



Missouri Board of Pharmacy

Published to promote compliance of pharmacy and drug law

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Board Promulgates New Prescription Delivery Rule

The Missouri Board of Pharmacy recently promulgated [20 CSR 2220-2.013](#), which establishes new requirements for prescription delivery. Under the rule, pharmacies are required to “develop and implement written policies and procedure to ensure the safe and appropriate delivery of prescription drugs within the temperature requirements recommended by the manufacturer or the *United States Pharmacopeia* (USP).” Additionally, [20 CSR 2220-2.013](#) identifies authorized delivery sites/locations for prescriptions filled by a Missouri-licensed pharmacy.

The following questions and answers have been provided to assist in compliance:

◆ **Does the new rule apply to all pharmacies, including mail order?**

Yes. The new rule applies to all Missouri-licensed pharmacies delivering filled prescriptions regardless of delivery method (eg, employee delivery, common carrier, or mail).

◆ **Do I need a policy and procedure manual if my pharmacy does not deliver prescriptions?**

No. [20 CSR 2220-2.013](#) only applies to pharmacies delivering filled prescriptions.

◆ **I do not know what may happen after I give a prescription to a commercial carrier (eg, FedEx or UPS). How can I “ensure delivery within temperature requirements” as required by the rule?**

The Board understands licensees cannot control or predict the activities of third-party carriers. The Board also recognizes extenuating circumstances may occur that are beyond a licensee’s control. Licensees should establish policies and procedures to ensure delivery within appropriate temperature requirements given normal and customary delivery times. The Board also recommends establishing a mechanism for patients to contact the pharmacy with delivery concerns.

◆ **Can pharmacies now deliver to drop sites?**

No. The rule establishes specific authorized prescription delivery locations. Except as otherwise allowed by [rule](#), prescriptions filled by a Missouri-licensed pharmacy may not be left at, accepted by, or delivered to a location, place of business, or entity not licensed as a pharmacy.

◆ **Where can prescriptions be delivered under the rule?**

Prescriptions can be delivered to any location identified by the patient or the patient’s authorized designee **if the prescription is delivered directly to the patient or designee**. Additionally, prescriptions can be delivered to:

- (A) The office of a licensed health care practitioner authorized to prescribe medication in the state of Missouri;
- (B) A long-term care facility as defined by [20 CSR 2220-2.140](#) where the patient resides;
- (C) A hospital, office, clinic, or other medical institution that provides health care services;
- (D) A residence designated by the patient or the patient’s authorized designee; or
- (E) The patient’s office or place of employment.

◆ **What about prescriptions for veterinary use?**

At the request of a customer, legally filled prescriptions for veterinary use may be delivered to a residence, business, or clinic designated by the customer.

◆ **What about controlled substances (CS)?**

Licensees must comply with all applicable CS laws and regulations, including, but not limited to, all applicable security requirements. Please contact Drug Enforcement Administration or Bureau of Narcotics and Dangerous Drugs for additional questions.

The full text of [20 CSR 2220-2.013](#) is available on the Board’s Web site. Licensees should review the rule in its entirety to ensure compliance with Missouri law.



FDA Issues New Guidelines for Sleep Aids Containing Zolpidem

Food and Drug Administration (FDA) has issued new dosing recommendations for sleep aids containing zolpidem. The new recommendations are based upon new data that shows that when taken at night, blood levels of zolpidem remain high enough in the morning to impair activities that require alertness, such as driving. The new guidelines halve the dosage for women because the new data showed that their bodies take longer to eliminate the drug.

FDA urges drug manufacturers and health care providers to follow the new dosing instructions, which apply to brand name and generic drugs containing zolpidem:

- ◆ Ambien[®], Edluar[™], and Zolpimist[®]: 5 mg for women, 5 mg or 10 mg for men
- ◆ Ambien CR[®]: 6.25 mg for women, 6.25 mg or 12.5 mg for men

Additionally, manufacturers of these drugs have been instructed to follow the new guidelines and print new patient information drug labels containing the new recommendations.

