



# Missouri Board of Pharmacy

*Published to promote compliance of pharmacy and drug law*

PO Box 625 • Jefferson City, MO 65102 • Web site: <http://pr.mo.gov/pharmacists.asp>

## New Emergency Dispensing Legislation

During the 2013 legislative session, the Missouri General Assembly enacted §338.200, which authorizes a Missouri pharmacist to dispense an emergency supply of medication if the pharmacist is unable to obtain refill authorization from the prescriber.

Under the new legislation, pharmacists may dispense an emergency supply if:

- ◆ In the pharmacist's professional judgment, interruption of therapy might reasonably produce undesirable consequences;
- ◆ The pharmacy previously dispensed or refilled a prescription from the applicable prescriber for the same patient and medication;
- ◆ The pharmacist informs the patient or the patient's agent at the time of dispensing that prescriber authorization is required for future refills. Notification can be made verbally, electronically, or in writing; and
- ◆ The emergency dispensing is documented in the patient's prescription record.

The amount dispensed must be limited to the amount needed for the emergency period as determined by the pharmacist within his or her professional judgment, provided the amount dispensed **shall not exceed a seven-day supply**. If the prescriber is deceased, incapacitated, or unable to provide medical services, **up to a 30-day supply** may be dispensed.

The Missouri Board of Pharmacy recognizes that certain medications are dispensed in manufacturer packaging that exceed a seven-day supply. However, §338.200.2 provides "the amount dispensed shall . . . not exceed a seven day supply" if the prescriber is not deceased or otherwise incapacitated. The Board recommends that pharmacists use their professional judgment as needed for the emergency period and to consult with your legal counsel in such circumstances.

The new legislation became effective on August 28, 2013, and is available online at [www.house.mo.gov/billtracking/bills131/billpdf/truly/HB0315T.PDF](http://www.house.mo.gov/billtracking/bills131/billpdf/truly/HB0315T.PDF). Licensees should read the statute in its entirety to ensure compliance.

## Lunch With the Chief!

The Board is sponsoring a new series of Webinars entitled "Lunch with the Chief" hosted by Chief Inspector Tom Glenski, RPh. Webinars will be held from noon to 1 PM. Chief Inspector Glenski will discuss current Board topics and answer related questions. Webinars are currently scheduled on the following dates:

- ◆ January 15, 2014
- ◆ April 8, 2014
- ◆ July 17, 2014
- ◆ October 15, 2014

Webinars are **free** and eligible for **one hour of continuing education (CE)** credit. Mark your calendars! Webinar registration will open on the Board's Web site two weeks prior to the scheduled date.

## They Have Moved!

The Board's pharmacist and intern licensing rules have been moved to 20 CSR 2220, Chapter 7. The revised rules have been updated to simplify the licensing process and are available online at [www.sos.mo.gov/adrules/csr/current/20csr/20c2220-7.pdf](http://www.sos.mo.gov/adrules/csr/current/20csr/20c2220-7.pdf).

## Board Inspectors

The Board recently welcomed three new inspectors. Contact information and county assignments for all inspectors are listed below.

Tom Glenski, RPh (Chief Inspector)	Davies, Dekalb, Gentry, Grundy, Harrison, Livingston, Mercer, Putnam, Sullivan, Worth	660/535-4374 <a href="mailto:tom.glenski@pr.mo.gov">tom.glenski@pr.mo.gov</a>
Bennie Dean, RPh	Clark, Knox, Lewis, Lincoln, Marion, Pike, Ralls, Scotland, Shelby, St Louis City,* St Louis County*	314/995-9739 <a href="mailto:bennie.dean@pr.mo.gov">bennie.dean@pr.mo.gov</a>

*continued on page 4*



## Enteric-Coated Aspirin Recalled for Potential Acetaminophen Mix-Up

In June 2013, Advance Pharmaceutical Inc initiated a voluntary recall of Rugby Laboratories label enteric-coated aspirin tablets, 81 mg (Lot 13A026; expiration date: January 2015) due to a complaint that a bottle labeled with this product name actually contained acetaminophen 500 mg tablets. This over-the-counter (OTC) product is packaged in bottles of 120 tablets with National Drug Code 0536-3086-41 and Universal Product Code 3 0536-3086-41 9. The affected lot was distributed nationwide by Rugby Laboratories to wholesalers and retailers. The manufacturer warns that inadvertently taking acetaminophen, 500 mg, instead of enteric coated aspirin, 81 mg, according to the directions on the label, can lead to an acetaminophen overdose and potential severe liver damage. The manufacturer indicates that consumers who take the dosage as indicated on the defective product labeling may be ingesting up to 24,000 mg of acetaminophen, which is about six times the maximum recommended daily dose of acetaminophen (4,000 mg).

