partners to receive testing for HIV and other STDs;
- Notification of the risk to self, others, and the public health if the STD is not completely treated;
- The responsibility of the sex partner to inform his/her sex partner(s) of the STD risk and importance of examination and treatment; and
- Other information deemed necessary by the Local Health Department.

Patient Re-testing: Patients treated for chlamydia and/or gonorrhea should be re-tested *three (3) months* after the treatment to identify possible re-infection.

Liability: Health care providers or pharmacists who dispense EPT in accordance with NAC 441A.200(2)(f) shall **not** be subject to liability or be deemed to have engaged in unprofessional conduct.

** Use of trade names is for identification only and does not imply endorsement.*

*** ceftriaxone 250 mg IM in a single dose or IF NOT AN OPTION cefixime 400 mg orally in a single dose OR single-dose injectable cephalosporin regimens PLUS azithromycin 1 gram orally in a single dose OR doxycycline 100 mg orally twice a day for 7 days.*

References:

1. *CDC STD Surveillance Report. Available online at:* https://www.cdc.gov/std/default.htm
2. *DPBH 2018 Fast Facts. Available online at:* http://dpbh.nv.gov/Programs/STD/dta/Publications/Sexually_Transmitted_Disease_(STD)_Prevention_and_Control_Program-_Publications/
3. *Nevada Administrative Code 441A. Available online at* https://www.leg.state.nv.us/NAC/NAC-441A.html
4. *STD Treatment Guidelines, 2015. Available online at* http://www.cdc.gov/std/treatment/.
5. *Expedited Partner Therapy in the Management of Sexually Transmitted Diseases. 2006. Available online:* www.cdc.gov/std/EPT

For More Information:

Elizabeth Kessler, Nevada DPBH STD & Adult Viral Hepatitis Program Manager, ekessler@health.nv.gov

Jennifer Somdahl, Nevada DPBH Syphilis Coordinator/Community Health Nurse II, jsomdahl@health.nv.gov

Ihsan Azzam, Ph.D., MD
Chief Medical Officer

Lisa Sherych,
Administrator

2019 - 2020 FISCAL YEAR QUARTERLY BUDGET REPORTS
BOARD NAME: Nevada State Board of Pharmacy
Budget Acct. # 000-BO22-04

	19/20 ORIGINAL BUDGET	19/20 W/P MODS	19/20 **Total Authorized**	1st Quarter Actual	2nd Quarter Actual	3rd Quarter Actual	4th Quarter Actual	19/20 Actual
REVENUES								
Adjustment	1,585,813		**1,585,813**					0
Grant Funds				0	0			0
Interest Income	32,600		**32,600**	11,040	9,659			20,699
Late Fees	29,477		**29,477**	2,480	10,680			13,160
Misc. Revenue	143,649		**143,649**	52,678	98,387			151,065
***Appriss/OpenBeds**				***300,000***	***0***			***300,000***
Registration Fees	558,729		**558,729**	161,221	190,490			351,711
Renewals (Lic-Fees)	1,405,592		**1,405,592**	451,563	935,677			1,387,240
SubGrant Funds				15,619	0			15,619
Total Revenues	3,755,860	0	**3,755,860**	994,601	1,244,893	0	0	2,239,494
EXPENSES								
Aid for Education	2000		**2,000**	0	0			0
DAG Cost	11,690		**11,690**	1,405	3,627			5,032
Equipment	50,281		**50,281**	538	4,386			4,924
Grant Funds				***31,737***	***47,731***			***79,468***
Operating	797,559		**797,559**	141,970	160,576			302,546
***Appriss/OpenBeds**				***300,000***	***0***			***300,000***
Payroll	2,763,241		**2,763,241**	625,550	622,616			1,248,166
SubGrant Funds				***10,774***	***16,691***			***27,465***
Travel In	70,557		**70,557**	16,900	18,108			35,008
Travel Out	60,532		**60,532**	3,676	7,397			11,073
Total Expenses	**3,755,860**	0	**3,755,860**	1,132,550	881,132	0	0	2,013,682
Balance	0	0	0	***-137,949***	363,761	0	0	***225,812***

Report Prepared By:
Telephone Number of Preparer: 850-1440

2019-2020 FISCAL YEAR MONTHLY BUDGET REPORTS
BOARD NAME: Nevada State Board of Pharmacy, 000-BO22-04
CURRENT MONTH: DECEMBER

Expenditures as of 12/31/2019

	19/20 APPROVED BUDGET	CURRENT MONTHLY REVENUE/EXPENSE	TOTAL YEAR TO DATE REVENUE/EXPENSE	APPROVED BUDGET AVAILABLE
REVENUES				
Adjustment	1,585,813			1,585,813
Grant Funds		0	0	
Interest Income	32,600	1,715	20,699	11,901
Late Fees	29,477	3,040	13,160	16,317
Misc. Revenue	143,649	12,192	151,065	-7,416
***Appriss/OpenBeds**		***0***	***300,000***	***-300,000***
Registration Fees	558,729	59,630	351,711	207,018
Renewal Fees	1,405,592	6,800	1,387,240	18,352
Subgrant Funds		0	15,619	-15,619
Total Revenues	3,755,860	83,377	2,239,494	1,516,366
EXPENSES				
AID FOR EDUCATION	2000	0	0	2,000
DAG Cost	11,690	1,466	5,032	6,658
Equipment	50,281	1,158	4,924	45,357
Grant Funds		15,719	79,467	-79,467
Operating	797,559	47,864	302,546	495,013
***Appriss-Healthcare**		***0***	***30,000***	***-30,000***
***Open Beds, Inc**		***0***	***270,000***	***-270,000***
Payroll	2,763,241	237,091	1,244,405	1,518,836
Subgrant Funds		5,507	31,225	-31,225
Travel In	70,557	4,688	35,009	35,548
Travel Out	60,532	0	11,073	49,459
Total Expenses	3,755,860	313,493	2,013,681	1,742,179
Balance	**0**	**-230,116**	**225,813**	**-225,813**

INVESTMENT REPORT

Investment Management Account:

Bank CD-Wells	$245,000	2.50%	02/15/20
Bank CD-Wells	$245,000	2.50%	02/28/20

Certificates of Deposit:

Heritage Bank	$100,000	0.65%	11/23/20

TOTAL **$590,000**

as of 12/31/19

William J. Stilling (NBN 9915)
STILLING & HARRISON, PLLC
215 S. State St., Ste. 500
Salt Lake City, Utah 84111
Telephone: 801-980-1888
Facsimile: (801) 341-2021
Email: bstilling@SHhealthlaw.com

Attorneys for All Respondents

BEFORE THE NEVADA STATE BOARD OF PHARMACY

NEVADA STATE BOARD OF PHARMACY, **Petitioner,** **v.** **SHAHN SHERAFAT, RPH** **Certificate of Registration No. 10909, and** **NELLIS CARE PHARMACY, LLC** **Certificate of Registration No. PH02838,** **Respondents.**	**CASE NO. 17-093-RPH-S** **17-093-PH-S** **RESPONDENTS' ANSWER AND NOTICE OF DEFENSE**

Respondent Shahn Sherafat, RPH and Nellis Care Pharmacy, LLC by and through their counsel William J. Stilling, of and for Stilling & Harrison, PLLC answer and provide notice of their defense to the Notice of Intended Action and Accusation ("Notice") in the above-entitled matter and declares as follows.

REQUEST FOR HEARING

Respondents request a hearing on the Notice of Intended Action and Accusation and will be available on October 9, 2019 in Las Vegas, Nevada.

FIRST DEFENSE

In answer to the Notice of Intended Action and Accusation, Respondents admit, deny, and allege as follows:

JURISDICTION

I.

Respondents admit the allegations in paragraph I, but denies any violations of Nevada laws or regulations.

PRIOR DISCIPLINE

II.

Paragraph II is irrelevant and prejudicial. The allegations in paragraph II purportedly occurred twenty years ago, are completely unrelated to any allegations in this Notice, and describe a single incident in a forty-year career as a pharmacist that is otherwise unblemished. In order to avoid unnecessary and unfair prejudice to Respondents, Respondents request that paragraph II be stricken from the Notice before being presented to Board members for the hearing scheduled on October 8, 2019.

FACTUAL ALLEGATIONS

III.

Respondents admit that Mr. Sherafat was the managing pharmacist/pharmacist in charge and the owner of Nellis Care at the times recited in the Notice (2017 through April 4, 2019). Respondents deny any violations occurred and the remaining allegations in paragraph III.

IV.

Respondents admit the allegations in paragraph IV.

V.

Respondents do not have sufficient knowledge to admit or deny the allegations in paragraph V and therefore deny the same.

VI.

Respondents admit the allegations in paragraph VI.

VII.

Respondents deny the allegations in paragraph VII. Older perpetual inventories had been removed from the binder after it became too full. Respondent Sherafat located the perpetual inventories on site and, on the Monday following the inspection, provided a DEA investigator copies of pages from perpetual inventories that she requested.

VIII.

Respondents deny the allegations in paragraph VIII. The perpetual inventories were stored on site at Nellis Care Pharmacy.

IX.

Respondents deny the allegations in paragraph IX.

X.

Respondents do not have sufficient knowledge to admit or deny the allegations in paragraph X and therefore deny the same.

XI.

Respondents deny the allegations in paragraph XI.

XII.

Respondents deny the allegations in paragraph XII.

XIII.

Respondents deny the allegations in paragraph XIII.

XIV.

Respondents deny the allegations in paragraph XIV.

XV.

Respondents do not have sufficient knowledge to admit or deny the allegations in paragraph XV and therefore deny the same.

XVI.

Respondents admit the allegations in paragraph XVI. Sherafat's decision to not renew his Certificate of Registration is based solely on his health and age, and is not related to the allegations in this Notice or the investigation.

APPLICABLE LAW

XVII.-XXIX.

Paragraphs XVII through XXIX are statements of law not subject to admission or denial by Respondents. Respondents do not have sufficient knowledge about the accuracy or temporal applicability of the laws and regulations recited to admit or deny the allegations and therefore deny the same.

FIRST CAUSE OF ACTION
Failure to Maintain Perpetual Inventories of Controlled Substances
(Respondent s Sherafat and Nellis Pharmacy)

XXX.

Respondents deny the allegations in paragraph XXX.

SECOND CAUSE OF ACTION
Failure to Maintain Accurate Biennial Inventories of Controlled Substances
(Respondents Sherafat and Nellis Pharmacy)

XXXI.

Respondents deny the allegations in paragraph XXXI.

THIRD CAUSE OF ACTION

Failure to Maintain Records of Controlled Substance Purchases

XXXII.

Respondents deny the allegations in paragraph XXXII.

FOURTH CAUSE OF ACTION

False Statements/Fraudulent and Deceitful Practices (Respondent Sherafat)

XXXIII.

Respondents deny the allegations in paragraph XXXIII.

FIFTH CAUSE OF ACTION

Managing Pharmacist Responsibilities (Respondent Sherafat)

XXXIV.

Respondents deny the allegations in paragraph XXXIV.

SIXTH CAUSE OF ACTION

Pharmacy/Pharmacy Owner Responsibility (Respondent Sherafat)

XXXV.

Respondents deny the allegations in paragraph XXXV.

XXXVI

PRAYER FOR RELIEF

Wherefore, Respondents request:

1. That the Board find that the allegations in the Notice and all evidence presented to the Board do not support imposing discipline on any of the Respondents.

2. That the Board dismiss all Causes of Acton in in the Notice.

3. That the Board provide further relief to Respondents as it finds just and proper.

SECOND DEFENSE

Each cause of action fails to state a claim upon which relief can be granted.

THIRD DEFENSE

The Nevada Board of Pharmacy is without authority to conclude whether any person or entity is in violation of any federal law or rule.

RESERVATION OF RIGHTS, DEFENSES, AND GENERAL DENIAL

1. Respondents reserve the right to assert other affirmative defenses in this matter and in any civil litigation that may follow and to provide additional facts and mitigating circumstances.

2. To the extent Respondents did not specifically admit allegations in the Notice of Intent and Accusation, they deny such allegations.

DATED this 30th day of August, 2019.

William J. Stilling
STILLING & HARRISON, PLLC
Attorneys for Respondents
Shahn Sherafat, RPH
Nellis Care Pharmacy, LLC

CERTIFICATE OF SERVICE

I hereby certify that on August 30, 2019, I caused to be served a true and correct copy of the foregoing **ANSWER AND NOTICE OF DEFENSE** by the method indicated below to:

S. Paul Edwards General Counsel Nevada State Board of Pharmacy 985 Damonte Ranch Pkwy #206 Reno, NV 89521 pedwards@pharmacy.nv.gov		☐ U.S. Mail postage prepaid ☐ Hand delivery ☐ Overnight Mail ☐ Facsimile ☑ Electronic Mail
David Wuest Executive Secretary Nevada State Board of Pharmacy 985 Damonte Ranch Pkwy #206 Reno, NV 89521 dwuest@pharmacy.nv.gov		☐ U.S. Mail postage prepaid ☐ Hand delivery ☐ Overnight Mail ☐ Facsimile ☑ Electronic Mail
Yenh Long Deputy Executive Secretary 985 Damonte Ranch Pkwy #206 Reno, NV 89521		☐ U.S. Mail postage prepaid ☐ Hand delivery ☐ Overnight Mail ☐ Facsimile ☑ Electronic Mail

U. S. Department of Justice
Drug Enforcement Administration
8701 Morrissette Drive
Springfield, Virginia 22152

www.dea.gov

NOV 1 5 2018

[redacted]
Janssen Pharmaceuticals, Inc.
1125 Trenton-Harbourton Road
Titusville, New Jersey 08560

[redacted]

This is in response to your letter dated October 8, 2018, to the Drug Enforcement Administration (DEA) in which you requested DEA's permission for specialty pharmacies, selected by Janssen Pharmaceuticals, Inc., to deliver patient-specific esketamine nasal spray directly to prescribing practitioners who do not have co-located pharmacies. The DEA appreciates the opportunity to address your request.

As you know, as a general matter, the DEA cannot provide individuals with definitive, private legal opinions about whether their particular activities relating to controlled substances comply with the requirements of the Controlled Substances Act (CSA) and DEA regulations. Among the reasons for this is that such letters cannot establish a rule that is legally binding on the recipient or the agency. At the same time, the DEA recognizes the importance of working with regulated entities to help guide them toward compliance with the law and regulations. In that vein, we can provide the following general information.

For purposes of this letter, we will address the following hypothetical scenario:

- A DEA-registered practitioner, acting in the usual course of his/her professional practice, issues a prescription for a controlled substance for a legitimate medical purpose, and the prescription complies in all other respects with DEA regulations found in 21 C.F.R. Part 1306.

- The practitioner determines, in the exercise of his/her sound medical discretion, that it is appropriate for the patient to self-administer the controlled substance while under the direct supervision of the practitioner at the practitioner's registered location.

- The prescription is for a single dose of the controlled substance for a particular patient - not a take-home supply for that patient and not for the practitioner's office stock.

- The practitioner indicates on the prescription that the controlled substance should be delivered by the pharmacy to the practitioner, at his/her registered location, for administration to the patient.

- The above activity is carried out in compliance with applicable State law and regulations.

- The controlled substance is to be administered only to the patient named on the prescription not later than 14 days after the date of receipt of the controlled substance by the practitioner.

Neither the CSA nor DEA regulations specifically address the foregoing scenario. Nonetheless, assuming all the foregoing facts apply, the DEA would consider it permissible under the CSA and DEA regulations for the pharmacy to deliver the controlled substance to the practitioner, at his/her registered location, provided the following conditions are met:

- The pharmacy treats its actions as a dispensing for purposes of the CSA and DEA regulations and complies with all applicable requirements thereunder. This includes, but is not limited to, keeping records pursuant to 21 C.F.R. Part 1304 indicating that the controlled substance was delivered to the practitioner and including the practitioner's name and address of the registered location to which it was delivered.

- The supervising practitioner treats his/her actions as administering for purposes of the CSA and DEA regulations and complies with all applicable requirements thereunder. This includes, but is not limited to, keeping records, to the extent required for the administering of controlled substances under 21 C.F.R. Part 1304, and maintaining security as required by the regulations in 21 C.F.R. §§ 1301.71(a) and 1301.75(b).

Finally, please be advised that while this letter represents the current view of the DEA, it is not a binding rule. The DEA is continuing to evaluate the issues related to your inquiry to determine whether it would be appropriate for the agency to propose an amendment to its regulations to specifically address this topic.

For further information regarding the DEA Diversion Control Division, please visit www.DEAdiversion.usdoj.gov. If you have any additional questions on this issue, please contact the Diversion Control Division Policy Section at (202) 307-7297.