The recommended doses of Intermezzo[®], a lower dose zolpidem product approved for middle-of-the-night awakenings, are not changing. At the time of Intermezzo's approval in November 2011, the label already recommended a lower dosage for women than for men. Additional details are available in an FDA Drug Safety Communication, available at www.fda.gov/Drugs/DrugSafety/ucm334033.htm.

What is the National Medication Error Rate? What Standards Are Available for Benchmarking?

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

A national or other regional medication error rate does not exist. It is not possible to establish a national medication error rate or set a benchmark for medication error rates. Each pharmacy organization is different. The rates that are tracked are a measure of the number of reports at a given organization, not the actual number of events or the quality of the care given. Most systems for measuring medication errors rely on voluntary reporting of errors and near-miss events. Studies have shown that even in good systems, voluntary reporting only captures the "tip of the iceberg." For this reason, counting reported errors yields limited information about how safe a pharmacy actually is. It is very possible that a pharmacy organization with a good

reporting system, and thus what appears to be a high error "rate," may have a safer system.

The National Coordinating Council for Medication Error Reporting and Prevention published a statement refuting the use of medication error rates. The statement, which is posted on the council's Web site (www.nccmerp.org), states the "Use of medication error rates to compare health care organizations is of no value." The council has taken this position for the following reasons:

- ◆ Differences in **culture** among health care organizations can lead to significant differences in the level of reporting of medication errors.
- ◆ Differences in the **definition** of a medication error among health care organizations can lead to significant differences in the reporting and classification of medication errors.
- ◆ Differences in the **patient populations** served by various health care organizations can lead to significant differences in the number and severity of medication errors occurring among organizations.
- ◆ Differences in the **type(s) of reporting and detection systems** for medication errors among health care organizations can lead to significant differences in the number of medication errors recorded.

According to the statement, the council believes that there are no acceptable incidence rates for medication errors. The goal of every health care organization should be to continually improve systems to prevent harm to patients due to medication errors. Pharmacies should monitor actual and potential medication errors that occur within their organization, and investigate the root cause of errors with the goal of identifying ways to improve the medication-use system to prevent future errors and potential patient harm. The value of medication error reporting and other data gathering strategies is to provide the information that allows an organization to identify weaknesses in its medication-use system and to apply lessons learned to improve the system. The sheer number of error reports is less important than the quality of the information collected in the reports, the organization's analysis of the information, and its actions to improve the system to prevent harm to patients.

It is more important to create the open environment that encourages the reporting of errors and near errors than to develop less meaningful comparative error rates.

ISMP Launches Program to Track Vaccine Errors

ISMP has launched a National Vaccine Error Reporting Program (VERP) that allows health care providers to confidentially report vaccine administration errors and near misses. Health care providers from all practice settings, including pharmacies and physicians' offices, are encouraged to report all mistakes related to vaccines, regardless of whether any harm resulted from the incident. The program will help ISMP "better quantify the sources of errors and advocate for vaccine name, labeling, device, information, and other needed product changes to ensure patient safety," stated Michael Cohen, ISMP president. The ISMP VERP was designed with the assistance of the California Department of Public Health and with input from experts in the field, indicates ISMP. Reports sent to the ISMP VERP will be shared with FDA and forwarded to the vaccine manufacturer when applicable. ISMP also plans to work with the Centers for Disease Control and Prevention on information received to address vaccine-related safety. VERP can be accessed at <http://verp.ismp.org/>.



Providers Should Ensure Only Diluted Forms of Acetic Acid Are Used, ISMP Warns

ISMP has issued a National Alert Network (NAN) notice advising that health care organizations should take immediate steps to ensure that only diluted acetic acid solutions are used in patient care. ISMP advises that the use and purchase of glacial acetic acid, the most concentrated form of acetic acid available, should be eliminated. Several cases of severe burns, scarring, and other permanent damage to skin or mucous membranes due to the inadvertent application of glacial acetic acid have been reported to the National Medication Errors Reporting Program operated by ISMP. ISMP provides the following steps for preventing further such events:

- ◆ Remove glacial acetic acid, which has no use in its current form in clinical medicine, from the pharmacy and replace with vinegar (5% solution) or commercially available diluted acetic acid 0.25% (for irrigation) or 2% (for otic use).
- ◆ Restrict purchasing so that pharmacy staff is purchasing acetic acid for all procedural areas.
- ◆ Restrict choices for purchasing so that glacial acetic acid is not selected by mistake.
- ◆ Ensure the correct strength is ordered.
- ◆ Educate staff about the differences between glacial acetic acid and diluted forms of acetic acid.
- ◆ Order 5% as “vinegar,” which reduces the potential for confusion with glacial acetic acid.
- ◆ Verify the product by requiring an independent double-check of acetic acid solutions before dispensing or applying the product.

Information on the cases reported and common reasons for the cases are included in the NAN alert, which is available on the ISMP Web site at www.ismp.org/NAN/files/20130121.pdf.

New FDA Training Video

FDA Drug Info Rounds, a series of online training videos, provides important and timely drug information to practicing clinical and community pharmacists so they can help patients make better medication decisions. In the latest Drug Info Rounds video, pharmacists discuss how FDA Drug Safety Communications let health care providers, patients, and consumers know about newly observed potential risks of FDA-approved drugs. Drug Info Rounds videos are developed with contributions from pharmacists in FDA’s Center for Drug Evaluation and Research, Office of Communications, and Division of Drug Information and are available on the FDA Web site at www.fda.gov/Drugs/ResourcesForYou/HealthProfessionals/ucm211957.htm.

Progress Made in Implementing Recommendations Intended to Prevent Acetaminophen Overdose

Compelling progress has been made by stakeholders seeking to address the public health issue of acetaminophen overdose, indicates a white paper published by the National Council for Prescription Drug Programs (NCPDP). In 2011, NCPDP made recommendations that the health care industry take actions to support the safe use of acetaminophen, including recommending that pharmacies produce prescription labels with the complete spelling of acetaminophen and eliminating use of abbreviations such as “acet” or “APAP.” Previous to that, in July 2010, the National Association of Boards of Pharmacy® (NABP®) recommended that “state boards of pharmacy

prohibit the use of the abbreviation ‘APAP’ on prescription labels, and require that ‘acetaminophen’ be spelled out to assist in preventing the well-recognized danger of acetaminophen induced hepatotoxicity.” The recommendation was based on established policy and a letter, sent by FDA to state boards of pharmacy, regarding the pharmacist’s role in educating patients about acetaminophen induced hepatotoxicity caused by unintentional overdose. The recommendation was also consistent with the report of the NABP Task Force on Uniform Prescription Labeling Requirements, which made recommendations to encourage use of prescription labels that are organized in a patient-centered manner. NCPDP reports that pharmacy retailers “estimated to collectively represent more than half of the prescriptions dispensed in 2011, have either implemented or committed to a phased implementation” of the recommendation to use the complete spelling of acetaminophen on prescription labels. “This update to our white paper provides additional guidance for those industry stakeholders who have not yet implemented the new pharmacy labeling practices for acetaminophen-containing medicines,” states Lee Ann Stember, president, NCPDP. The updated white paper is accompanied by a bulletin (PDF), available at www.ncdpd.org/pdf/wp/NCPDPAcetaminophenInfoBulletin_PharmacyStakeholders.pdf, developed for pharmacists that summarizes some of NCPDP’s key recommendations regarding acetaminophen. In addition, the white paper, available for download at www.ncdpd.org/ind_WP.aspx, includes a list of resources for pharmacists to use in educating staff and pharmacy staff to use in educating patients (see Appendix D of the white paper). More information is available in an NCPDP news release available at www.ncdpd.org/press/013113_NCPDP_Acetaminophen%20WP_FINAL.pdf.

Pharmacists Rated High for Honesty and Ethical Standards in Gallup’s 2012 Poll

Pharmacists ranked as the second most trusted profession in the 2012 Gallup Poll that asked consumers to rate 22 professions according to their honesty and ethical standards. Pharmacists were ranked as very high or high in this category by 75% of those surveyed, with nurses ranking first at 85%, and medical doctors third at 70%. Additional information on the results of the 2012 poll is available on the Gallup Web site at www.gallup.com/poll/159035/congress-retains-low-honesty-rating.aspx.