Consumers who have bottles from the affected lot should stop using the product and return it to the pharmacy or store where it was purchased and should contact a health care provider if they are experiencing any problems that may be related to using the product. Food and Drug Administration (FDA) notes that any adverse reactions related to the use of the product should be reported to FDA's MedWatch Program. More information about this recall is available on the FDA Web site at [www.fda.gov/Safety/Recalls/ucm357909](http://www.fda.gov/Safety/Recalls/ucm357909).

## Barcoding Technology for Community Pharmacy

**ISMP**  
INSTITUTE FOR SAFE MEDICATION PRACTICES

*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](http://www.ismp.org). ISMP is a federally certified patient safety organization, providing legal protection and confidentiality for submitted patient safety data and error reports. ISMP is also an FDA MedWatch partner. Call 1-800/FAIL-SAF(E) to report medication errors to the ISMP Medication Errors Reporting Program or report online at [www.ismp.org](http://www.ismp.org). ISMP address: 200 Lakeside Dr, Suite 200, Horsham, PA 19044. Phone: 215/947-7797. E-mail: [ismpinfo@ismp.org](mailto:ismpinfo@ismp.org).*

Barcoding technology is well-established in industries outside of the health care sector and is now being used within health care to enhance efficiency and safety, and in pharmaceutical wholesale operations to improve supply chain inventory and efficiency. Numerous studies prove the effectiveness and cost benefits of using barcoding technology during the drug dispensing process. About 75% of wrong drug or wrong dose errors are captured and corrected using barcode technology<sup>1</sup> and there is sufficient evidence that barcode scanning is becoming the standard of practice in pharmacies.

Although barcoding technology is mature with abundant evidence regarding its effectiveness, a 2006<sup>2</sup> study showed that only half (53.5%) of United States community pharmacies utilize a barcode scanner for verification/identification of medications. The study also

revealed significantly lower adoption in independent pharmacies (11.5%) compared to chain pharmacies (62.6%).

According to a survey conducted by ISMP in 2009, the most frequently reported reasons for implementing barcode scanning for product verification included a desire to improve the accuracy and safety of the dispensing process, the ease with which the technology fits with pharmacy workflow, improvement of staff efficiency and inventory control, and a belief that the technology was necessary to stay in business. The most common reasons for **not** implementing barcode scanning for product verification, other than cost, included uncertainty regarding the "right" vendor product, satisfaction with the current system (without barcode product verification), and perceptions that the technology would reduce staff efficiency.

ISMP has developed a tool, Assessing Barcode Verification System Readiness in Community Pharmacies, to help address the reasons why barcode scanning has not been implemented and to facilitate the adoption of this technology in an estimated 27,327 community pharmacies that do not currently utilize it for product verification.

Given the resource commitment to purchase barcoding systems and the potential for technology to have a profound effect upon the work environment, this tool will help community pharmacy managers and owners better understand the issues related to barcode product verification systems. It will also help managers assess the pharmacy's readiness for the technology, prepare for the selection of a system, and implement the technology effectively.

Barcode scanning to verify prescription products prior to dispensing improves the safety and quality of pharmacy care provided to patients and increases efficiency during the provision of pharmacy services. Although technology should not be seen as a panacea, it can be a useful tool when used appropriately and combined with other patient safety strategies.<sup>3</sup> Does your pharmacy use barcode technology for product verification? If not, please access this free tool, at [www.ismp.org/AHRQ/Default.asp?link=sa](http://www.ismp.org/AHRQ/Default.asp?link=sa).

<sup>1</sup>Cochran GL, Jones KJ, Brockman J, Skinner A, et al. "Errors prevented by and associated with barcode medication systems." *Joint Comm J Qual Pt Safety*. 2007;33(5):293-301.