Sincerely,

Keith Brown
Deputy Assistant Administrator
Diversion Control Division

DAILYMED

LABEL: SPRAVATO- esketamine hydrochloride solution

VIEW PACKAGE PHOTOS

NDC Code(s): 50458-028-00, 50458-028-02, 50458-028-03
Packager: Janssen Pharmaceuticals Inc.

Category: HUMAN PRESCRIPTION DRUG LABEL
DEA Schedule: CIII
Marketing Status: New Drug Application

DRUG LABEL INFORMATION

Updated November 5, 2019

If you are a consumer or patient please visit this version.

VIEW ALL SECTIONS

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use SPRAVATO® safely and effectively. See full prescribing information for SPRAVATO®. SPRAVATO® (esketamine) nasal spray, CIII ...

TABLE OF CONTENTS

Table of Contents

BOXED WARNING (WHAT IS THIS?)

Sedation - Patients are at risk for sedation after administration of SPRAVATO [see Warnings and Precautions (5.1)].

WARNING: SEDATION; DISSOCIATION; ABUSE AND MISUSE; AND SUICIDAL THOUGHTS AND BEHAVIORS

Sedation

Patients are at risk for sedation after administration of SPRAVATO *[see WARNINGS AND PRECAUTIONS (5.1)]*.

Dissociation

Patients are at risk for dissociative or perceptual changes after administration of SPRAVATO *[see WARNINGS AND PRECAUTIONS (5.2)]*.

Because of the risks of sedation and dissociation, patients must be monitored for at least 2 hours at each treatment session, followed by an assessment to determine when the patient is considered clinically stable and ready to leave the healthcare setting *[see WARNINGS AND PRECAUTIONS (5.1, 5.2)]*.

Abuse and Misuse

> SPRAVATO has the potential to be abused and misused. Consider the risks and benefits of prescribing SPRAVATO prior to use in patients at higher risk of abuse. Monitor patients for signs and symptoms of abuse and misuse *[see WARNINGS AND PRECAUTIONS (5.3)]*.

Because of the risks of serious adverse outcomes resulting from sedation, dissociation, and abuse and misuse, SPRAVATO is only available through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the SPRAVATO REMS *[see WARNINGS AND PRECAUTIONS (5.4)]*.

Suicidal Thoughts and Behaviors

Antidepressants increased the risk of suicidal thoughts and behavior in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors. SPRAVATO is not approved for use in pediatric patients *[see WARNINGS AND PRECAUTIONS (5.5)]*.

CLOSE

1 INDICATIONS AND USAGE

SPRAVATO® is indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression (TRD) in adults [see Clinical Studies (14.1)]. Limitations of ...

2 DOSAGE AND ADMINISTRATION

2.1 Important Considerations Prior to Initiating and During Therapy - SPRAVATO must be administered under the direct supervision of a healthcare provider. A treatment session consists of nasal ...

3 DOSAGE FORMS AND STRENGTHS

Nasal Spray: 28 mg of esketamine per device. Each nasal spray device delivers two sprays containing a total of 28 mg esketamine.

4 CONTRAINDICATIONS

SPRAVATO is contraindicated in patients with: Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels) or arteriovenous malformation ...

5 WARNINGS AND PRECAUTIONS

5.1 Sedation - In clinical trials, 49% to 61% of SPRAVATO-treated patients developed sedation based on the Modified Observer's Alertness/Sedation scale (MOAA/s) [see Adverse Reactions (6.1)], and ...

6 ADVERSE REACTIONS

The following adverse reactions are discussed in more detail in other sections of the labeling: Sedation [see Warnings and Precautions (5.1)] Dissociation [see Warnings and Precautions ...

7 DRUG INTERACTIONS

7.1 Central Nervous System Depressants - Concomitant use with CNS depressants (e.g., benzodiazepines, opioids, alcohol) may increase sedation [see Warnings and Precautions (5.1)]. Closely monitor ...

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy - Pregnancy Exposure Registry - There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to antidepressants, including SPRAVATO, during pregnancy ...

9 DRUG ABUSE AND DEPENDENCE

9.1 Controlled Substance - SPRAVATO contains esketamine hydrochloride, the (S)-enantiomer of ketamine and a Schedule III controlled substance under the Controlled Substances Act. 9.2 ...

10 OVERDOSAGE

Management of Overdosage - There is no specific antidote for esketamine overdose. In the case of overdose, the possibility of multiple drug involvement should be considered. Contact a Certified ...

11 DESCRIPTION

SPRAVATO contains esketamine hydrochloride, a non-competitive N-methyl-D-aspartate (NMDA) receptor antagonist. Esketamine is the S-enantiomer of racemic ketamine. The chemical name is ...

12 CLINICAL PHARMACOLOGY

12.1 Mechanism of Action - Esketamine, the S-enantiomer of racemic ketamine, is a non-selective, non-competitive antagonist of the N-methyl-D-aspartate (NMDA) receptor, an ionotropic glutamate ...

13 NONCLINICAL TOXICOLOGY

13.1 Carcinogenesis, Mutagenesis, Impairment of Fertility - Carcinogenesis - Once-daily intranasal administration of esketamine at doses equivalent to 4.5, 15, and 45 mg/kg/day (based on a ...

14 CLINICAL STUDIES

14.1 Treatment Resistant Depression - Short-Term Study - SPRAVATO was evaluated in a randomized, placebo-controlled, double-blind, multicenter, short-term (4-week), Phase 3 study (Study 1 ...

16 HOW SUPPLIED/STORAGE AND HANDLING

SPRAVATO nasal spray is available as an aqueous solution of esketamine hydrochloride in a stoppered glass vial within a nasal spray device. Each nasal spray device delivers two sprays containing a ...

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Medication Guide). Sedation and Dissociation - Inform patients that SPRAVATO has potential to cause sedation, dissociative ...

SPL UNCLASSIFIED SECTION

Manufactured for: Janssen Pharmaceuticals, Inc. Titusville, NJ 08560 - © 2019 Janssen Pharmaceutical Companies

MEDICATION GUIDE

This Medication Guide has been approved by the U.S. Food and Drug Administration.Issued: 11/2019 MEDICATION GUIDE - SPRAVATO® (sprah vah' toe) CIII - (esketamine) nasal ...

INSTRUCTIONS FOR USE

SPRAVATO® (SPRAH VAH' TOE) CIII - (esketamine) Nasal Spray Device - 28 mg per device - Each device delivers two sprays containing a total of 28 mg of esketamine. Important - This device ...

PRINCIPAL DISPLAY PANEL - TWO 28 MG DEVICE BLISTER PACK KIT

NDC 50458-028-02 - Spravato™ (esketamine) nasal spray - CIII - 56 mg Dose Kit - Two 28 mg - Nasal Spray Devices - 56 mg dose = 2 devices (4 sprays) Each device delivers two sprays - containing a total of 28 ...

INGREDIENTS AND APPEARANCE

Product Information

VIEW ALL SECTIONS

FIND ADDITIONAL RESOURCES (also available in the left menu)

SAFETY

Boxed Warnings, Report Adverse Events, FDA Safety Recalls, Presence in Breast Milk

RELATED RESOURCES

Medline Plus, Clinical Trials, PubMed, Biochemical Data Summary

MORE INFO ON THIS DRUG

View Label Archives, RxNorm, Get Label RSS Feed, View NDC Code(s)NEW!

Proposed Regulation of the Nevada State Board of Pharmacy

Workshop

January 16, 2020

Explanation – Language in ***blue italics*** is new; language in ***red text*** [~~***omitted material***~~] is language to be omitted, and language in ***green text*** indicates prior Board-approved amendments that are in the process of being codified.

AUTHORITY: §1, NRS 639.070

A REGULATION relating to the treatment of partners for a shared communicable disease upon the diagnosis of one of the partners.

Section 1. NAC 639.

A prescription ordered in accordance with the Center for Disease and Control (CDC) Sexually Transmitted Diseases Treatment Guidelines Expedited Partner Therapy (EPT) or Patient Delivered Partner Therapy (PDPT) is a valid prescription in the State of Nevada.

Technical Bulletin
Division of Public and Behavioral Health

October, 2019

Topic: **Expedited Partner Therapy**

Contact: **Elizabeth Kessler, STD & Adult Viral Hepatitis Program Manager**
Jennifer Somdahl, Syphilis Coordinator
Office of Public Health Investigations and Epidemiology

To: **Health Care Providers Treating Chlamydia or Gonorrhea**

Current Situation

Nationally since 2014, the number of reported chlamydia and gonorrhea cases has continued to rise. In 2018, Nevada ranked 14th in the United States for its chlamydia rate with a rate of 584.0 per 100,000 population, higher than the national average of 539.9 per 100,000 population[1]. Gonorrhea rates in 2018 ranked 12th in the nation with 216.0 cases per 100,000 higher than the national average of 179.1 cases per 100,000 population.[1] From 2017 to 2018 chlamydia rates increased by 7.7% and gonorrhea rates increased by 15.5%.[2]

Background

According to the 2015 Centers for Disease and Control (CDC) Sexually Transmitted Diseases Treatment Guidelines, Expedited Partner Therapy (EPT) or patient delivered partner therapy (PDPT), is the clinical practice of treating the sex partners of persons who receive a chlamydia or gonorrhea diagnosis through prescribed medications to the patient.[3] Under Nevada Administrative Code (NAC 441A.200(2)(f)), EPT is permissible in Nevada.[3] These laws include the use of the most current CDC Sexually Transmitted Treatment Guidelines, which include the use of EPT for patients with chlamydia and gonorrhea.

- **Recommendations** Nevada Division of Public and Behavioral Health (DPBH) considers the EPT standard of care based on the recommendations from the 2015 CDC STD Treatment guidelines.[4] Clinicians who treat patients for chlamydia or gonorrhea are strongly advised to review and comply with current CDC recommendations and be aware of the alarming increase in STD trends in Nevada.
- Symptomatic partners receiving EPT should be encouraged to seek medical attention through educational counseling of index cases with written materials.
- Health care providers and staff should work with their agency's pharmacy and therapeutics to ensure EPT medications are available.
- Providers who know of, or provide services to, a case or suspected case of gonorrhea or chlamydia are required by law (NAC 441A.230) to report the case or suspected case to their local health authority. Reporting forms can be found at: http://dpbh.nv.gov/Programs/OPHIE/Public_Health_Informatics_and_Epidemiology_-_Home/

Summary Guidance for the Use of EPT[4]

Eligible Patients: Persons with a clinical diagnosis of Chlamydia trachomatis or Neisseria gonorrhea, preferably confirmed with a laboratory test, particularly when other management strategies are unavailable and impractical, or unlikely to be successful.

Eligible Partners: Patients with sex partners treated for chlamydia and/or gonorrhea who were exposed within the previous 60 days (or most recent sex partner if none in the previous 60 days), and who are unable or unlikely to seek medical care.

- ***Not recommended***: gonorrhea and chlamydial infection in men who have sex with men, women with trichomoniasis, patients with infectious syphilis, and pregnant women.

First-choice Partner Management Strategy: Attempt to refer partners for complete clinical evaluation, STD/HIV testing, counseling, and treatment.

Recommended Drug Regimens for Sex Partners Receiving EPT: *

- ***Patients diagnosed with chlamydia, but not gonorrhea: ****
  - Azithromycin 1 gram orally in a single dose OR

- Doxycycline 100 mg orally BID for 7 days

- ***Patients diagnosed with gonorrhea but not chlamydia: *****
  - Ceftriaxone 250 mg IM in a single dose PLUS
  - Azithromycin 1 gram orally in a single dose
- ***Patients diagnosed with both gonorrhea and chlamydia: *****
  - Ceftriaxone 250 mg IM in a single dose PLUS
  - Azithromycin 1 gram orally in a single dose

Informational Materials: Health care professionals must provide patients participating in EPT with counseling and written materials to include:

- A warning about administering EPT to pregnant partners;
- Information about the antibiotic and dosage prescribed or provided;
- Information about the treatment and prevention of STDs;
- The requirement of abstinence until a period of time after treatment;
- Notification of the importance of sex partners to receive testing for HIV and other STDs;
- Notification of the risk to self, others, and the public health if the STD is not completely treated;
- The responsibility of the sex partner to inform his/her sex partner(s) of the STD risk and importance of examination and treatment; and
- Other information deemed necessary by the Local Health Department.

Patient Re-testing: Patients treated for chlamydia and/or gonorrhea should be re-tested *three (3) months* after the treatment to identify possible re-infection.

Liability: Health care providers or pharmacists who dispense EPT in accordance with NAC 441A.200(2)(f) shall **not** be subject to liability or be deemed to have engaged in unprofessional conduct.

** Use of trade names is for identification only and does not imply endorsement.*

*** ceftriaxone 250 mg IM in a single dose or IF NOT AN OPTION cefixime 400 mg orally in a single dose OR single-dose injectable cephalosporin regimens PLUS azithromycin 1 gram orally in a single dose OR doxycycline 100 mg orally twice a day for 7 days.*

References:

1. *CDC STD Surveillance Report. Available online at:* https://www.cdc.gov/std/default.htm
2. *DPBH 2018 Fast Facts. Available online at:* http://dpbh.nv.gov/Programs/STD/dta/Publications/Sexually_Transmitted_Disease_(STD)_Prevention_and_Control_Program-_Publications/
3. *Nevada Administrative Code 441A. Available online at* https://www.leg.state.nv.us/NAC/NAC-441A.html
4. *STD Treatment Guidelines, 2015. Available online at* http://www.cdc.gov/std/treatment/.
5. *Expedited Partner Therapy in the Management of Sexually Transmitted Diseases. 2006. Available online:* www.cdc.gov/std/EPT

For More Information:

Elizabeth Kessler, Nevada DPBH STD & Adult Viral Hepatitis Program Manager, ekessler@health.nv.gov

Jennifer Somdahl, Nevada DPBH Syphilis Coordinator/Community Health Nurse II, jsomdahl@health.nv.gov

Ihsan Azzam, Ph.D., MD
Chief Medical Officer

Lisa Sherych,
Administrator

Proposed Regulation of the Nevada State Board of Pharmacy

Workshop

January 16, 2020

Explanation – Language in ***blue italics*** is new; language in ***red text*** [~~***omitted material***~~] is language to be omitted, and language in ***green text*** indicates prior Board-approved amendments that are in the process of being codified.

AUTHORITY: NRS 639.070; AB 319

Section. 1. Chapter 639 of NAC is hereby amended by adding thereto the following provisions:

1. A petition for review of criminal history pursuant to AB 319:
(a) must be in writing on a form prescribed by the Board; and
(b) must not be submitted prior to completion of a criminal background check by the petitioner.
2. Upon receiving a petition for review of criminal history, the Board will place the matter on the agenda for the next regularly scheduled meeting of the Board, but in any event, not later than 90 days after the receipt of the petition unless a continuance is requested by the petitioner.
3. The petitioner must appear before the Board to answer any questions regarding his or her criminal history. If the petitioner fails to appear, the Board will not consider the petition for review of criminal history.
4. After review of the petition for review of criminal history, the Board will issue a non-binding determination whether the criminal history submitted will disqualify the petitioner from obtaining any certificate, license, registration or permit issued by the Board within 30 days.

Section. 1. NAC 639.220 is hereby amended as follows:

1. The Board hereby adopts the following schedule of fees:

For the examination of an applicant for registration as a pharmacist.....	Actual cost of the examination
For the investigation or registration of an applicant as a registered pharmacist.....	$200
For the investigation, examination or registration of an applicant as a registered pharmacist by reciprocity.....	200
For the investigation or issuance of an original license to conduct a retail pharmacy.....	500
For the biennial renewal of a license to conduct a retail pharmacy.....	500

For the investigation or issuance of an original license to conduct an institutional pharmacy.....	500
For the biennial renewal of a license to conduct an institutional pharmacy.	500
For the investigation or issuance of an original license to conduct a pharmacy in a correctional institution.....	500
For the biennial renewal of a license to conduct a pharmacy in a correctional institution.....	500
For the issuance of an original or duplicate certificate of registration as a registered pharmacist.....	50
For the biennial renewal of registration as a registered pharmacist.....	200
For the reinstatement of a lapsed registration (in addition to the fees for renewal for the period of lapse).....	100
For the initial registration of a pharmaceutical technician or pharmaceutical technician in training.....	50
For the biennial renewal of registration of a pharmaceutical technician or pharmaceutical technician in training.....	50
For the investigation or registration of an intern pharmacist.....	40
For the biennial renewal of registration as an intern pharmacist.....	40
For the investigation or registration of an advanced practice registered nurse or a physician assistant to prescribe drugs that are not controlled substances.....	80
For the biennial renewal of registration of an advanced practice registered nurse or a physician assistant to prescribe drugs that are not controlled substances.....	80
For authorization of a physician, advanced practice registered nurse, physician assistant, euthanasia technician, ambulatory surgical center, facility for treatment with narcotics, researcher, instructional user or any other authorized person to prescribe or possess controlled substances.....	200
For the biennial renewal of authorization of a physician, advanced practice registered nurse, physician assistant, euthanasia technician, ambulatory surgical center, facility for treatment with narcotics, researcher, instructional user or any other authorized person to prescribe or possess controlled substances.....	200
For the investigation or issuance of an original license to engage in business as an authorized warehouse, medical products provider or medical products wholesaler.....	500
For the biennial renewal of a license to engage in business as an authorized warehouse, medical products provider or medical products wholesaler.....	500
For the investigation or issuance of an original license to a manufacturer or wholesaler.....	500
For the biennial renewal of a license for a manufacturer or wholesaler.....	500
For the reissuance of a license issued to a pharmacy, when no change of ownership is involved, but the license must be reissued because of a change in the information required thereon.....	50

For authorization of a practitioner, other than a licensed veterinarian, to dispense controlled substances or dangerous drugs, or both, for each location where the practitioner will dispense controlled substances or dangerous drugs, or both..... 300

For the biennial renewal of authorization of a practitioner, other than a licensed veterinarian, to dispense controlled substances or dangerous drugs, or both, for each location where the practitioner will dispense controlled substances or dangerous drugs, or both..... 300

For authorization of a licensed veterinarian to dispense controlled substances or dangerous drugs, or both..... 150

For the biennial renewal of authorization of a licensed veterinarian to dispense controlled substances or dangerous drugs, or both..... 150

For a petition for review of criminal history pursuant to AB 319 50

2. The penalty for failure to pay the renewal fee for any license, permit or certificate within the statutory period, as provided in subsection 6 of NRS 639.170, is 50 percent of the renewal fee for each period of delinquency in addition to the renewal fee for each period of delinquency.