Pharmacists & Technicians:
Don't Miss Out on Valuable CPE Credit.
Set Up Your NABP e-Profile and Register for CPE Monitor Today!

Continuing pharmacy education (CPE) providers who are accredited by the Accreditation Council for Pharmacy Education (ACPE) have integrated CPE Monitor® into their systems and are requiring pharmacists and pharmacy technicians to provide an NABP e-Profile ID number and date of birth (MMDD) in order to process ACPE-accredited CPE credit.

Visit www.MyCPEmonitor.net to set up your NABP e-Profile and register for CPE Monitor and avoid possible delays in your CPE reporting.

CPE Monitor is a national collaborative service from NABP, ACPE, and ACPE providers that will allow licensees to track their completed CPE credit electronically.

Pharmacy/Drug Distributor Renewals

Pharmacy and drug distributor renewals will be mailed in July. Renewals will be mailed to the official **mailing address** designated with the Board. Avoid renewal delays by updating your mailing address with the Board now. **Note: An official change of address application must be filed if the pharmacy's/distributorship's physical address has changed.**

Verify Technician Licensure Status

Pharmacy technician registration will end on May 31. Technicians not renewed by May 31, **are not authorized to work**. Licensees should check the Board's Web site on June 1, to ensure your technicians have been validly renewed.

Additionally, the Board regularly publishes the following lists, which contain additional information on pharmacy technicians prohibited or restricted from working:

- ◆ **Employment Disqualification List:** Includes technicians that have been disqualified from working in Missouri. Individuals on the **Employment Disqualification List** are **prohibited** from working as a Missouri pharmacy technician.
- ◆ **Conditional Registration List:** Identifies individuals with restricted technician registrations. Conditionally registered technicians **are authorized to work** in Missouri subject to the terms and conditions designated by the Board. An abbreviated listing of technician conditional terms/conditions may be found on the back of the technician's conditional registration.
- ◆ **"HB 600" List:** Includes technicians/pharmacists that have been suspended for tax purposes. Individuals on the HB 600 list are **prohibited** from working as a technician until removed from the list.

The technician lists are available on the [Board's Web site](#) and are frequently updated. The Board also sends out electronic alerts (e-alerts) when names are added to the list. Licensees should establish procedures for regularly checking the technician listings to ensure pharmacy staff are appropriately authorized to work. Sign up for e-alerts [here](#) or on the Board's Web site.

Gold Certificates

The following pharmacists will receive gold certificates in honor of maintaining a license with the Board for 50 years. Each gold certificate is signed by the Board president, all Board members, and the executive director, and is accompanied by a letter of congratulations from the Board. Congratulations to those who have served the public for 50 years as a pharmacist!

Bailin, Richard I.	St Louis	MO
Barbieri, Samuel J.	Arma	KS
Baur, Ronald K.	Frontenac	MO

Blitstein, Raymond E.	Centennial	CO
Bodner, Jr, Andrew	Prairie Village	KS
Bolen, Roy A.	Clever	MO
Burns, Frank R.	Leavenworth	KS
Coleman, Thomas E.	Ballwin	MO
Cusick, Timothy J.	St Louis	MO
Davis, David E.	St Charles	MO
Depriest, Robert A.	O' Fallon	MO
Doering, Kenneth W.	Arnold	MO
Gerstein, A. N.	Ballwin	MO
Gordon, Allen J.	Hermosa Beach	CA
Gruver, Jay S.	Platte City	MO
Guth, Jr, Lloyd W.	Cape Girardeau	MO
Hanneke, Betty S.	Webster Groves	MO
Hendrickson, James L.	Cape Girardeau	MO
Henson, Dennis D.	Clarksville	TN
Hillestad, Mary L.	Columbia	IL
Horton, Ralph G.	Fenton	MO
Hughes, Ann A.	St Charles	MO
Ingram, Lois M.	Warrenton	MO
Karch, Larry L.	San Diego	CA
Klostermann, Roy J.	Chesterfield	MO
Kube, Joseph E.	Florissant	MO
Leodler, Peter M.	Quitman	TX
Link, Larry A.	Camdenton	MO
Lo Grasso, Pete A.	St Charles	MO
Morgan, Robert N.	St Louis	MO
Mulik, Charles A.	Neosho	MO
Pescetto, Charles F.	Kansas City	MO
Saufnauer, James A.	Ellisville	MO
Schlozman, Harold S.	Leawood	KS
Schoeneck, Thomas J.	St Joseph	MO
Shannon, John T.	Eureka	MO
Shark, Francis E.	Florissant	MO
Sherman, Ronald T.	Parker	CO
Shiple, Robert J.	St Charles	MO
Streib, Phillip L.	Black	MO
Stuckmeyer, Donald V.	St Louis	MO
Tuley, Joseph M.	Fenton	MO
Tzinberg, Leslie	St Louis	MO
Urban, George	Port Barrington	IL
Wuenschel, William F.	Rolla	MO
Zimmerman, Peter A.	Ballwin	MO