Ukens C. "New study sheds light on medication errors." *Drug Topics*. 2002;146(21):33.

<sup>2</sup>Skrepnek GH, Armstrong EP, Malone DC, Abarca J, et al. "Workload and availability of technology in metropolitan community pharmacies." *J Amer Pharm Assoc*. 2006; 46(2):154-160.

<sup>3</sup>American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices. "Pathways for medication safety: assessing bedside bar-coding readiness." 2002. Accessed on October 15, 2010 at: [www.ismp.org/selfassessments/PathwaySection3.pdf](http://www.ismp.org/selfassessments/PathwaySection3.pdf).

## ISMP Launches Medication Safety Alert! Newsletter Tailored for LTCFs

ISMP has launched a new *ISMP Medication Safety Alert!* publication, *Long-Term Care Advise-ERR*, as a means to provide medication error prevention information tailored to assist staff and providers in long-term care facilities (LTCFs).

With *ISMP Medication Safety Alert!* publications making a significant impact on preventing medication errors, ISMP is now providing this new resource tailored to LTCFs. ISMP notes that medication errors reported to ISMP Medication Errors Reporting Program include reports from LTCFs. More information and a link to subscribe to this new publication are available in the Newsletters section of the ISMP Web site at [www.ismp.org/newsletters/longtermcare](http://www.ismp.org/newsletters/longtermcare).



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

## **FDA Warns of Rare Skin Reactions in Patients Taking Acetaminophen**

FDA has issued a consumer update that warns of rare but serious skin reactions that may occur in patients taking acetaminophen. These complications include three serious skin reactions: Stevens-Johnson Syndrome (SJS), toxic epidermal necrolysis (TEN), and acute generalized exanthematous pustulosis (AGEP). SJS and TEN can both be fatal, and usually require hospitalization. Patients suffering from AGEP commonly recover within a few weeks after they stop taking the medication that caused the reaction.

Symptoms of these conditions include skin rashes, blisters, and widespread damage to the surface of the skin. Patients taking acetaminophen or other compounds that contain acetaminophen should be advised to stop taking the medication if they experience such symptoms and should consult their health care providers or seek an emergency department immediately.

FDA emphasizes that this information should be viewed within the context of millions of patients who, over generations, have used and benefited from acetaminophen and stresses that severe allergic skin reactions are an extremely rare condition. Further, the agency notes that many medications can cause allergic reactions, and skin allergy warnings have already been added to the drug labels of other categories of OTC analgesics including ibuprofen and naproxen. "This new information is not intended to worry consumers or health care professionals, nor is it meant to encourage them to use other medications," said Sharon Hertz, MD, deputy director of FDA's Division of Anesthesia, Analgesia, and Addiction Products. "However, it is extremely important that people recognize and react quickly to the initial symptoms of these rare but serious side effects, which are potentially fatal." The full consumer update is available on the FDA Web site at [www.fda.gov/ForConsumers/ConsumerUpdates/ucm363010.htm](http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm363010.htm).

## **Reminder to Purchase Drugs Only from Licensed Wholesalers, Including VAWD-Accredited Wholesale Distributors**

To ensure that patients are receiving safe, FDA-approved medications, pharmacists and other health care providers should purchase prescription drugs either directly from the manufacturer or from wholesale drug distributors licensed in the US as advised by FDA. The agency provides a list of state agencies for assistance in verifying licensure at [www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm281446.htm](http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/ucm281446.htm).

Another way that pharmacies can be assured of the legitimacy of a wholesale distributor is to look for the National Association of Boards of Pharmacy® (NABP®) Verified-Accredited Wholesale Distributors® (VAWD®) Seal. Those wholesale distributors that achieve VAWD accreditation are in compliance with state and federal laws and NABP's VAWD criteria. NABP has recently revised the VAWD criteria to allow virtual manufacturers and virtual wholesale distributors – a growing segment of the pharmaceutical wholesale industry – to qualify for VAWD, as well as to implement other changes aimed to help to ensure that the drug supply chain remains secure.