3. Any person who has been registered as a pharmacist in this State for at least 50 years is not required to pay the fee for the biennial renewal of a certificate of registration as a registered pharmacist.

4. The provisions of this section concerning the fee for the biennial renewal of the authorization to dispense controlled substances or dangerous drugs do not apply to an advanced practice registered nurse who is required to pay a fee pursuant to NAC 639.870.

5. A health center:

(a) Which is a federally qualified health center as defined in 42 U.S.C. § 1396d(l)(2)(B), as that section existed on March 1, 2000, that provides health care primarily to medically underserved persons in a community; and

(b) Which is not a medical facility as defined in NRS 449.0151,

Ê is not required to pay the fee for the collective certification of advanced practice registered nurses in the employ of a public or nonprofit agency as set forth in subsection 1.

6. A practitioner employed by or serving as an independent contractor of a health center:

(a) Which is a federally qualified health center as defined in 42 U.S.C. § 1396d(l)(2)(B), as that section existed on March 1, 2000, that provides health care primarily to medically underserved persons in a community; and

(b) Which is not a medical facility as defined in NRS 449.0151,

Ê is not required to pay a fee to the Board for a change of address or for an additional address at which the practitioner dispenses drugs.

7. A practitioner who is exempt from the payment of a fee pursuant to subsection 6 shall notify the Board in writing of each change of address or additional address, or both.

8. In addition to any other fees paid by an applicant for a certificate, license or permit issued pursuant to chapter 639 of NRS, the Board my require the applicant to pay the actual costs of inspection incurred by the Board.

Proposed Regulation of the Nevada State Board of Pharmacy

Workshop (Draft)

January 16th, 2020

Explanation – Language in ***blue italics*** is new; language in ***red text*** [~~***omitted material***~~] is language to be omitted, and language in *green text* indicates prior Board-approved amendments that are in the process of being codified.

AUTHORITY: §1, NRS 639.070

A. **A REGULATION** relating to authorizing the delivery of a prescription drug to a practitioner for administration to the ultimate user or patient if the FDA has made a determination that the drug is dangerous for the ultimate user or patient to possess.

Section 1. NAC 639.

a. A prescription to be dispensed to an ultimate user may be furnished to a practitioner if the medication being dispensed to the ultimate user has been mandated by the Food and Drug Administration (FDA) to be administered only under the direct supervision of a healthcare provider.

b. The practitioner must be licensed as required by both State and Federal Law to possess the medication.

c. The practitioner must comply with all State and Federal Laws regarding the handling of the medication.

d. The medication must be stored separately from the practitioner's stock of medication.

e. The medication must be administered to only the patient named on the prescription not later than 14 days after the receipt of the medication. If the medication is not administered within 14 days it must be destroyed or donated in compliance with NRS 453B.

Valley Anesthesiology Consultants

To Whom It May Concern:

I am writing this letter to express my concerns regarding recent changes in allowed scope of practice of CRNAs in Nevada. As you are likely aware, it has been made mandatory that physician anesthesiologists complete all post-operative orders on patients undergoing surgery. In my opinion, this unilateral change in patient care puts patients at risk of suboptimal management in certain instances. With that in my mind, I would urge that you reconsider your decision regarding this matter.

CRNAs are trained to care for patients in the entire peri-operative setting. In fact, one could argue that pre and intra-operative care are far more demanding from a clinical standpoint than the post-operative setting. Pre-operatively, the CRNA has to evaluate the patient, order testing if appropriate, make any suggestions regarding medical optimization of the patient prior to surgery, and finally, give an adequate assessment of a patient's risk regarding surgery in anesthesia. Intra-operatively, the CRNA must employ their in-depth knowledge of pharmacology and physiology in order to maintain stability of a patient's vital signs. Post-operatively, the CRNA must use the knowledge and experience they've gained from taking care of that very same patient pre-operatively and intra-operatively in order to formulate a plan for treating any immediate post-operative issues such as pain, nausea and vomiting, or any lability on vital signs. It goes against logic to suggest that the supervising anesthesiologist would have the same degree of intimate familiarity with the patient as the CRNA who has been by their side for the entire surgery. For this reason, the CRNA should be allowed, and is certainly more qualified, to dictate the final portion of their peri-operative course.

If our ultimate goal of enhanced patient care is shared, then I urge you to allow CRNAs the ability to place post-operative orders for their patients. The burden of responsibility has already been placed on them for the most critical parts of the patient's care. They have certainly administered medications with much more potency and potential for untoward effects in the operating room than the few medications they would order in the recovery room. Not only would their immediate presence prevent the delay in patient care that might occur while waiting for the attending to write orders, but their thorough knowledge of the patient's medical history and, more importantly, their intra-operative course, would enable them to provide a more informed post-anesthetic care plan. Please feel free to contact me at 702-339-8747 should you have any questions.

Sincerely,

Timothy Beckett, MD
Managing Partner, Valley Anesthesiology Consultants

Scheduling: 702.487.6880 • Fax: 702.473.5455 • 10120 South Eastern Avenue Suite 200 • Henderson, Nevada 89052

AGENDA ITEM 25

FENNEMORE CRAIG
ATTORNEYS

Lynn S. Fulstone
Director
lfulstone@fclaw.com

300 S. Fourth Street, Suite 1400
Las Vegas, Nevada 89101
PH (702) 791-8245 | FX (702) 791-8246
fennemorecraig.com

October 31, 2019

Via E-Mail and FedEx

Mr. David Wuest, Executive Secretary
Nevada State Board of Pharmacy
985 Damonte Ranch Pkwy, Ste. 206
Reno, Nevada 89521

Re: Petition Requesting a Declaratory Order or Advisory Opinion

Dear Mr. Wuest:

The Nevada Association of Nurse Anesthetists ("Petitioner"), acting by and through Fennemore Craig, P.C., respectfully submits to the Nevada State Board of Pharmacy (the "Board of Pharmacy") pursuant to Section 639.150 of the Nevada Administrative Code ("NAC"), this Petition for a Declaratory Order or an Advisory Opinion (the "Petition"). Specifically, Petitioner requests that the Board of Pharmacy make a determination, consistent with the current scope of practice, that a certified registered nurse anesthetist ("CRNA") licensed by the Nevada State Board of Nursing (the "Board of Nursing") need not obtain a license from the Board of Pharmacy and/or a registration from the Drug Enforcement Administration ("DEA") to select and administer preanesthetic medications, intraoperative anesthesia and postanesthetic medications when such medications are ordered by the CRNA for surgical procedures from a DEA registered institutional pharmacy providing services for a Nevada licensed hospital or medical facility.

BACKGROUND

Petitioner is a professional organization for CRNAs in Nevada. CRNAs are professional registered nurses who have obtained, through additional education and successful completion of a national examination, certification as anesthesia nursing specialists.[1] This specialized education focuses on all aspects of clinical anesthesia practice, including pharmacology and pharmacotherapeutics. The Board of Nursing first adopted regulations establishing standards and authorizing functions that CRNAs may perform in 1986.[2] The Nevada State Legislature subsequently recognized CRNAs in 1987.[3] Under Nevada law, CRNAs are authorized "to administer anesthetic agents to a person under the care of a licensed physician, a licensed dentist

[1] *See* NEV. REV. STAT. § 632.014(1).
[2] NEV. ADMIN. CODE § 632.500 to 632.550, inclusive.
[3] S.B. 458, 64th Leg. (Nev. 1987) (adding definition of CRNAs to the NRS).

or a licensed podiatric physician."[4] CRNAs practice in every setting in which anesthesia is delivered, including, but in no way limited to, traditional hospital surgical suites and obstetrical delivery rooms, critical access hospitals, ambulatory surgical centers and rural clinics.[5] Historically, CRNAs have not been required to obtain a license from the Board of Pharmacy or DEA registration in order to select, order, and administer anesthetic agents to inpatients for preoperative, intraoperative, or postoperative use when the anesthetic agents are ordered by the CRNA solely from the institutional pharmacy. A Declaratory Order or an Advisory Opinion is necessary to confirm that this customary practice of CRNAs authorized by Nevada regulations does not constitute "prescribing" under Nevada law and to clarify that CRNAs do not need a license from the Board of Pharmacy or DEA registration so long as the CRNA performs services for patients in a Nevada licensed hospital or medical facility, and orders preanesthetic medications, intraoperative anesthesia and postanesthetic medications solely from the hospital's or facility's institutional pharmacy that is licensed by the State Board of Pharmacy and registered with the DEA. Such a Declaratory Order or Advisory Opinion would be consistent with Nevada statutes and regulations and would not change practices that have been acceptable in Nevada for over two decades.

LEGAL AUTHORITY

A person may petition the Board of Pharmacy for a declaratory order or advisory opinion as to the applicability of any statutory provision, regulation or decision of the Board of Pharmacy.[6] The Board of Pharmacy is responsible for regulating the practice of pharmacy in Nevada, including the dispensing, prescribing and administration of drugs.[7] Additionally, the Board of Pharmacy may "issue certificates, licenses and permits required" by Chapters 639, 453, or 454 of the Nevada Revised Statutes ("NRS").[8] The Board of Pharmacy, therefore, has discretion to determine which acts constitute the prescribing of drugs under Nevada law and which practitioners are required to obtain a license from the Board of Pharmacy and/or DEA registration under specific circumstances. For these reasons, the Board has authority under both the NRS and NAC to issue a declaratory opinion in response to this Petition.

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[4] NEV. REV. STAT. § 632.014(2).
[5] CRNAs are often the exclusive anesthesia providers to a majority of rural Nevadans.
[6] NEV. ADMIN. CODE § 639.150; NEV. REV. STAT. § 233B.120.
[7] NEV. REV. STAT. § 639.070(1); *See also* NEV. REV. STAT. §§454.211 and 639.0065 (defining the term "dispense" to include prescribing and administering controlled substances and dangerous drugs).
[8] NEV. REV. STAT. § 639.070(c).

DISCUSSION

1. **The practice of CRNAs - selecting, ordering, and administering anesthetic agents preoperatively, intraoperatively, and postoperatively – does not constitute "prescribing" under Nevada law and is consistent with Nevada statutory law.**

CRNAs in Nevada are authorized to select, order, and administer anesthetic agents in preoperative, intraoperative, and postoperative settings.[9] This regulatory authority does not contravene any applicable Nevada statutory authority. Neither the Nevada State Legislature nor the Board of Pharmacy has defined the term "order" in the context of administration of anesthetic agents. Rather, the focus of the current Nevada statutory and regulatory framework is who is authorized to possess, administer, prescribe or dispense controlled substances and dangerous drugs.

There is no dispute that a registered nurse, including a CRNA, may possess and administer a drug or medicine.[10] Further, the furnishing of anesthetic agents by a pharmacy in a medical facility to an inpatient during the inpatient's procedure, test, or treatment at a medical facility does not constitute "dispensing."[11] The statutory definition of "dispense" in Chapter 454 and 639 does not include the furnishing of a dangerous drug or controlled substance by a hospital pharmacy for inpatients.[12] The Board of Pharmacy regulations further clarify that the term "dispense" refers to furnishing drugs in quantities greater than that necessary for the needs of the ultimate user.[13] "The term does not include the furnishing of a controlled substance or dangerous drug by a pharmacy in a medical facility to an inpatient of the medical facility in which the pharmacy is located."[14]

Similarly, the practice of CRNAs does not constitute "prescribing" under Nevada law because a "chart order" for an inpatient specifying drugs for inpatient use does not constitute "prescribing" drugs under Nevada law.[15] The Nevada State Legislature defines "prescription" as follows:

NRS 639.013 "Prescription" defined.

1. "Prescription" means:
    a. An order given individually for the person for whom prescribed, directly from the practitioner to a pharmacist or indirectly by means of an order

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[9] NEV. ADMIN. CODE § 632.500, attached hereto as **Exhibit 1**; *see also* NEV. REV. STAT. § 632.014.
[10] NEV. REV. STAT. § 454.213(1)(c).
[11] NEV. ADMIN. CODE § 639.450.
[12] NEV. REV. STAT. §§ 639.0065(2) (regulating controlled substances) and 454.211(2) (regulating dangerous drugs).
[13] NEV. ADMIN. CODE § 639.450.
[14] *Id.*
[15] NEV. REV. STAT. §§ 639.013(2) and 454.00961(2).

signed by the practitioner or by an electronic transmission from the practitioner to a pharmacist.

b. A chart order written for an inpatient specifying drugs which the inpatient is to take home upon discharge.

2. The term does not include a chart order written for an inpatient for use while he or she is an inpatient.

NRS 454.00961 "Prescription" defined.

1. "Prescription" means:
   a. An order given individually for the person for whom prescribed, directly from the practitioner, or the practitioner's agent, to a pharmacist or indirectly by means of an order signed by the practitioner or an electronic transmission from the practitioner to a pharmacist.
   b. A chart order written for an inpatient specifying drugs which he or she is to take home upon discharge.
2. "Prescription" does not include a chart order written for an inpatient for use while he or she is an inpatient.

The term "inpatient" is not defined in NRS Chapter 639 or 454. However, its usage throughout the pharmacy statutes and regulations suggests a broader connotation than that conferred by the Nevada State Board of Health.[16] The pertinent distinction between "patient" and "inpatient" appears to be whether the order from practitioner to patient requires (1) the patient to fill the order at a pharmacy for the patient's own use or (2) the practitioner to fill the order at an institutional pharmacy for the practitioner to administer to patient at a medical facility. Whether the patient is technically an "inpatient" or "outpatient" at a hospital or medical facility is of little import to this analysis.

Indeed, an "institutional pharmacy" is defined as a pharmacy that is part of or is operated in conjunction with a medical facility as defined in NRS 449.0151.[17] The definition of a "medical facility" includes:

1. A surgical center for ambulatory patients;
2. An obstetric center;

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[16] NEV. ADMIN. CODE § 449.289 defines "inpatient" as "a person who has been formally admitted into a hospital for diagnosis or treatment." NEV. ADMIN. CODE § 449.297 defines "outpatient" as "a person who has been registered or accepted for care in a hospital but who has not been formally admitted as an inpatient, and who does not remain in the hospital for more than 48 hours. Even this distinction may relate more to reimbursement status rather than whether or not drugs are being dispensed since in both the case where a patient is admitted to the hospital and when a patient remains in a hospital for observation for 48 hours, drugs may be administered to the patients in the hospital pursuant to a chart order.

[17] NEV. REV. STAT. § 639.0085.

3. An independent center for emergency medical care;
4. An agency to provide nursing in the home;
5. A facility for intermediate care;
6. A facility for skilled nursing;
7. A facility for hospice care;
8. A hospital;
9. A psychiatric hospital;
10. A facility for the treatment of irreversible renal disease;
11. A rural clinic;
12. A nursing pool;
13. A facility for modified medical detoxification;
14. A facility for refractive surgery;
15. A mobile unit; and
16. A community triage center.[18]

The term "institutional pharmacy" further includes "[a] pharmacy on the premises of the medical facility which provides a system of distributing and supplying medication to the facility, whether or not operated by the facility" and "[a] pharmacy off the premises of the medical facility which provides services only to the patients of the facility and provides a system of distributing medication based upon chart orders from the medical facility."[19] The overall statutory framework clearly contemplates a system of distributing medication to medical facilities so medical facilities can administer medication to their patients. To adopt a limiting definition of the term "inpatient" would lead to an absurd result given the breadth of medical procedures, tests and treatments that do not require a patient's formal admission to a hospital or medical facility.