New Disciplinary Actions

Pharmacists

Casey, Lauren S., #2008027465 – Raymore, MO. Suspension for thirty (30) days followed by three (3) years probation. Filled and dispensed fraudulent CS prescriptions for personal consumption. Section 338.055.2(5), (13), (15), and (17), RSMo.

Brad M. Conley, #2008029245 – Fulton, MO. Voluntary surrender and cannot reapply for three (3) years. Viola-

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tion of discipline involving failure to provide copy of discipline order to employer; failure to submit compliance reports; failure to comply with drug testing program requirements; submitted diluted urine samples; failure to comply with alcohol/drug abuse treatment program requirements; and worked as a pharmacist-in-charge (PIC) without prior approval of the Board.

Peter A. Forrester, #2013002238 – Shawnee, KS. Restricted license issued on probation for five (5) years. Disciplinary action in other states involving prescription refills for CS without authorization and failure to maintain required records. Section 338.055.2(8) and (15), RSMo.

Mary R. Richardson, #029924 – Kansas City, MO. Suspension for six (6) months followed by five (5) years probation. As PIC, misappropriated CS from employer for personal consumption; violated Kansas disciplinary order. Section 338.055.2(13), (15), and (17), RSMo.

Timothy E. Thompson, #2011032868 – Rogersville, MO. Suspension for ninety (90) days followed by five (5) years probation. While PIC, misappropriated CS for personal consumption; pled guilty to misdemeanor driving while intoxicated – alcohol. Section 338.055.2(1), (2), (5), (13), (15), and (17), RSMo.

Huong N. Tran, #2013003613 – St Louis, MO. Restricted license issued on probation for three (3) years. Disciplinary action in other states involving fraudulently obtaining dangerous drugs and pled *nolo contendere* to misdemeanor theft. Section 338.055.2(8) and (15), RSMo.

Pharmacies

Advantage Pharmacy, LLC, #2013005750 – Hattiesburg, MS. Restricted pharmacy permit issued on probation until May 17, 2014. Disciplinary action in another state involving record keeping of CS. The records disclosed a CS shortage of 165,000 tablets of hydrocodone and more than 21,000 doses of alprazolam. Section 338.055.2(8), RSMo.

CVS Pharmacy #8559, #2006015499 – Kansas City, MO. Voluntary surrender of permit. CS losses; failed to maintain adequate security to deter theft of drugs by personnel. Section 338.055.2(5), (6), (13), and (15), RSMo.

Drug Distributors

Cargo Largo, #2012019126 – Kansas City, MO. Restricted license issued on probation for two (2) years. Operated without a valid drug distributor license. Section 338.055.2(6), RSMo.

Quick Care Oxygen System, #2012037544 – Chesterfield, MO. Restricted license issued on probation for four (4) years. Operated as a drug distributor without a license. Section 338.055.2(6), RSMo.

Patient Safety

Visit the Board's Web site for additional information on the **MoSaferX** patient safety initiative. Help us ensure **Safe Practice, Safe Patients, and a Safe Missouri.**



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