The revised VAWD criteria responds to changing business models and helps safeguard drugs in distribution at a time when there is an increased risk of counterfeit and substandard drugs entering the legitimate US drug supply chain. In particular, the criteria have been revised

to provide stronger assurance that drugs diverted from pharmacies and unlawful sources are prevented from entering into the supply chain.

For a listing of VAWD-accredited facilities, please visit [www.nabp.net/programs/accreditation/vawd](http://www.nabp.net/programs/accreditation/vawd).

## **Voluntary Recall of Unexpired Sterile Products After Reports of Adverse Events**

FDA has announced a voluntary recall of all lots of unexpired sterile products produced by Specialty Compounding, LLC, in Cedar Park, TX. FDA received reports of 15 adverse events at two hospitals (Corpus Christi Medical Center Doctors Regional and Corpus Christi Medical Center Bay Area) potentially related to the use of these sterile products. Affected patients received an intravenous infusion of calcium gluconate supplied by the company.

Patients who were administered the injectable drug products are at risk of life-threatening infections. The recall applies to all unexpired sterile compounded medications dispensed by the company, including all strengths and dosage forms. Recalled products were distributed directly to hospitals and physicians' offices in Texas, and to patients located nationwide (with the exception of North Carolina). No calcium gluconate was shipped outside the state of Texas. Health care providers and patients should stop using all recalled products and return them to Specialty Compounding.

## **Veterinarians Not Eligible for NPIs, CMS Clarifies**

Centers for Medicare and Medicaid Services (CMS) has become aware of cases in which veterinarians are told, incorrectly, that they must provide a National Provider Identifier (NPI) number for prescriptions they have written to be dispensed. The agency has issued a clarification, stressing that veterinarians do not meet the regulatory definition of "health care provider," and thus may not obtain NPI numbers. The clarification also states that "Any entity that insists veterinarians obtain an NPI [is] attempting to require veterinarians to obtain NPIs fraudulently." CMS also notes that "if a veterinarian fulfills the definition of 'health care provider' in a profession other than furnishing veterinary services," such as if they are also a nurse practitioner, "the veterinarian would be eligible for an NPI but would select a Nurse Practitioner code (not a Veterinarian code) from the Healthcare Provider Taxonomy Code Set when applying for an NPI."



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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 a National Association of Boards of Pharmacy® (NABP®) e-Profile ID number and date of birth (MMDD) in order to process ACPE-accredited CPE credit.

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\*County/city is shared by multiple inspectors. Visit the Board's Web site for zip code assignment listings at <http://pr.mo.gov/boards/pharmacy/Inspectors.pdf>.

### **CE for Board Meeting Attendance**

As part of the recent revision of the Board's licensing rules, licensees can now earn CE credit for attending a complete open session meeting of the Board (See 20 CSR 2220-7.080(7)). Licensees may earn up to four hours for each open session meeting with a maximum of eight hours of CE credit each biennial pharmacist renewal period. Stay informed and earn free CE! Visit the Board's Web site for future meeting dates and times at <http://pr.mo.gov/pharmacists-meetings.asp>.

### **Inspection Tips**

In certain instances, Board regulations require the assigning of an expiration date of the lessor of one year or the manufacturer's original expiration date (20 CSR 2220-2.140, 20 CSR 2220-3.040). When assigning an expiration date to a drug product repackaged on October 15, 2013, the one-year expiration date would be October 14, 2014. The expiration date would not be "10/14," which implies the product expires on October 31, 2014. Pharmacists-in-charge should educate the pharmacy's staff about the importance of assigning the correct expiration date.

### **New Disciplinary Actions Pharmacists**

**Faerber, Ronald E., #029075**, Columbia, MO. Public Censure. Failed to sign immunization protocol and to submit a notification of intent to the Board prior to administering vaccines. Section 338.055.2(15), RSMo.

**Robinson, Adrian D., #2001000225**, Lenexa, KS. Public Censure. Failed to sign immunization protocol and to submit a notification of intent to the Board prior to administering vaccines. Section 338.055.2(5), (6), (13), and (15), RSMo.

**Sullivan, Sherri D., #044189**, Columbia, MO. Public Censure. Failed to sign immunization protocol and to submit a notification of intent to the Board prior to administering vaccines. Section 338.055.2(15), RSMo.