Importantly, the scope of practice for CRNAs is limited to "preoperative, intraoperative, and postoperative" settings.[20] As such, CRNAs are only authorized to select, order and administer anesthetic agents for patients during the patients' procedure, test, or treatment at a licensed hospital or medical facility. The statutory definition of a "chart order" is an order entered on the chart of an inpatient in a hospital or medical facility licensed by the Division of Public and Behavioral Health of the Department of Health and Human Services.[21] Given the limited scope of CRNAs practice and the distinction between a "prescription" and "chart order" under Nevada law, the "ordering" authorized to be performed by CRNAs is synonymous to a chart order and is clearly not a prescription.

The current statutory and regulatory framework does not define who is permitted to make a chart order. Although CRNAs are not expressly included in the statutory definition of a

[18] NEV. REV. STAT. § 449.0151.
[19] NEV. REV. STAT. § 454.00905(1) and (2).
[20] NEV. ADMIN. CODE § 632.500.
[21] NEV. REV. STAT. § 639.004 and NEV. ADMIN. CODE § 639.442.

"practitioner," the hospital or institutional pharmacies from which CRNAs "order" anesthetic agents are included in the statutory definition of a "practitioner" to the extent they are licensed or registered to distribute, dispense or administer drugs.[22] The logical rationale for including hospitals and institutional pharmacies as "practitioners" in this context would mean that it is unnecessary for a CRNA to obtain a license from the Board of Pharmacy or DEA registration when ordering anesthetic agents from a licensed and DEA registered hospital or institutional pharmacy for the CRNA to administer to the patient at the hospital or medical facility. Moreover, it is unnecessarily duplicative and does not address any State or Federal policy goals to have CRNAs obtain such a license from the Board of Pharmacy or DEA registration under these circumstances, since CRNAs are performing services solely for patients within the hospital or medical facility.

2. **The practice of CRNAs does not constitute "prescribing" under Federal law.**

The current statutory and regulatory framework under Federal law also suggests that the practice of CRNAs does not constitute "prescribing." "Prescription means an order for medication which is dispensed to or for an ultimate user but does not include an order for medication which is dispensed for immediate administration to the ultimate user (e.g., an order to dispense a drug to a bed patient for immediate administration in a hospital is not a prescription)."[23] Further, the DEA has promulgated clear exceptions to the requirement of DEA registration for individual practitioners administering, dispensing or prescribing controlled substances under the registration of the hospital or institutional pharmacy.[24] 21 C.F.R. § 1301.22 provides, in pertinent part:

> (c) An individual practitioner who is an agent or employee of a hospital or other institution may, when acting in the normal course of business or employment, administer, dispense, or prescribe controlled substances under the registration of the hospital or other institution which is registered in lieu of being registered him/herself, provided that:
>
> (1) Such dispensing, administering or prescribing is done in the usual course of his/her professional practice;
> (2) Such individual practitioner is authorized or permitted to do so by the jurisdiction in which he/she is practicing;
> (3) The hospital or other institution by whom he/she is employed has verified that the individual practitioner is so permitted to dispense, administer, or prescribe drugs within the jurisdiction;
> (4) Such individual practitioner is acting only within the scope of his/her employment in the hospital or institution;

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[22] NEV. REV. STAT. §§ 639.0125(2) and 454.00958(2).
[23] 21 C.F.R. § 1300.01.
[24] 21 C.F.R. § 1301.22.

> (5) The hospital or other institution authorizes the individual practitioner to administer, dispense or prescribe under the hospital registration and designates a specific internal code number for each individual practitioner so authorized. The code number shall consist of numbers, letters, or a combination thereof and shall be a suffix to the institution's DEA registration number, preceded by a hyphen (e.g., APO123456–10 or APO123456–A12); and
> (6) A current list of internal codes and the corresponding individual practitioners is kept by the hospital or other institution and is made available at all times to other registrants and law enforcement agencies upon request for the purpose of verifying the authority of the prescribing individual practitioner.

This regulation suggests that practitioners in institutional settings who issue orders for medications for direct administration to a patient, such as CRNAs in their normal scope of practice, are not prescribing within the meaning of 21 C.F.R. § 1300.01, and would be exempt from registration. Federal policy concerns have to do with controls and procedures against theft of controlled substances. Accordingly, the DEA distinguishes institutional settings where CRNAs issuing orders for anesthetic agents for direct administration to patients are subject to the controls or procedures of the DEA registrant, such as a hospital or institutional pharmacy, from situations outside institutional settings or where CRNAs dispense and administer their own drugs. Thus, if a CRNA does not "prescribe" and if the CRNA is an agent or employee of a DEA registrant, it follows that the CRNA does not have to register with the DEA.

CONCLUSION

The practice of CRNAs issuing orders for anesthetic agents from hospital or institutional pharmacies for direct administration to patients does not constitute "prescribing" pursuant to the definition of "prescription" in NRS 639.013 and NRS 454.00961 or 21 C.F.R. § 1300.01. Given the limited scope of CRNAs practice and the distinction between a "prescription" and "chart order" under Nevada law, the "ordering" performed by CRNAs is synonymous to a chart order and is clearly not a prescription. For these reasons, we respectfully request a declaratory order or advisory opinion concluding that a CRNA licensed by the State Board of Nursing is not required to obtain a license from the Board of Pharmacy and/or DEA registration to order anesthetic agents from an institutional pharmacy located at a Nevada licensed hospital or medical facility for patient services at the hospital or medical facility.

Thank you for your time and consideration. Please do not hesitate to contact our office should you have any questions and/or comments.

Sincerely,

FENNEMORE CRAIG, P.C.

Lynn S. Fulstone

Lynn S. Fulstone

LFUL/cada

Cc: Robert Erickson, CRNA, President
Nevada Association Nurse Anesthetists

Paul Edwards, General Counsel
Nevada State Board of Pharmacy

EXHIBIT 1

Nevada Administrative Code § 632.500. Authorized functions. (NRS 632.120)

1. A certified registered nurse anesthetist may, in addition to those functions authorized for the registered nurse, perform the following acts, when it has been determined by a patient's physician, dentist or podiatric physician that an anesthetic is necessary for a procedure, test or other treatment, in accordance with the applicable policies and procedures regarding the administration of anesthetics:

(a) Obtain a history of the patient's health, as appropriate to the anticipated procedure, test or treatment;

(b) Assess the client's condition, as appropriate to the anticipated procedure, test or treatment;

(c) Recommend, request and order pertinent diagnostic studies and evaluate the results of those studies;

(d) Prepare a written preanesthetic evaluation of the patient and obtain the patient's informed consent for the anesthesia;

(e) Select, order and administer preanesthetic medication;

(f) Order, prepare and use any equipment and supplies necessary for the administration of anesthesia and perform or order any necessary safety checks on the equipment;

(g) Order and prepare any drugs used for the administration of anesthesia;

(h) Select and order anesthesia techniques, agents and adjunctive drugs;

(i) Perform and manage general, regional and local anesthesia and techniques of hypnosis;

(j) Perform tracheal intubation and extubation and provide mechanical ventilation;

(k) Provide perianesthetic invasive and noninvasive monitoring, as appropriate, and respond to any abnormal findings with corrective action;

(l) Manage the patient's fluid, blood and balance of electrolytes and acid base;

(m) Recognize abnormal response by a patient during anesthesia, select and take corrective action;

(n) Identify and manage any related medical emergency requiring such techniques as cardiopulmonary resuscitation, airway maintenance, ventilation, tracheal intubation, pharmacological cardiovascular support and fluid resuscitation;

(o) Evaluate the patient's response during emergence from anesthesia and institute pharmacological or supportive treatment to ensure adequate recovery from anesthesia;

(p) Provide care consistent with the principles of infection control and anesthesia safety to prevent the spread of disease and prevent harm to the anesthetized patient and others in the anesthetizing environment;

(q) Select, order and administer postanesthetic medication;

(r) Report to the person providing postanesthetic care the patient's physical and psychological condition, perioperative course and any anticipated problems;

(s) Initiate, order and administer respiratory support to ensure adequate ventilation and oxygenation in the immediate postanesthetic period;

(t) Release the patient from the postanesthetic care unit or discharge the patient from the ambulatory surgical setting;

(u) Include in a timely manner as a part of the patient's medical records a thorough report on all aspects of the patient's anesthesia care; and

(v) Assess the patient's postanesthetic condition, evaluate the patient's response to anesthesia and take corrective action.

2. In addition, the nurse anesthetist may accept additional responsibilities which are appropriate to the practice setting and within his or her expertise. Such responsibilities may include, but are not limited to, the selection and administration of drugs and techniques for the control of pain in the preoperative, intraoperative and postoperative setting.

AANA
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
222 South Prospect Avenue
Park Ridge, Illinois 60068-4001
847.692.7050
AANA.com

Safe and effective anesthesia
CARE
for every patient.

Certified Registered Nurse Anesthetists Fact Sheet

History: Nurse anesthetists have been providing anesthesia care to patients in the United States for more than 150 years. The CRNA (Certified Registered Nurse Anesthetist) credential came into existence in 1956. The title "nurse anesthesiologist," which is synonymous with the title "nurse anesthetist," is used by some CRNAs.

Prolific Providers: CRNAs are anesthesia professionals who safely administer *more than 49 million anesthetics* to patients each year in the United States, according to the American Association of Nurse Anesthetists (AANA) 2019 Member Profile Survey.

Rural America: CRNAs are the primary providers of anesthesia care in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, pain management and trauma stabilization services.

Anesthesia Safety: According to a 1999 report from the Institute of Medicine, anesthesia care is nearly 50 times safer than it was in the early 1980s. Numerous outcomes studies have demonstrated that there is no difference in the quality of care provided by CRNAs and their physician counterparts.

Practice of Nursing: CRNAs provide anesthesia in collaboration with surgeons, dentists, podiatrists, anesthesiologists, and other qualified healthcare professionals. When anesthesia is administered by a nurse anesthetist, it is recognized as the practice of nursing; when administered by a physician anesthesiologist, it is recognized as the practice of medicine. Regardless of whether their educational background is in nursing or medicine, all anesthesia professionals give anesthesia the same way.

Autonomy and Responsibility: As advanced practice registered nurses, CRNAs practice with a high degree of autonomy and professional respect. They carry a heavy load of responsibility and are compensated accordingly.*

Practice Settings: CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities.

Military Presence: Nurses first provided anesthesia on the battlefields of the American Civil War. During WWI, nurse anesthetists became the predominant providers of anesthesia care to wounded soldiers on the front lines; today, CRNAs continue to be the primary providers of anesthesia care to U.S. military personnel on front lines, navy ships, and aircraft evacuation teams around the globe.

Cost-Efficiency: Managed care plans recognize CRNAs for providing high-quality anesthesia care with reduced expense to patients and insurance companies. *The cost-efficiency of CRNAs helps control escalating healthcare costs.*

Supervision Opt-Out: In 2001, the Centers for Medicare & Medicaid Services (CMS) changed the federal physician supervision rule for nurse anesthetists to allow state governors to opt out of this facility reimbursement requirement (which applies to hospitals and ambulatory surgical centers) by meeting three criteria: 1) consult the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state, 2) determine that opting out is consistent with state law, and 3) determine that opting out is in the best interests of the state's citizens. To date, 17 states have opted out of the federal physician supervision requirement, including: Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana, South Dakota, Wisconsin, California,

Colorado, and Kentucky. Additional states do not have supervision requirements in state law and are eligible to opt out should the governors elect to do so.

Malpractice Premiums: On a nationwide basis, the average 2018 malpractice liability insurance premium for self-employed CRNAs was 33 percent less than it was in 1988. When trended for inflation through 2018, the reduction in premiums was even greater at 68 percent.

Direct Reimbursement: Legislation passed by Congress in 1986 made nurse anesthetists the first nursing specialty to be accorded direct reimbursement rights under the Medicare program.

AANA Membership: Nearly 54,000 of the nation's nurse anesthetists (including CRNAs and student registered nurse anesthetists) are members of the AANA (or nearly 90 percent of all U.S. nurse anesthetists). More than 40 percent of nurse anesthetists are men, compared with less than 10 percent of nursing as a whole.

Education Requirements: The minimum education and experience required to become a CRNA include**:

- A baccalaureate or graduate degree in nursing or other appropriate major.
- An unencumbered license as a registered professional nurse and/or APRN in the United States or its territories and protectorates.
- A minimum of one-year full-time work experience, or its part-time equivalent, as a registered nurse in a critical care setting within the United States, its territories, or a U.S. military hospital outside of the United States. The average experience of RNs entering nurse anesthesia educational programs is 2.9 years.
- Graduation with a minimum of a master's degree from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs. As of August 2019, there were 121 accredited nurse anesthesia programs in the United States and Puerto Rico utilizing 1,870 active clinical sites; 91 nurse anesthesia programs are approved to award doctoral degrees for entry into practice.***
- Nurse anesthesia programs range from 24-51 months, depending on university requirements. Programs include clinical settings and experiences. Graduates of nurse anesthesia educational programs have an average of 9,369 hours of clinical experience.
- Some CRNAs pursue a fellowship in a specialized area of anesthesiology such as chronic pain management following attainment of their degree in nurse anesthesia.

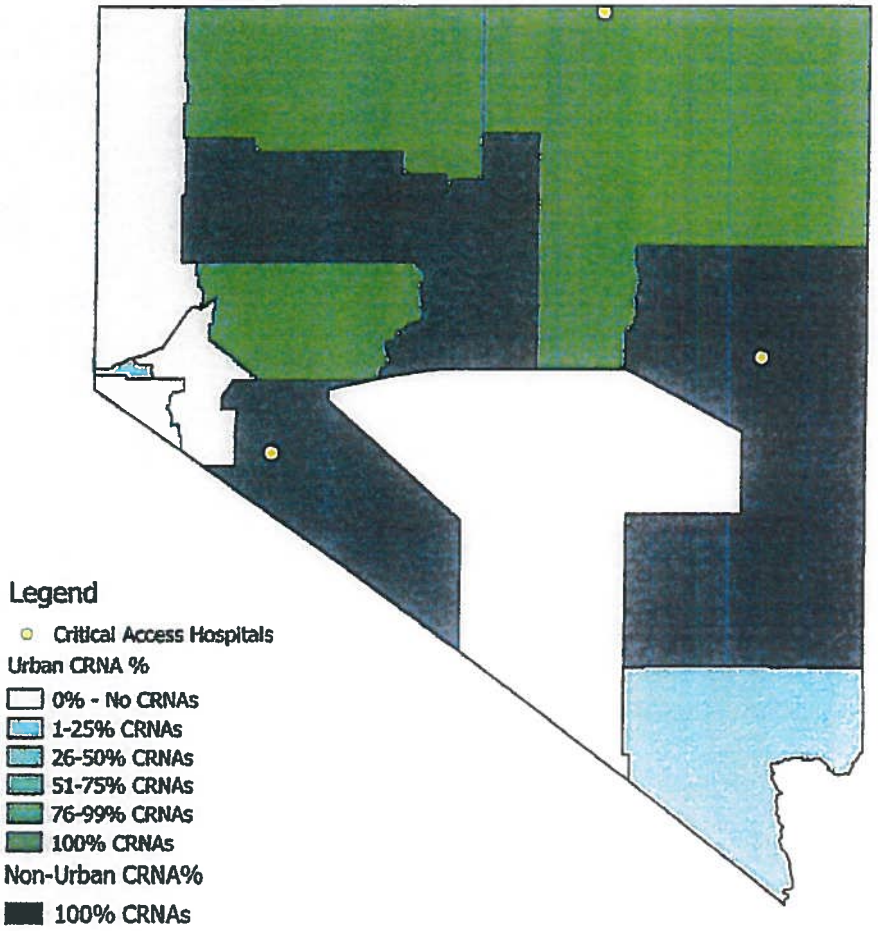
Certification: Before they can become CRNAs, graduates of nurse anesthesia educational programs must pass the National Certification Examination.

CPC Program, formerly Recertification: In 2016, the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA) launched the Continued Professional Certification (CPC) Program, which replaced the former recertification program. The CPC Program focuses on lifelong learning and is based on eight-year periods comprised of two four-year cycles. Each four-year cycle has a set of components that include 60 Class A credits (assessed continuing education), 40 Class B credits (professional activities), four Core Modules (current literature and evidence-based knowledge; voluntary during the first four-year cycle, required beginning in 2020), a 2-year Check-in at the midpoint of each four-year cycle, and a performance standard assessment (no pass/fail) every eight years.

*For information about CRNA compensation, please contact the AANA Public Relations Department at 847-655-1143.
**Nurse anesthesia educational programs have admission requirements in addition to the above minimums. A complete list of programs and information about each of them can be found at https://www.coacrna.org/accredited-programs/Pages/CRNA-School-Search.aspx
*** Beginning Jan. 1, 2022, all students matriculating into an accredited program must be enrolled in a doctoral program.

Most recently updated: August 8, 2019

Nevada Urban Areas (Metropolitan and Micropolitan)
CRNAs as a % of Anesthesia Providers per CBSA



Core-Based Statistical Area CBSA	MDAs	CRNAs	% CRNAs
Carson City, NV	8	1	11
Elko, NV	0	5	100
Fallon, NV	0	5	100
Fernley, NV	0	0	0
Gardnerville Ranchos, NV	19	0	0
Las Vegas-Henderson-Paradise, NV	270	58	18
Pahrump, NV	0	0	0
Reno, NV	86	0	0
Winnemucca, NV	0	1	100
Non-Urban Areas	0	2	100

Data Source: 2018 Physician Compare
Urban areas are represented as Core-Based-Statistical Areas (CBSAs), which are clusters of counties with > 50,000 aggregate population (Metropolitan) or counties with a city > 10,000 (Micropolitan). Grey areas indicate non-urban counties or counties not represented in either a metropolitan or micropolitan area. Providers with multiple practice locations among multiple CBSAs were only counted once per CBSA or non-urban area.

Nevada Association of Nurse Anesthetists:

Petition Requesting a Declaratory Order or Advisory Opinion

Nevada State Board of Pharmacy

January 16, 2020

FENNEMORE CRAIG ATTORNEYS

What is a Certified Registered Nurse Anesthetist (CRNA)?

NRS 632.014:

CRNA refers to a Registered Nurse who:

1. Has completed a nationally accredited program in the science of anesthesia; and
2. Is certified by the Board of Nursing to administer anesthetic agents to a person under the care of a licensed physician, a licensed dentist or a licensed podiatric physician.

FENNEMORE CRAIG ATTORNEYS

What Does NVANA Want?

Confirmation from this Board (under NAC 639.150) that CRNAs do not need a license from this Board or a DEA Registration to order anesthetic agents from a hospital pharmacy or medical facility, or administer anesthesia at that hospital or medical facility

BUT:

Petitioner is **NOT** Requesting Prescriptive Authority

FENNEMORE CRAIG ATTORNEYS

What Can CRNAs Do?

NAC 632.500:

CRNAs Can:

- Select, **order** and administer preanesthetic medication
- **Order** and prepare any drugs used for the administration of anesthesia
- Select and **order** anesthesia techniques, agents and adjunctive drugs
- Select, **order** and administer postanesthetic medication

FENNEMORE CRAIG ATTORNEYS

Aren't "Ordering" and "Prescribing" the Same Thing?

Short answer: **NO**

NRS 454.00961(2) (Nevada's "Dangerous Drugs" Statute) and
NRS 639.013 (2) (This Board's Statute) **AGREE**:

> Under BOTH statutes, the term "Prescription" does not include a chart order written for an inpatient for use while he or she is an inpatient.

FENNEMORE CRAIG ATTORNEYS

Who / What Is A "Practitioner"?

Once again:

NRS 454.00958(2) (Nevada's "Dangerous Drugs" Statute) and
NRS 639.0125 (This Board's Statute) **AGREE**:

Chapter 454: A practitioner is "...A pharmacy, hospital, or other institution licensed or registered to distribute, dispense, conduct research with respect to or to administer a dangerous drug in the course of professional practice."

Chapter 639: A practitioner is a "...hospital, pharmacy or other institution licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or to administer drugs in the course of professional practice or research in this State."

FENNEMORE CRAIG ATTORNEYS

How Should Drugs Be Regulated? Preventing The "Tacklebox"

It is unnecessarily duplicative and does not address any State or Federal policy goals to have CRNAs obtain a Board of Pharmacy license or DEA registration where CRNAs are "ordering" anesthesia from an institutional pharmacy for patients for use at that same institution.

TAKEAWAY?

Separate licensure / registration = less effective drug controls

FENNEMORE CRAIG ATTORNEYS

Must CRNAs Register With The DEA?

Short answer: **NO**

21 C.F.R. 1301.22:

Mid-level practitioners who are agents or employees of a hospital or other institution ***may***, when acting in the usual course of business or employment, administer, dispense, or prescribe controlled substances under the registration of the hospital or other institution in which they are an employee.

FENNEMORE CRAIG ATTORNEYS

In Sum, What Is The Current State of NV Law?

- NRS 632.014 and NAC 632.500 authorize CRNAs to select, **order** and administer anesthesia in the usual course of professional practice
- CRNAs "order" but **DO NOT** "prescribe"
- Pharmacies, hospitals and other institutions are "practitioners" and **CAN** "prescribe"
- CRNAs are agents or employees of the hospitals and other institutions and are authorized to operate under their DEA registration number

Conclusion: CRNAs do not need a license from this Board or a DEA Registration to order anesthetic agents from a hospital pharmacy or medical facility, or administer anesthesia at that hospital or medical facility.

FENNEMORE CRAIG ATTORNEYS

Thank you! Questions?

Richard I. Dreitzer, Esq.
rdreitzer@fclaw.com
702-692-8028

Chelsie A. Adams, Esq.
cadams@fclaw.com
702-791-8237

FENNEMORE CRAIG ATTORNEYS

From: Anderson Hu, MD <ahu@valleyanesthesiology.com>
Sent: Thursday, December 19, 2019 10:28 PM
To: Jeff Jedynak, CRNA
Subject: RE: Letter

To whom it may concern:

Hello my name is Dr. Anderson Hu and I am currently the chief of the anesthesia for Centennial Hills Hospital in Las Vegas Nevada. I have been in collaborative practice with Nurse anesthetists for the last 8 years. I have been asked to provide my expert opinion regarding nurse anesthetists and their ability to order medications during the perioperative period.

In my expert opinion, nurse anesthetist are qualified to order medications for patients during their perioperative stay. Nurse anesthetists spend the most amount of time with each patient by actively performing anesthesia for each case. The intimate time spent with each patient allows nurse anesthetists to know how each patient reacts to medications given and then in turn can develop the best plan to order postoperative medications. According to NRS 632.014, which is a definition that states nurse anesthetist can "administer anesthesia". Being that this is a general definition, the administration of anesthesia would include selecting, ordering, and administering medications, treatments, and procedures during the entire perioperative stay, which includes preoperative intraoperative and postoperative care.

With NRS 632.014 being a general definition, I sought out more specific guidance. NAC632.500 is authorized functions for certified registered nurse anesthetists. In regards to ordering, I refer to line 1(q), "select, order, and administer post anesthetic medications" is an authorized function of nurse anesthetists. Line 2 states "In addition, the nurse anesthetist may accept responsibilities which are appropriate to the practice setting and within his or her expertise. Such responsibilities include but are not limited to the selection and administration of drugs and techniques

(c) Conducting hearings pursuant to this chapter;

(d) Duplicating and verifying records of the Board; and

(e) Surveying, evaluating and approving schools of practical nursing, and schools and courses of professional nursing,

and collect the fees established pursuant to this subsection.

4. For the purposes of this chapter, the Board shall, by regulation, define the term "in the process of obtaining accreditation."

5. The Board may adopt such other regulations, not inconsistent with state or federal law, as may be necessary to carry out the provisions of this chapter relating to nursing assistant trainees, nursing assistants and medication aides - certified.

6. The Board may adopt such other regulations, not inconsistent with state or federal law, as are necessary to enable it to administer the provisions of this chapter.

[Part 5:256:1947; A 1955, 608] — (NRS A 1985, 311; 1989, 2008, 2050; 1993, 1218; 1999, 1326; 2003, 336; 2011, 1327; 2015, 2994; 2017, 1738; 2019, 529, 1490, effective January 1, 2020)

And, with an understanding of the further specifications of their license:

NAC 632.500 Authorized functions. (NRS 632.120)

1. A certified registered nurse anesthetist may, in addition to those functions authorized for the registered nurse, perform the following acts, when it has been determined by a patient's physician, dentist or podiatric physician that an anesthetic is necessary for a procedure, test or other treatment, in accordance with the applicable policies and procedures regarding the administration of anesthetics:

(a) Obtain a history of the patient's health, as appropriate to the anticipated procedure, test or treatment;

(b) Assess the client's condition, as appropriate to the anticipated procedure, test or treatment;

(c) Recommend, request and order pertinent diagnostic studies and evaluate the results of those studies;

(d) Prepare a written preanesthetic evaluation of the patient and obtain the patient's informed consent for the anesthesia;

(e) Select, order and administer preanesthetic medication;

(f) Order, prepare and use any equipment and supplies necessary for the administration of anesthesia and perform or order any necessary safety checks on the equipment;

(g) Order and prepare any drugs used for the administration of anesthesia;

(h) Select and order anesthesia techniques, agents and adjunctive drugs;

(i) Perform and manage general, regional and local anesthesia and techniques of hypnosis;

(j) Perform tracheal intubation and extubation and provide mechanical ventilation;

(k) Provide perianesthetic invasive and noninvasive monitoring, as appropriate, and respond to any abnormal findings with corrective action;

(l) Manage the patient's fluid, blood and balance of electrolytes and acid base;

(m) Recognize abnormal response by a patient during anesthesia, select and take corrective action;

(n) Identify and manage any related medical emergency requiring such techniques as cardiopulmonary resuscitation, airway maintenance, ventilation, tracheal intubation, pharmacological cardiovascular support and fluid resuscitation;

(o) Evaluate the patient's response during emergence from anesthesia and institute pharmacological or supportive treatment to ensure adequate recovery from anesthesia;

(p) Provide care consistent with the principles of infection control and anesthesia safety to prevent the spread of disease and prevent harm to the anesthetized patient and others in the anesthetizing environment;

(q) Select, order and administer postanesthetic medication;

(r) Report to the person providing postanesthetic care the patient's physical and psychological condition, perioperative course and any anticipated problems;

(s) Initiate, order and administer respiratory support to ensure adequate ventilation and oxygenation in the immediate postanesthetic period;

(t) Release the patient from the postanesthetic care unit or discharge the patient from the ambulatory surgical setting;

(u) Include in a timely manner as a part of the patient's medical records a thorough report on all aspects of the patient's anesthesia care; and

(v) Assess the patient's postanesthetic condition, evaluate the patient's response to anesthesia and take corrective action.

2. In addition, the nurse anesthetist may accept additional responsibilities which are appropriate to the practice setting and within his or her expertise. Such responsibilities may include, but are not limited to, the selection and administration of drugs and techniques for the control of pain in the preoperative, intraoperative and postoperative setting.

(Added to NAC by Bd. of Nursing, eff. 8-5-86; A 5-12-93)

Andrew T. Jackson, Pharm. D.,

Director of Pharmacy

Centennial Hills Hospital Medical Center

From: Anderson Hu, MD <ahu@valleyanesthesiology.com>
Sent: Thursday, December 19, 2019 10:28 PM
To: Jeff Jedynak, CRNA
Subject: RE: Letter

To whom it may concern:

Hello my name is Dr. Anderson Hu and I am currently the chief of the anesthesia for Centennial Hills Hospital in Las Vegas Nevada. I have been in collaborative practice with Nurse anesthetists for the last 8 years. I have been asked to provide my expert opinion regarding nurse anesthetists and their ability to order medications during the perioperative period.

In my expert opinion, nurse anesthetist are qualified to order medications for patients during their perioperative stay. Nurse anesthetists spend the most amount of time with each patient by actively performing anesthesia for each case. The intimate time spent with each patient allows nurse anesthetists to know how each patient reacts to medications given and then in turn can develop the best plan to order postoperative medications. According to NRS 632.014, which is a definition that states nurse anesthetist can "administer anesthesia". Being that this is a general definition, the administration of anesthesia would include selecting, ordering, and administering medications, treatments, and procedures during the entire perioperative stay, which includes preoperative intraoperative and postoperative care.

With NRS 632.014 being a general definition, I sought out more specific guidance. NAC632.500 is authorized functions for certified registered nurse anesthetists. In regards to ordering, I refer to line 1(q), "select, order, and administer post anesthetic medications" is an authorized function of nurse anesthetists. Line 2 states "In addition, the nurse anesthetist may accept responsibilities which are appropriate to the practice setting and within his or her expertise. Such responsibilities include but are not limited to the selection and administration of drugs and techniques

for the control of pain in the preoperative, intraoperative, and postoperative setting." These authorized functions use the word "order" many times.

In regards to patient care, certified registered nurse anesthetist have the training which includes the ordering of medications. Trying to restrict the practice of a nurse anesthetist would delay appropriate patient care by not consistently having the necessary medications available during the postoperative course. As a physician, it is difficult to develop an appropriate medication plan for a patient if I am unable to see all of the intraoperative course and responses to certain medications. Over-ordering of medications would be reduced as pain medication orders placed by physicians offer coverage for mild, moderate, and severe pain scales. Nurse anesthetists would have the ability to place orders which are tailored to the patient which is appropriate since they have spent the most time with each patient.

In my opinion, nurse anesthetists are qualified to order medications during the perioperative period per their scope of practice. Not only are they capable, they would be the appropriate practitioner to order postoperative medications, as they know the patient as well as anyone involved in the perioperative period. With patient care being of upmost importance, any delay of patient care should be prevented if possible.

Regards,

Anderson Hu

Director of Anesthesiology Centennial Hills Hospital

303-886-5310

ahu@valleyanesthesiology.com

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NVANA Nevada Association of Nurse Anesthetists

Safe and Effective Anesthesia Care for *Every Patient*

01-15-2020

To Whom It May Concern,

As the Director of Pharmacy Services, I have been associated with the practice of Certified Registered Nurse Anesthetists (CRNA) for several years, performing functions as part of a dedicated anesthesiology group under the direction of physician anesthesiologists at Centennial Hills Hospital. During such time, the pharmacy has performed reviews and audits of medication ordering, administration, and wasting regularly, and when necessary, interviews have been held with CRNAs for documentation verification and instruction.

Based on my experience, I am in support of the continued ability of CRNAs to perform duties and functions as outlined in their respective rules and nursing statutes, and supported by their certifications and parameters of licensure.

Having reference to the following NRS statute:

NRS 632.120 Duties; regulations; additional fees. [Effective January 1, 2020.]

1. The Board shall:

(a) Adopt regulations establishing reasonable standards:

(1) For the denial, renewal, suspension and revocation of, and the placement of conditions, limitations and restrictions upon, a license to practice professional or practical nursing or a certificate to practice as a nursing assistant or medication aide - certified.

(2) Of professional conduct for the practice of nursing.

(3) For prescribing and dispensing controlled substances and dangerous drugs in accordance with applicable statutes.

(4) For the psychiatric training and experience necessary for an advanced practice registered nurse to be authorized to make the diagnoses, evaluations and examinations described in NRS 433A.160, 433A.240, 433A.430, 484C.300, 484C.320, 484C.330, 484C.340 and 484C.350 and the certifications described in NRS 433A.170, 433A.195 and 433A.200.

(b) Prepare and administer examinations for the issuance of a license or certificate under this chapter.

(c) Investigate and determine the eligibility of an applicant for a license or certificate under this chapter.

(d) Carry out and enforce the provisions of this chapter and the regulations adopted pursuant thereto.

(e) Develop and disseminate annually to each registered nurse who cares for children information concerning the signs and symptoms of pediatric cancer.

2. The Board may adopt regulations establishing reasonable:

(a) Qualifications for the issuance of a license or certificate under this chapter.

(b) Standards for the continuing professional competence of licensees or holders of a certificate. The Board may evaluate licensees or holders of a certificate periodically for compliance with those standards.

3. The Board may adopt regulations establishing a schedule of reasonable fees and charges, in addition to those set forth in NRS 632.345, for:

(a) Investigating licensees or holders of a certificate and applicants for a license or certificate under this chapter;

(b) Evaluating the professional competence of licensees or holders of a certificate;

(c) Conducting hearings pursuant to this chapter;

(d) Duplicating and verifying records of the Board; and

(e) Surveying, evaluating and approving schools of practical nursing, and schools and courses of professional nursing,

and collect the fees established pursuant to this subsection.

4. For the purposes of this chapter, the Board shall, by regulation, define the term "in the process of obtaining accreditation."

5. The Board may adopt such other regulations, not inconsistent with state or federal law, as may be necessary to carry out the provisions of this chapter relating to nursing assistant trainees, nursing assistants and medication aides - certified.

6. The Board may adopt such other regulations, not inconsistent with state or federal law, as are necessary to enable it to administer the provisions of this chapter.

[Part 5:256:1947; A 1955, 608] — (NRS A 1985, 311; 1989, 2008, 2050; 1993, 1218; 1999, 1326; 2003, 336; 2011, 1327; 2015, 2994; 2017, 1738; 2019, 529, 1490, effective January 1, 2020)

And, with an understanding of the further specifications of their license:

NAC 632.500 Authorized functions. (NRS 632.120)

1. A certified registered nurse anesthetist may, in addition to those functions authorized for the registered nurse, perform the following acts, when it has been determined by a patient's physician, dentist or podiatric physician that an anesthetic is necessary for a procedure, test or other treatment, in accordance with the applicable policies and procedures regarding the administration of anesthetics:

(a) Obtain a history of the patient's health, as appropriate to the anticipated procedure, test or treatment;

(b) Assess the client's condition, as appropriate to the anticipated procedure, test or treatment;

(c) Recommend, request and order pertinent diagnostic studies and evaluate the results of those studies;

(d) Prepare a written preanesthetic evaluation of the patient and obtain the patient's informed consent for the anesthesia;

(e) Select, order and administer preanesthetic medication;

(f) Order, prepare and use any equipment and supplies necessary for the administration of anesthesia and perform or order any necessary safety checks on the equipment;

(g) Order and prepare any drugs used for the administration of anesthesia;

(h) Select and order anesthesia techniques, agents and adjunctive drugs;

(i) Perform and manage general, regional and local anesthesia and techniques of hypnosis;

(j) Perform tracheal intubation and extubation and provide mechanical ventilation;

(k) Provide perianesthetic invasive and noninvasive monitoring, as appropriate, and respond to any abnormal findings with corrective action;

(l) Manage the patient's fluid, blood and balance of electrolytes and acid base;

(m) Recognize abnormal response by a patient during anesthesia, select and take corrective action;

(n) Identify and manage any related medical emergency requiring such techniques as cardiopulmonary resuscitation, airway maintenance, ventilation, tracheal intubation, pharmacological cardiovascular support and fluid resuscitation;

(o) Evaluate the patient's response during emergence from anesthesia and institute pharmacological or supportive treatment to ensure adequate recovery from anesthesia;

(p) Provide care consistent with the principles of infection control and anesthesia safety to prevent the spread of disease and prevent harm to the anesthetized patient and others in the anesthetizing environment;

(q) Select, order and administer postanesthetic medication;

(r) Report to the person providing postanesthetic care the patient's physical and psychological condition, perioperative course and any anticipated problems;

(s) Initiate, order and administer respiratory support to ensure adequate ventilation and oxygenation in the immediate postanesthetic period;

(t) Release the patient from the postanesthetic care unit or discharge the patient from the ambulatory surgical setting;

(u) Include in a timely manner as a part of the patient's medical records a thorough report on all aspects of the patient's anesthesia care; and

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(Added to NAC by Bd. of Nursing, eff. 8-5-86; A 5-12-93)

Andrew T. Jackson, Pharm. D.,

Director of Pharmacy

Centennial Hills Hospital Medical Center

Valley Anesthesiology Consultants

To Whom It May Concern:

I am writing this letter to express my concerns regarding recent changes in allowed scope of practice of CRNAs in Nevada. As you are likely aware, it has been made mandatory that physician anesthesiologists complete all post-operative orders on patients undergoing surgery. In my opinion, this unilateral change in patient care puts patients at risk of suboptimal management in certain instances. With that in my mind, I would urge that you reconsider your decision regarding this matter.

CRNAs are trained to care for patients in the entire peri-operative setting. In fact, one could argue that pre and intra-operative care are far more demanding from a clinical standpoint than the post-operative setting. Pre-operatively, the CRNA has to evaluate the patient, order testing if appropriate, make any suggestions regarding medical optimization of the patient prior to surgery, and finally, give an adequate assessment of a patient's risk regarding surgery in anesthesia. Intra-operatively, the CRNA must employ their in-depth knowledge of pharmacology and physiology in order to maintain stability of a patient's vital signs. Post-operatively, the CRNA must use the knowledge and experience they've gained from taking care of that very same patient pre-operatively and intra-operatively in order to formulate a plan for treating any immediate post-operative issues such as pain, nausea and vomiting, or any lability on vital signs. It goes against logic to suggest that the supervising anesthesiologist would have the same degree of intimate familiarity with the patient as the CRNA who has been by their side for the entire surgery. For this reason, the CRNA should be allowed, and is certainly more qualified, to dictate the final portion of their peri-operative course.

If our ultimate goal of enhanced patient care is shared, then I urge you to allow CRNAs the ability to place post-operative orders for their patients. The burden of responsibility has already been placed on them for the most critical parts of the patient's care. They have certainly administered medications with much more potency and potential for untoward effects in the operating room than the few medications they would order in the recovery room. Not only would their immediate presence prevent the delay in patient care that might occur while waiting for the attending to write orders, but their thorough knowledge of the patient's medical history and, more importantly, their intra-operative course, would enable them to provide a more informed post-anesthetic care plan. Please feel free to contact me at 702-339-8747 should you have any questions.

Sincerely,

Timothy Beckett, MD
Managing Partner, Valley Anesthesiology Consultants

To Whom It May Concern:

CRNAs have been administering anesthesia for over 150 years. More than 49 million anesthetics are given each year by CRNAs. CRNAs give anesthesia in all settings where anesthesia is administered.

As I am sure you are aware, CRNAs are extensively educated in the use of medications related to administering anesthesia. CRNAs have an average of greater than 9,000 hours of clinical experience before they can be certified. Testing regarding medication use is a large component of our certification. We are required by state law and national certification rules to obtain continuing education regarding current usage of medications. This is not for providing medication for a patient's use at home, but for providing medication to administer the actual anesthetic. All we request is that we can reaffirm our ability to provide safe and efficient care. In one of my practice settings, the CRNA is the individual assigned to manage a critical incident, not the MD. It is well within a CRNAs skill set to manage this. Thank you for your consideration.

Please feel free to contact me.

Joanne Heins, MAE, CRNA, BSN, RN
702-286-5707
jkheins57@gmail.com

Nevada Board of Pharmacy
985 Damonte Ranch Pkwy #206
Reno, Nevada, 89521

January 16, 2020

To Whom It May Concern:

This letter is to inform you about our profession.

History
Nurse anesthetists have been providing anesthesia care to patients in the United States for more than 150 years. The CRNA (Certified Registered Nurse Anesthetist) credential came into existence in 1956. We are the only professional nurse anesthesia association in Nevada and we call ourselves *Nevada Association of Nurse Anesthetists (NVANA)*.

Nevada Practice
There are less than 100 CRNAs in our state, with the majority concentrated in the Las Vegas area. In the past two years, it has been increasingly concerning to see others attempt to define, interpret, and restrict our practice. The objective of NVANA at today's Board of Pharmacy meeting is to respectfully request a declaratory order or advisory opinion concluding that a CRNA licensed by the Nevada State Board of Nursing is not required to obtain a license from the Nevada Board of Pharmacy and/or DEA registration to order anesthetic agents from an institutional pharmacy located at a Nevada licensed hospital or medical facility for patient services at the hospital or medical facility. We are not seeking changes to regulations that have been on the books for over 25 years (NAC 632.500).

Prolific Providers
CRNAs are anesthesia professionals who safely administer *more than 49 million anesthetics* to patients each year in the United States, according to the American Association of Nurse Anesthetists (AANA) 2019 Member Profile Survey.

Rural America
CRNAs are the primary providers of anesthesia care in rural America, enabling healthcare facilities in these medically underserved areas to offer obstetrical, surgical, pain management, and trauma stabilization services.

Anesthesia Safety
According to a 1999 report from the Institute of Medicine (now the Health and Medicine Division of the National Academies of Sciences, Engineering and Medicine), anesthesia care is nearly 50 times safer than it was in the early 1980s. Numerous outcomes studies have demonstrated that there is no difference in the quality of care provided by CRNAs and their physician counterparts.

Practice of Nursing
CRNAs provide anesthesia in collaboration with surgeons, dentists, podiatrists, physician anesthesiologists, and other qualified healthcare professionals. When anesthesia is administered by a nurse anesthetist, it is recognized as the practice of nursing; when administered by a physician anesthesiologist, it is recognized as the practice of medicine. Regardless of whether their educational background is in nursing or medicine, all anesthesia professionals give anesthesia the same way.

Autonomy and Responsibility
As advanced practice registered nurses, CRNAs practice with a high degree of autonomy and professional respect. CRNAs carry a heavy load of responsibility and are compensated accordingly.

Practice Settings
CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals; ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities.

Military Presence
Nurses first provided anesthesia on the battlefields of the American Civil War. During WWI, nurse anesthetists became the predominant providers of anesthesia care to wounded soldiers on the front lines; today, CRNAs continue to be the primary providers of anesthesia care to U.S. military personnel on front lines, navy ships, and aircraft evacuation teams around the globe.

Cost-Efficiency
Managed care plans recognize CRNAs for providing high-quality anesthesia care with reduced expense to patients and insurance companies. *The cost-efficiency of CRNAs helps control escalating healthcare costs*.

Direct Reimbursement
Legislation passed by Congress in 1986 made nurse anesthetists the first nursing specialty to be accorded direct reimbursement rights under the Medicare program.

AANA Membership
Nearly 54,000 of the nation's nurse anesthetists (including CRNAs and student registered nurse anesthetists) are members of the AANA (or nearly 90 percent of all U.S. nurse anesthetists). More than 40 percent of nurse anesthetists are men, compared with less than 10 percent of nursing as a whole.

Education Requirements
The minimum education and experience required to become a CRNA include:

- A baccalaureate or graduate degree in nursing or other appropriate major.

- An unencumbered license as a registered professional nurse and/or APRN in the United States or its territories and protectorates.
- A minimum of one year full-time work experience, or its part-time equivalent, as a registered nurse in a critical care setting within the United States, its territories, or a U.S. military hospital outside of the United States. The average experience of RNs entering nurse anesthesia educational programs is 2.9 years.
- Graduation with a minimum of a master's degree from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs. As of August 2019, there were 121 accredited nurse anesthesia programs in the United States and Puerto Rico utilizing 1,870 active clinical sites; 91 nurse anesthesia programs are approved to award doctoral degrees for entry into practice.
- Nurse anesthesia programs range from 24-51 months, depending on university requirements. Programs include clinical settings and experiences. Graduates of nurse anesthesia educational programs have an average of 9,369 hours of clinical experience.
- Some CRNAs pursue a fellowship in a specialized area of anesthesiology such as chronic pain management following attainment of their degree in nurse anesthesia.
- **Certification**

  Before they can become CRNAs, graduates of nurse anesthesia educational programs must pass the National Certification Examination.

Thank you for your consideration as we work together for the best interest of our patients and all Nevadans.

Sincerely Yours,

Robert Erickson, MSN, CRNA
Past President, Nevada Association of Nurse Anesthetists
10529 Longoria Garden Street
Las Vegas, Nevada, 89141

01-15-2020

To Whom It May Concern,

As the Director of Pharmacy Services, I have been associated with the practice of Certified Registered Nurse Anesthetists (CRNA) for several years, performing functions as part of a dedicated anesthesiology group under the direction of physician anesthesiologists at Centennial Hills Hospital. During such time, the pharmacy has performed reviews and audits of medication ordering, administration, and wasting regularly, and when necessary, interviews have been held with CRNAs for documentation verification and instruction.

Based on my experience, I am in support of the continued ability of CRNAs to perform duties and functions as outlined in their respective rules and nursing statutes, and supported by their certifications and parameters of licensure.

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and collect the fees established pursuant to this subsection.

4. For the purposes of this chapter, the Board shall, by regulation, define the term "in the process of obtaining accreditation."

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(b) Assess the client's condition, as appropriate to the anticipated procedure, test or treatment;

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(d) Prepare a written preanesthetic evaluation of the patient and obtain the patient's informed consent for the anesthesia;

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(Added to NAC by Bd. of Nursing, eff. 8-5-86; A 5-12-93)

Andrew T. Jackson, Pharm. D.,

Director of Pharmacy

Centennial Hills Hospital Medical Center

Financial Statements
June 30, 2019

Nevada State Board of Pharmacy

Nevada State Board of Pharmacy
Table of Contents
June 30, 2019

EideBailly

CPAs & BUSINESS ADVISORS

Independent Auditor's Report

To the Members of the Board
Nevada State Board of Pharmacy
Reno, Nevada

Report on the Financial Statements
We have audited the accompanying financial statements of the Nevada State Board of Pharmacy (Board) as of and for the year ended June 30, 2019, and the related notes to the financial statements, which collectively comprise the Board's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility
Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Nevada State Board of Pharmacy, as of June 30, 2019, and the changes in financial position for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, budgetary comparison, pension and OPEB information on pages 4-7, 24, 25-26 and 27-28, respectively, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required management discussion and analysis, pension and OPEB information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

The budgetary comparison information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the budgetary comparison information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Report on Summarized Comparative Information

The 2018 financial statements of the Board were audited by Kohn & Company LLP, who joined Eide Bailly LLP on December 3, 2018, and whose reported dated November 18, 2018 expressed an unmodified audit opinion on those audited financial statements. In our opinion, the summarized comparative information after restatement presented herein as of and for the year ended June 30, 2018 is consistent, in all material respects, with the audited financial statements from which it has been derived.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated December 2, 2019, on our consideration of the Nevada State Board of Pharmacy's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Nevada State Board of Pharmacy's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Nevada State Board of Pharmacy's internal control over financial reporting and compliance.

Eide Bailly LLP

Reno, Nevada
December 2, 2019

Management's Discussion and Analysis
June 30, 2019

Nevada State Board of Pharmacy

year-end. The objective of this statement is to address certain issues that have been raised with respect to GASB Statements No. 67, No. 68, and No. 73 regarding (1) the presentation of payroll-related measures in required supplementary information, (2) the selection of assumptions and the treatment of deviations from the guidance in an Actuarial Standard of Practice for financial reporting purposes, and (3) the classification of payments made by employers to satisfy employee (plan member) contribution requirements. Management has implemented the statement during the year ended June 30, 2018

During the year ended June 30, 2018, the Board implemented GASB Statement No. 75. *Accounting and Financial Reporting for Postemployment Benefits other than Pensions* (GASB 75) as required. The purpose of the statement is to improve accounting and financial reporting by state and local governments for postemployment benefits other than pensions (other postemployment benefits or OPEB). It also improves information provided by state and local governmental employers about financial support for OPEB that is provided by other entities. Total OPEB Liability (referred to as the Actuarial Accrued Liability under GASB 45) must be determined using the Entry Age Normal actuarial cost method as opposed to the Projected Unit Credit actuarial cost method used under GASB 45. This change in actuarial cost method resulted in a decrease in the Total OPEB Liability.

The impact of the implementation of these standards to the current year is to include certain deferred inflows and outflows of resources and reflect a net pension liability for the PERS retirement program and a net other post-employment liability as it relates to the Board. The financial impact resulted in the net position of the Board being a deficit of $3,726,479 and $2,400,275 at June 30, 2019 and 2018, respectively.

Statement of Activities

Revenue: The program revenue received by the Board is generated through the registration, renewal and licensure of pharmacies and pharmacists. Total revenue received by the Board for fiscal year ended June 30, 2019 was approximately $2,600,000, representing a $107,000 decrease from the fiscal year ended June 30, 2018.

Expenses: Operating expenses for the fiscal year ended June 30, 2019 were approximately $4,300,000, representing an increase over the fiscal year ended June 30, 2018 of approximately $932,000. The increase primarily relates to an increase in retirement benefits, and professional contract services with offsetting decreases in salaries.

General Fund Budgetary Highlights

Total revenue received was less than the budgeted amount by approximately $742,000. The categories of license and renewal fees were the primary variances.

Total expenses were higher than the budgeted amounts by $160,000. The primary areas where expenses were higher were costs for other contract services, software, and credit card processing costs.

Economic Factors and Next Year's Budget

The Board is charged with, and given statutory authority, to provide public protection through the licensure and regulation of pharmacies and pharmacists. The Board provides direction of staff actions toward its mission of public protection through licensure and disciplinary measures.

To this end, the Board has implemented a variety of changes that include continued software development to automate various job functions which provides cost savings in personnel services. Staff has been directed to continue seeking areas in which operating expenses can be reduced without jeopardizing the high level of customer service the licensees and public have come to know.

Through the Board members' and management's review of the annual budget and monthly income and expense statements, it is expected that these tools will continue to provide the Board with sufficient long and short-term planning information.

Following are the condensed statements of net position for the years ended June 30:

	2019 Actual Government-Wide	2018 Actual Government-Wide (Restated)
Assets		
Cash and cash equivalents	$ 3,005,120	$ 2,742,304
Accounts receivable	16,346	13,243
Prepaid expenses and deposits	20,808	16,680
Capital assets, net of accumulated depreciation	35,980	63,795
Total assets	3,078,254	2,836,022
Deferred Outflows of Resources	1,304,670	995,569
Total assets and deferred outflows of resources	4,382,924	3,831,591
Liabilities		
Accrued expenses	445,106	152,808
Wholesaler license deposits	100,000	100,000
License fees received in advance	2,482,814	1,601,248
Net other post-employment benefit liability	1,323,832	1,101,166
Net pension liability	3,490,261	3,010,553
Total liabilities	7,842,013	5,965,775
Deferred Inflows of Resources	267,390	266,091
Total liabilities and deferred inflows of resources	8,109,403	6,231,866
Net Position		
Net position		
Invested in capital assets	35,980	63,795
Unrestricted	(3,762,459)	(2,464,070)
Total Net Position	$ (3,726,479)	$ (2,400,275)

Nevada State Board of Pharmacy
Statement of Net Position and Governmental Fund Balance Sheet
June 30, 2019

	General Fund	Adjustments (Note 9)	Statement of Net Position
Assets			
Cash and investments	$ 3,005,120	$ -	$ 3,005,120
Prepaid expenses	14,337	-	14,337
Accounts Receivable	16,346	-	16,346
Deposits	6,471	-	6,471
Capital assets, net of accumulated depreciation	-	35,980	35,980
Total assets	3,042,274	35,980	3,078,254
Deferred Outflows of Resources - Pension Requirement	-	1,304,670	1,304,670
Total assets and deferred outflows of resources	3,042,274	1,340,650	4,382,924
Liabilities			
Accounts payable	317,044	-	317,044
Accrued compensated absences			
Due within one year	-	90,000	90,000
Due in more than one year	-	38,062	38,062
Wholesaler license deposits	100,000	-	100,000
Licensing fees received in advance			
Due within one year	2,032,358	-	2,032,358
Due in more than one year	450,456	-	450,456
Net other post-employment benefit liability	-	1,323,832	1,323,832
Net pension liability	-	3,490,261	3,490,261
Total liabilities	2,899,858	4,942,155	7,842,013
Deferred Inflows of Resources			
Net other post-employment benefit liability	-	88,765	88,765
Net pension liability	-	178,625	178,625
Total deferred inflows of resources	-	267,390	267,390
Total liabilities and deferred inflows of resources	2,899,858	5,209,545	8,109,403
Fund Balance/Net Position			
Fund balance			
Nonspendable			
Prepaid expenses and deposits	20,808	(20,808)	-
Unassigned	121,608	(121,608)	-
Total fund balances	142,416	(142,416)	-
Total liabilities and fund balance	$ 3,042,274		
Net position			
Invested in capital assets, net of related debt		35,980	35,980
Unrestricted		(3,762,459)	(3,762,459)
Total Net Position		$ (3,726,479)	$ (3,726,479)

See Notes to Financial Statements

Nevada State Board of Pharmacy

Statement of Activities and Governmental Fund Revenue, Expenditures, and Changes in Fund Balance

Year Ended June 30, 2019

	General Fund	Adjustments (Note 9)	Statement of Activities
Expenditures/Expenses			
Board operations	$ 3,861,038	$ 423,456	$ 4,284,494
Program Revenue			
Charges for services, licensing revenue	2,562,762	(533)	2,562,229
Net program revenue	(1,298,276)	(423,989)	(1,722,265)
General Revenue			
Grant revenue	151,290	-	151,290
Investment income	32,263	-	32,263
Other income	212,508	-	212,508
	396,061	-	396,061
Excess (Deficiency) of Revenue over (under) Expenditures	(902,215)	902,215	-
Change in Net Position	-	(1,326,204)	(1,326,204)
Fund Balance/Net Position			
Beginning of year	1,044,631	(3,444,906)	(2,400,275)
End of Year	$ 142,416	$ (3,868,895)	$ (3,726,479)

See Notes to Financial Statements

Note 1 - Reporting Entity and Summary of Significant Accounting Policies

The Nevada State Board of Pharmacy (the Board) was created in 1901. The Board is regulated by the Nevada Revised Statutes, which also specify the authorized activities of the Board. The Board is the licensing and regulatory agency for pharmacists and pharmacies as well as fifteen other license types in the State of Nevada.

The financial statements of the Board have been prepared in accordance with generally accepted accounting principles as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles.

The following is a summary of the more significant accounting policies.

Reporting Entity

Effective July 1, 2001, Chapter 353 of the Nevada Revised Statutes (NRS) was amended to exempt certain professional and occupational boards from the state budget act and the provisions governing the administration of state funding. The provisions of Chapter 353 do not apply to boards created pursuant to chapters 623 to 625A, inclusive, 628, 630 to 640A inclusive, 641 to 644, inclusive, 654 and 656 of the NRS and the officers and employees thereof. Accordingly, the Board's budgeting and accounting practices and procedures have been removed from the oversight of the Department of Administration.

The Board's financial statements are not included in the financial statements of the State of Nevada since the State does not exercise financial or administrative control over the Board. This is in conformance with GASB codification Section 2100, Defining the Government Reporting Entity.

Basis of Presentation

The Board is defined as a single-program special-purpose entity under GASB Statement No. 14, paragraph 131 as amended by GASB Statement No. 39. This classification allows for the preparation of GASB 34 financial statements under an optional reporting method which combines the fund and government-wide statements into a single presentation. Under standard GASB 34 methodology, the government-wide statement of net position and statement of activities are presented independently from the respective fund balance sheet and statement of revenues, expenditures, and fund balance. A reconciliation of adjustments provided on the modified financial statements demonstrates the changes from the fund financial statements to the government-wide financial statements in order to assist the reader in evaluating these statements. The Board has utilized this optional method of presentation.

GASB Statement No. 62, Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements, requires the Board to apply all applicable GASB pronouncements and, unless they conflict with or contradict GASB pronouncements all Financial Accounting Standards Board (FASB) Statements and Interpretations, Accounting Principles Board Opinions, and Accounting Research Bulletins issued on or before November 30, 1989. Accordingly, the Board has not applied FASB pronouncements issued after that date.

Basis of Accounting

The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows.

Governmental fund financial statements are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenue is recognized as soon as they are both measurable and available. "Measurable" means the amount of the transaction can be determined and "available" means collectable within the current period or soon enough thereafter to pay liabilities of the current period. Expenditures generally are recorded when a liability is incurred, as under accrual accounting.

The Board has only governmental fund types.

Budget Data

The Board prepares an annual budget. The budget is prepared on a basis similar to generally accepted accounting principles under the modified accrual basis of accounting. All annual appropriations lapse at fiscal year-end.

Cash and Cash Equivalents

Cash is maintained in two commercial banks in Reno, Nevada. The Board participates in the State of Nevada collateralization program to assure that funds deposited are protected.

Cash also consists of time certificates of deposit, which are stated at fair value. The net increase (decrease) in the fair value of the investments is the difference between the cost (if purchased during the fiscal year) or the fair value of the investments at the beginning of the year, and the fair value of the investments at the end of the year. Changes in fair value of the certificates are reflected, together with interest income, as investment income in the accompanying financial statements. The Board's certificates are held in its name and it participates in the State of Nevada collateralization program to assure that funds deposited are protected. By statutes, all cash must be deposited in entities that are located in the State of Nevada.

Capital Assets

Capital assets, which include furniture, fixtures, and equipment, are reported in the net position column in the government-wide financial statements. Capital assets are defined by the Board as assets with an initial, individual cost of $500 and an estimated useful life of at least one year. Such assets are recorded at historical cost. Donated assets are recorded at estimated fair market value at the date of donation. The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend asset lives are expensed as incurred. Capital assets are depreciated using the straight-line method over three to twenty years.

Under the modified accrual basis of accounting, acquisitions are considered expenditures in the year purchased.

Compensated Absences

Compensated absences are accounted for in accordance with GASB Statement 16, Accounting for Compensated Absences, which requires that a liability for compensated absences relating to services already rendered and that are not contingent on a specified event be accrued as an employee earns the rights to the benefits. Compensated absences relating to future services or that are contingent on a specified event will be accounted for in the period those services are rendered or those events take place. The Board policy permits employees to accumulate earned but unused comp time, vacation and sick benefits subject to certain limitations on hours based on years of service. The sick time paid upon termination is limited to certain payout requirements and has hereby been reflected in the accompanying financial statements based upon these limitations. For the governmental fund, only the portion of the compensated absences paid from available resources, within 60 days following year-end, are reflected as a liability. The full liability is reflected in the government-wide financial statements.

Wholesaler License Deposits

In accordance with statutes, non-publicly traded companies that are wholesalers of prescription drugs must provide a bond, cash deposit or other form of security. There is one company that provided cash as security under this statute. The cash and liability are reflected in the accompanying financial statements.

Licensing and Licensing Fees Received in Advance

Licensing revenue includes fees for applications, registration and renewal, fines and penalties for late registration and disciplinary fines and charges for administrative duties performed by the Board.

The Board administers its licensing registration on biennial periods from November through October. Licensing fees received in advance represents revenue from the biennial renewals of licenses and the registration of new licenses and is recognized ratably over the license period.

Deferred Outflows and Inflows of Resources

In addition to assets, a separate section is reported for deferred outflows of resources. This separate financial statement element, deferred outflows of resources, represents a consumption of net position that applies to a future period and will not be recognized as an outflow of resources (expense/expenditure) until then. The changes in proportion and differences between employer contributions and proportionate share of contributions as well as contributions made after the measurement period for pensions qualify for reporting in this category.

In addition to liabilities, a separate section is reported for deferred inflows of resources. This separate financial statement element, deferred inflows of resources, represents an acquisition of net position that applies to a future period and will not be recognized as an inflow of resources (revenue) until that time. Differences between expected and actual experience and between projected and actual investment earnings on pension plan investments qualify for reporting in this category.

Fund Equity and Net Position

In the governmental fund financial statements, fund balances are classified as follows:

Nonspendable - represents amounts that are either not in a spendable form or are legally or contractually required to remain intact. The Board includes fund balances that have been prepaid for expenses and deposits on hand in this category.

Restricted – represents amounts which can be spent only for specific purposes because of state or federal laws, or externally imposed conditions. The Board has no restricted fund balances.

Committed – represents amounts which can be used only for specific purposes determined by the members of the governing Board's formal action through a resolution or action. The Board has no committed funds.

Assigned - represents amounts that are intended by the Board for specific purposes but do not require action by the governing Board. The Board has no assigned funds.

Unassigned – represents all amounts not included in spendable classifications.

The Board's policy is to first apply expenditures against non-spendable fund balances and then unassigned balances. On an annual basis, assigned fund balances are determined based upon available resources.

Equity is classified as net position and displayed in the three following components, as applicable:

- Net invested in capital assets – consists of capital assets, net of accumulated depreciation and any related debt.
- Restricted net position – consists of net position with constraints placed on their use either by (1) external groups such as creditors, grantors, contributors, or laws and regulations of other governments; or (2) law through constitutional provisions or enabling legislation.
- Unrestricted net position – net position that is neither classified as "invested in capital assets" nor as "restricted."

Pensions

For purposes of measuring the net pension liability, deferred outflows of resources, deferred inflows of resources and pension expense, information about the fiduciary net position of the Public Employees' Retirement System of Nevada (PERS) and additions to/deductions from PERS's fiduciary net position have been determined on the same basis as they are reported by PERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Postemployment Benefits Other Than Pensions (OPEB)

For purposes of measuring the net OPEB liability, deferred outflows of resources and deferred inflows of resources related to OPEB, and OPEB expense, information about the fiduciary net position of the Self Insurance Trust Fund, Public Employees' Benefits Program (PEBP) and additions to/deductions from PEBP's fiduciary net position have been determined on the same basis as they are reported by PEBP. For this purpose, PEBP recognizes benefit payments when due and payable in accordance with the benefit terms. PEBP's cash and cash equivalents consist of short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash and (b) so near to materiality that they present insignificant risk of changes in value due to charging interest rates.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

Note 2 - Deposits with Financial Institutions

The Board maintains its checking accounts and certificates of deposit in one commercial bank account and one brokerage account. The time certificates of deposit are held in the name of the Board. The accounts are insured by the Federal Deposit Insurance Corporation (FDIC) up to $250,000 in the aggregate per bank for the checking accounts and $250,000 for the time deposits.

The bank balances at June 30, 2019 totaled $2,110,444, $1,610,444 of which is not covered by the FDIC and is collateralized with securities held by the Nevada Pooled Collateral program. By provisions of statutes, the Board is required to deposit all money in banks or savings and loan associations located in the State of Nevada.

Note 3 - Capital Assets

The Board has custodial responsibility to the State of Nevada for furniture, fixtures and equipment acquired with resources of the Board. The capital asset activity during the year is as follows:

	July 1, 2018	Increases	Decreases	June 30, 2019
Capital assets, being depreciated				
Office furniture and equipment	$ 776,835	$ -	$ (21,496)	$ 755,339
Software	399,989	-	(270,929)	129,060
Vehicle	123,225	-	-	123,225
Leasehold improvements	17,723	-	(17,723)	-
	1,317,772	-	(310,148)	1,007,624
Less accumulated depreciation	(1,253,977)	(27,282)	309,615	(971,644)
Net capital assets	$ 63,795	$ (27,282)	$ (533)	$ 35,980

Note 4 - Long-Term Obligations

Activity on long-term obligations as provided in the government-wide financial statements is as follows:

	July 1, 2018	Increases	Decreases	June 30, 2019	Current Portion
Licensing fees received in advance	$ 1,601,248	$ 3,406,245	$ (2,524,679)	$ 2,482,814	$ 2,032,358
Compensated absences	144,092	85,618	(101,648)	128,062	90,000
	$ 1,745,340	$ 3,491,863	$ (2,626,327)	$ 2,610,876	$ 2,122,358

Note 5 - Operating Lease

The Board currently leases office space in Reno and Las Vegas, Nevada. The leases for Reno and Las Vegas expire on October 31, 2018 and March 31, 2022, respectively. The monthly rental payments range from $2,600 to $6,870. The Board also leases a copier with monthly payments of $258 which expires in April of 2022.

The following is a schedule by years of future minimum rental payments:

Years Ending June 30,	
2020	$ 35,497
2021	36,472
2022	26,637

Note 6 - Pensions

General Information About the Pension Plan

Plan Description

PERS (System) administers a cost-sharing, multiple-employer, defined benefit public employees' retirement system which includes both Regular and Police/Fire members. The System was established by the Nevada Legislature in 1947, effective July 1, 1948. The System is administered to provide a reasonable base income to qualified employees who have been employed by a public employer and whose earnings capacities have been removed or substantially impaired by age or disability.

Benefits Provided

a) Benefits, as required by the Nevada Revised Statutes (NRS or statute), are determined by the number of years of accredited service at time of retirement and the member's highest average compensation in any 36 consecutive months with special provisions for members entering the System on or after January 1, 2010 and for members entering the System on or after July 1, 2015. Benefit payments to which participants or their beneficiaries may be entitled under the plan include pension benefits, disability benefits, and survivor benefits.
b) Monthly benefit allowances for members are computed as 2.5% of average compensation for each accredited year of service prior to July 1, 2001. For service earned on and after July 1, 2001, this multiplier is 2.67% of average compensation. For members entering the System on or after January 1, 2010, there is a 2.5% service time factor and for regular members entering the System on or after July 1, 2015, there is a 2.25% multiplier. The System offers several alternatives to the unmodified service retirement allowance which, in general, allow the retired employee to accept a reduced service retirement allowance payable monthly during his or her lifetime and various optional monthly payments to a named beneficiary after his or her death.
c) Post-retirement increases are provided by authority of NRS 286.575 – 286.579.

Vesting

a) Regular members entering the System prior to January 1, 2010 are eligible for retirement at age 65 with five years of service, at age 60 with 10 years of service, or at any age with thirty years of service. Regular members entering the System on or after January 1, 2010, are eligible for retirement at age 65 with five years of service, or age 62 with 10 years of service, or any age with thirty years of service. Regular members who entered the System on or after July 1, 2015 are eligible for retirement at age 65 with 5 years of service, or at age 62 with 20 years of service or at age 55 with 30 years of service or at any age with 33 1/3 years of service.
b) The normal ceiling limitation on monthly benefits allowances is 75% of average compensation. However, a member who has an effective date of membership before July 1, 1985, is entitled to a benefit of up to 90% of average compensation. Both Regular and Police/Fire members become fully vested as to benefits upon completion of five years of service.

Contributions

a) The authority for establishing and amending the obligation to make contributions and member contribution rates is set by statute. New hires, in agencies which did not elect the Employer-Pay Contribution (EPC) plan prior to July 1, 1983 have the option of selecting one of two contribution plans. Contributions are shared equally by employer and employee. Employees can take a reduced salary and have contributions made by the employer (EPC) or can make contributions by a payroll deduction matched by the employer.
b) The System's basic funding policy provides for periodic contributions at a level pattern of cost as a percentage of salary throughout an employee's working lifetime in order to accumulate sufficient assets to pay benefits when due.
c) The System receives an actuarial valuation on an annual basis indicating the contribution rates required to fund the System on an actuarial reserve basis. Contributions actually made are in accordance with the required rates established by the Nevada Legislature. These statutory rates are increased/decreased pursuant to NRS 286.421 and 286.450.
d) The actuary funding method used is the Entry Age Normal Cost Method. It is intended to meet the funding objective and result in a relatively level long-term contributions requirement as a percentage of salary.
e) For the fiscal year ended June30, 2019, respectively, the Statutory Employer/employee matching rate was 14.50% for Regular employees. The Employer-pay contribution (EPC) rate was 28.00%, for June 30, 2019 for Regular employees.

Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

At June 30, 2019, the Board reported a liability of $3,490,261 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2018, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Board's proportion of the net pension liability was based on total contributions due on wages paid during the measurement period. Each employer's proportion of the net pension liability is based on their combined employer and member contributions relative to the total combined employer and member contributions for all employers for the period ended June 30, 2018. At June 30, 2018, the Board's proportion was .02559% percent.

For the years ended June 30, 2019 and 2018, the Board recognized pension expense of $406,655 and $335,129, respectively. Amounts totaling $254,976 resulting from Board contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in year ended June 30, 2019. For the year ended June 30, 2019, the Board contributed $254,976 under the statutes requirements based on covered

payroll of $1,711,106 which equates to 13.89% overall to the plan. At June 30, 2019, the Board reported deferred outflows of resources and deferred inflows of resources related to pension from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 109,340	$ 162,008
Changes of assumptions	183,915	-
Net difference between projected and actual investment earnings on pension plan investments	-	16,617
Changes in proportion	756,439	-
Contributions subsequent to the measurement date	254,976	-
	$ 1,304,670	$ 178,625

Amounts reported as deferred outflows of resources and deferred inflows of resources, without regard to the contributions subsequent to the measurement date, related to pensions will be recognized in pension expense as follows:

Years Ending June 30,	
2020	$ 234,309
2021	195,725
2022	132,932
2023	171,320
2024	118,133
2025	18,650
	$ 871,069

The net difference between projected and actual investment earnings on pension plan investments will be recognized over five years, all the other above deferred outflow and deferred inflows will be recognized over the average expected remaining services lives, which was 6.39 years for the measurement period ending June 30, 2018.

Reconciliation of the net pension liability at June 30, 2019 is as follows:

Beginning net pension liability	$ 3,010,553
Pension expense	406,655
Employer contributions	(237,423)
Current year net deferred (inflows) and outflows	310,476
Ending net pension liability	$ 3,490,261

Actuarial Assumptions

The System's net pension liability was measured as of June 30, 2017, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The total pension liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation rate	2.75%
Payroll growth	5.00%, including inflation
Investment rate of return	7.50%
Productivity pay increase	0.50%
Projected salary increases	Regular: 4.25% to 9.15%, depending on service Rates include inflation and productivity increases
Consumer price index	2.75%
Other assumptions	Same as those used in the June 30, 2018 funding actuarial valuation

Actuarial assumptions used in the June 30, 2018 valuation were based on the results of the experience review completed in 2017.

The discount rate used to measure the total pension liability was 7.50% as of June 30, 2018. The projection of cash flows used to determine the discount rate assumed that employee and employer contributions will be made at the rate specified in statute. Based on that assumption, the pension plan's fiduciary net position at June 30, 2018, was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability as of June 30, 2018 and June 30, 2017.

Investment Policy

The System's policies which determine the investment portfolio target asset allocation are established by the System. The asset allocation is reviewed annually and is designed to meet the future risk and return needs of the System. The following was the System's adopted policy target asset allocation as of June 30, 2017:

Asset Class	Target Allocation	Long-Term Geometric Expected Real Rate of Return *
Domestic Equity	42%	6.60%
International Equity	18%	7.37%
Domestic Fixed Income	30%	36.00%
Real estate	5%	5.94%
Private equity	5%	13.41%

*As of June 30, 2018, PERS' long-term inflation assumption was 2.75%.

Discount Rate and Pension Liability Discount Rate Sensitivity

The following presents the net pension liability of the PERS as of June 30, 2018, calculated using the discount rate of 7.50%, as well as what the PERS net pension liability would be if it were calculated using a discount rate that is 1 percentage-point lower (6.50%) or 1 percentage-point higher (8.50%) than the current discount rate:

	1% Decrease Discount Rate (6.50%)	Discount Rate (7.50%)	1% Increase Discount Rate (8.50%)
Net pension liability	$ 5,321,953	$ 3,010,553	$ 1,967,567

Pension Plan Fiduciary Net Position

Additional information supporting the Schedule of Employer Allocations and the Schedule of Pension Amounts by Employer is located in the PERS Comprehensive Annual Financial Report (CAFR) available on the PERS website at www.nvpers.org under Quick Links – Publications.

Note 7 - Other Post Employment Retirement Benefits (OPEB)

General Information About the OPEB Plan

Plan Description

Employees of the Board are provided with OPEB through the Self Insurance Trust Fund, Public Employees' Benefits Program (PEBP) - a cost-sharing multiple employer defined benefit OPEB plan administered by the Public Employees' Benefits Program Board (PEBP Board) which was created in 1983 by the Nevada Legislature to administer group health, life and disability insurance for covered employees, both active and retired, of the State, and certain other participating public employers within the State of Nevada. PEBP does not provide for refunds of employee contributions. The Self Insurance Trust Fund issues a publicly available financial report that can be obtained at https://pebp.state.nv.us/. The Board is reporting plan information consistently with the PEBP's accounting methods and assumptions as disclosed in the annual report. No information has come to our attention that indicates significant changes to the plan's disclosures.

Benefits Provided

PEBP provides medical, dental, vision, mental health and substance abuse and also offers fully insured HMO products. Long-term disability and life insurance benefits are fully insured by outside carriers.

Contributions

Per NRS 287 contribution requirements of the participating entities and covered employees are established and may be amended by the PEBP Board. The Boards' contractually required contribution for the year ended June 30, 2018 was $39,654, actuarially determined as an amount that is expected to finance the costs of benefits earned by employees during the year. Employees are not required to contribute to the OPEB plan.

OPEB Liabilities, OPEB Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB

At June 30, 2019, the Board reported a liability of $1,323,832 for its proportionate share of the net OPEB liability. The net OPEB liability was measured as of June 30, 2018, and the total OPEB liability used to calculate the net OPEB liability was determined by an actuarial valuation as of that date. The Board's proportion of the net OPEB liability was based on a projection of the Board's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating state agencies, actuarially determined. At June 30, 2019, the Board's proportion was 0.0100%.

For the year ended June 30, 2019, the Board recognized OPEB expense of $70,437. At June 30, 2019, the Board reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of assumptions	$ -	$ 88,600
Asset experience	-	165
	$ -	$ 88,765

Amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

Years Ending June 30,	
2020	$ (29,146)
2021	(29,146)
2022	(24,440)
2023	(6,033)
	$ (88,765)

Actuarial Assumptions

The total OPEB liability in the June 30, 2018 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.75 percent
Salary increases	4.37 percent, average
Investment rate of return	3.58 percent
Healthcare cost trend rates	7.5 percent for 2018, see report for additional years

Mortality rates were based on the RP-2000 Combined Mortality projected to 2014 with Scale AA, set back one year for females. Disabled Mortality rates were based on the RP-2000 Disabled Retiree Mortality projected to 2014 with Scale AA, set forward three years.

The actuarial assumptions used in the June 30, 2018 valuation were based on the results of an actuarial valuation date of January 1, 2018, adjusted by using roll-forward procedures to determine the liability at the measurement date.

Discount Rate

The discount rate basis under GASB 75 is required to be consistent with a 20-Year Municipal Bond Index. The Bond Buyer General Obligation 20-Bond Municipal Bond Index is used for the determination of the discount rate.

The discount rates as of July 1, 2018, July 1, 2017 and July 1, 2016 are 3.58%, 2.85%, and 3.80%, respectively. Additional detail regarding the discount rates as of June 30, 2018, June 30, 2017, and June 30, 2016 are provided in the "Actuarial Assumptions and Methods" section of the report proved by the PEBP Board.

Sensitivity of the Board's Proportionate Share of the Net OPEB Liability to Changes in the Discount Rate

The following presents the Board's proportionate share of the net OPEB liability, as well as what the Board's proportionate share of the net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower or 1-percentage-point higher than the current discount rate:

	1% Decrease 2.58%	Discount Rate 3.58%	1% Increase 4.58%
Net OPEB liability (asset)	$ 1,458,629	$ 1,323,832	$ 1,206,683

Sensitivity of the Board's proportionate share of the net OPEB liability to changes in the healthcare cost trend rates.

The following presents the Board's proportionate share of the net OPEB liability, as well as what the Board's proportionate share of the net OPEB liability would be if it were calculated using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates:

	Health Care Cost Trend Rates		
	1% Decrease 5.5% Decreasing to 3.5%)	6.5% Decreasing to 4.5%)	1% Increase 7.5% Decreasing to 5.5%)
Net OPEB liability (asset)	$ 1,234,828	$ 1,323,832	$ 1,428,907

OPEB Plan Fiduciary Net Position

Detailed information about the OPEB plan's fiduciary net position is available in the separately issued PEBP financial report.

Note 8 - Compliance with Nevada Revised Statutes and Nevada Administrative Code

The Board conformed to all significant statutory constraints on its financial administration during the fiscal year.

Note 9 - Conversion to Government-Wide Financial Statements

Adjustments on the face of the financial statements were made to the fund balance sheet and statement of revenue, expenditures, and changes in fund balance in order to reconcile the fund financial statements to the government-wide statements of net position and activities. These adjustments detail the effect of the capitalization of fixed assets of $1,007,624, accumulated depreciation of $971,644, depreciation expense of $27,282, long-term accrued compensated absences of $128,062, net deferred inflows and outflows of $1,037,280, the net pension liability of $3,490,261, and the net OPEB liability of $1,323,832.

Required Supplementary Information
June 30, 2019

Nevada State Board of Pharmacy

Nevada State Board of Pharmacy

Pension Information - Schedule of Changes in Net Pension Liability
Last Ten Fiscal Years

	2018	2017	2016	2015	2014
Proportion of the net pension liability (asset)	0.02559%	0.02264%	0.01972%	0.01766%	0.01720%
Proportionate share of the net pension liability (asset)	$ 3,490,261	$ 3,010,553	$ 2,654,412	$ 2,024,299	$ 1,793,062
Covered payroll	$ 1,711,106	$ 1,457,180	$ 1,117,746	$ 1,053,952	$ 1,002,366
Proportionate share of the net pension liability (asset) as a percentage of its covered payroll	203.98%	206.60%	237.48%	192.07%	178.88%
Plan fiduciary net position as a percentage of the total pension liability	75.24%	74.40%	72.20%	75.10%	76.30%

Note: Only five years of information is available due to reporting changes with GASB 68 for Fiscal Year 2015.

Nevada State Board of Pharmacy

Pension Information - Schedule of Contributions

Last Ten Fiscal Years

	2019	2018	2017	2016	2015
Contractually required contributions	$ 254,976	$ 237,423	$ 184,648	$ 153,565	$ 125,087
Contributions in relation to contratually required contributions	(254,976)	(237,423)	(184,648)	(153,565)	(125,087)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -	$ -
Covered payroll	$ 1,835,986	$ 1,711,106	$ 1,457,180	$ 1,117,745	$ 1,053,952
Contributions as a percentage of covered payroll	13.89%	13.88%	12.67%	13.74%	11.87%

Note: Only five years of information is available due to reporting changes with GASB 68 for Fiscal Year 2015.

Nevada State Board of Pharmacy

Other Post-Employment Benefit Information - Schedule of Contributions

Last Ten Fiscal Years

	2018	2017
Contractually Required Contribution	$ 39,654	$ 32,195
Contributions in Relation to the Contractually Required Contribution	(39,654)	(32,195)
Contribution Deficiency (Excess)	$ -	$ -
Board's Covered Payroll	$ 1,711,106	$ 1,407,868
Contributions as A Percentage of Covered Payroll	2.32%	2.29%

Note: Only two years of information is available due to reporting changes with GASB 75 for Fiscal Year 2018.

Note 1 - Other Post-Employment Benefit (OPEB)

Changes of Benefit Terms

None.

Changes of Assumptions

The assumed discount rate used by the actuary to determine the post-employment benefits liability at June 30, 2019 was increased to 3.87% from 2.58% at June 30, 2018. The effect of the change would result in a decrease in the liability.

Supplementary Information
June 30, 2019

Nevada State Board of Pharmacy

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Nevada State Board of Pharmacy
Condensed Schedules of Net Assets
Years Ended June 30, 2019 and 2018

	2019 Actual Government-Wide	2018 Actual Government-Wide (Restated)
Assets		
Cash and cash equivalents	$ 3,005,120	$ 2,742,304
Accounts receivable	16,346	13,243
Prepaid expenses and deposits	20,808	16,680
Capital assets, net of accumulated depreciation	35,980	63,795
Total assets	3,078,254	2,836,022
Deferred Outflows of Resources	1,304,670	995,569
Total assets and deferred outflows of resources	4,382,924	3,831,591
Liabilities		
Accrued expenses	445,106	152,808
Wholesaler license deposits	100,000	100,000
License fees received in advance	2,482,814	1,601,248
Net other post-employment benefit liability	1,323,832	1,101,166
Net pension liability	3,490,261	3,010,553
Total liabilities	7,842,013	5,965,775
Deferred Inflows of Resources	267,390	266,091
Total liabilities and deferred inflows of resources	8,109,403	6,231,866
Net Position		
Net position		
Invested in capital assets	35,980	63,795
Unrestricted	(3,762,459)	(2,464,070)
Total Net Position	$ (3,726,479)	$ (2,400,275)

Nevada State Board of Pharmacy
Condensed Schedules of Activities
Years Ended June 30, 2019 and 2018

	2019 Actual Government-Wide	2018 Actual Government-Wide (Restated)
Expenses		
Operations	$ 1,197,906	$ 620,589
Personnel	2,998,156	2,603,636
Travel	88,432	128,313
Total expenses	4,284,494	3,352,538
Program Revenue		
Fees, licensing, and permits (charges for services)	2,562,229	2,670,156
General Revenue		
Grant revenue	151,290	77,676
Investment income	32,263	30,055
Other income	212,508	132,980
Total general revenue	396,061	240,711
Total revenue	2,958,290	2,910,867
Change in Net Position	$ (1,326,204)	$ (441,671)

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CPAs & BUSINESS ADVISORS

Independent Auditors' Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

To the Members of the Board
Nevada State Board of Pharmacy
Reno, Nevada

We have audited, in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities and the fund information of the Nevada State Board of Pharmacy (Board), as of and for the year ended June 30, 2019, and the related notes to the financial statements which collectively comprise the Nevada State Board of Pharmacy's basic financial statements, and have issued our report thereon dated December 2, 2019.

Internal Control over Financial Reporting
In planning and performing our audit of the financial statements, we considered the Nevada State Board of Pharmacy's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Nevada State Board of Pharmacy's internal control. Accordingly, we do not express an opinion on the effectiveness of the Nevada State Board of Pharmacy's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control over financial reporting that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that have not been identified. We did identify a deficiency in internal control, described in the accompanying schedule of findings and responses as item 2019-001 that we consider to be a material weaknesses.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Nevada State Board of Pharmacy's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Nevada State Board of Pharmacy's Response to Findings

Nevada State Board of Pharmacy's response to the findings identified in our audit are described in the accompanying *schedule of findings and responses*. Nevada State Board of Pharmacy's responses were not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the responses.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Eide Bailly LLP

Reno, Nevada
December 2, 2019

2019-001:	**Financial Reporting Material Weakness**
Criteria:	Management is responsible for establishing and maintaining an effective system of internal control over financial statement reporting. One of the components of an effective system of internal control over financial reporting is the preparation of full disclosure financial statements that do not require adjustment as part of the audit process.
Condition:	As auditors, we assisted in the preparation of the full disclosure financial statements and noted unreconciled items on one of the bank reconciliations which were not current.
Cause:	Procedures have not been implemented to ensure Board personnel possess the experience to prepare the Board's full disclosure financial statements in accordance with generally accepted accounting principles and stale reconciling items are properly corrected or adjusted as necessary.
Effect:	Financial information prepared by the Board may not comply with generally accepted accounting principles.
Recommendation:	We recommend the Board implement procedures to provide training in the preparation of governmental financial statements in accordance with generally accepted accounting principles and management review and approve all reconciliations.
Views of Responsible Officials:	Nevada State Board of Pharmacy agrees with this finding.