

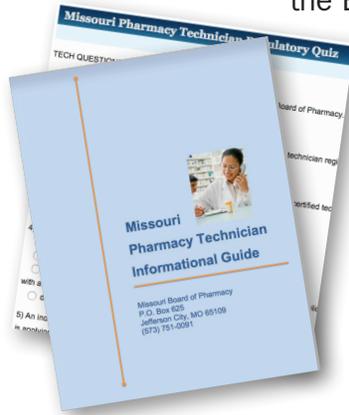


New pharmacy tech resources

As part of its ongoing effort to increase compliance, the Board has issued a new Pharmacy Technician Guide. The Guide contains important compliance information for new and current technicians and addresses topics such as:

- Applying for a technician registration.
- Authorized technician activities.
- Recognizing prescription fraud.
- Top technician compliance violations.
- Patient confidentiality.

To complement the Technician Guide,



the Board has also released an online Pharmacy Technician Compliance Quiz. The 30-question Quiz tests a technician's knowledge of basic Missouri compliance requirements. It is free and may be completed anonymously on the Board's website.

A final score report is provided at the end of the Quiz along with an explanation of any incorrect answers.

The Guide and Quiz are available at pr.mo.gov/pharmacists.asp.

It's renewal time for technicians

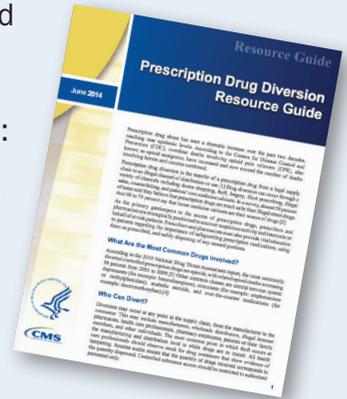
Pharmacy technician renewal information will be mailed March 1. To prevent delay, address changes should be submitted to the Board as soon as possible.

Submit them online or fax them to 573-526-3464.

CMS drug diversion resource guide online

The Centers for Medicare & Medicaid Services' most recent **Prescription Drug Diversion Resource Guide** is available online. Find information on:

- The most common drugs involved.
- Common drug-seeking behaviors.
- Spotting fraudulent prescriptions.
- Submitting Medicaid diversion reports.

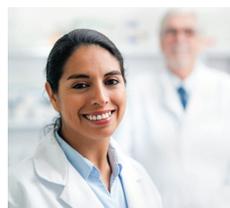


Produced by the Missouri Department of Insurance, Financial Institutions & Professional Registration

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Processing prescriptions with incorrect prescriber information

The Board receives complaints from prescribers about pharmacies processing prescriptions with incorrect prescriber information.

This incorrect data has caused prescribers to receive erroneous drug utilization review letters from insurance and state programs, inappropriate pharmacy refill requests and, in one case, a physician being told the pharmacy would be reporting them to the DEA for failure to supply an emergency Schedule II hard copy within seven days.

Besides causing the prescriber undue hassle and stress, the incorrect data in a pharmacy's computer system may be considered a violation of pharmacy record keeping/labeling requirements and patient confidentiality/HIPAA regulations when patient information is released to a non-treating provider.

Pharmacists-in-charge should review pharmacy procedures and educate staff, including data entry technicians, to ensure the correct information is being processed.

Board investigations into these complaints reveal the pharmacy may have chosen the incorrect prescriber or the pharmacy's computer system has incorrect NPI/DEA data. Some of the causes have been:

- Data entry error when entering the prescription.
- Physicians with the same names.
- Inability to decipher the prescriber's signature.
- Reliance on prescriber databases that had incorrect information.
- Pharmacy staff updating a prescriber's information file with wrong NPI/DEA number.
- Forwarding an existing prescription in a computer system when a new prescription was received without verifying/changing the prescriber.
- Reliance on long-term care facility correspondence for the correct prescriber information.

Verifying pharmacists are responsible for ensuring accurate prescription and data information. This includes ensuring the correct prescriber is identified on the prescription label and entered into the pharmacy's record keeping system.



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New year, new certification required for regulated sellers of SLCPs

Under the federal Combat Methamphetamine Epidemic Act (CMEA), an **annual** self-certification must be filed with the Drug Enforcement Administration by all regulated sellers of scheduled listed chemical products (SLCPs) such as ephedrine, pseudoephedrine and phenylpropanolamine.

In self-certifying, the regulated seller must confirm that:

- The employees who will be selling SLCPs have undergone the required CMEA training.
- Training records are maintained.
- Sales to individuals do not exceed 3.6 grams of ephedrine, pseudoephedrine or phenylpropanolamine per day.
- SLCPs are stored behind the counter or in a locked cabinet.

- Nonliquid forms are packaged as required.
- A written or electronic logbook containing the required information on sales of these products is properly maintained.
- The logbook information will be disclosed only to federal, state or local law enforcement and only to ensure compliance with Title 21 of the U.S. Code or to facilitate a product recall.

A regulated seller is prohibited from selling SLCPs unless it has self-certified with the DEA. Self-certifications may be submitted through the **DEA Diversion website**. You will be able to print your compliance certificate after it has been submitted online.

Board inspectors will ask for proof of the pharmacy's self-certification during an inspection. **Remember, this is an annual requirement and not a one-time event.**

Save the date **April 14** Lunch with the Chief

The next "Lunch with the Chief Inspector" webinar will be April 14 from noon to 1 p.m. Webinars are free and eligible for one hour of continuing education. Topic areas will be announced later. Mark your calendars now. Webinar registration opens about two weeks before the registration date. Watch the Board's email alerts for registration details.

Mark your calendars for these upcoming webinar dates:

- **July 16**
- **October 13**

Have a suggestion for a webinar topic? Email your ideas to compliance@pr.mo.gov.

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Letters mailed to licensees randomly selected for CE audit

Letters have been mailed to all licensees randomly selected for the continuing education (CE) audit for the 2012-2014 pharmacist renewal period.

- Audited licensees must submit proof of 30 CE hours earned between Sept. 1, 2012, and Oct. 31, 2014.
- Except for college credits, which are addressed below, CE must have been earned from an ACPE-accredited provider or previously approved by the Board. Non-ACPE continuing education hours not pre-approved by the Board cannot be accepted. **This includes continuing medical education (CME) hours. CME hours cannot be used unless the program was approved in advance by the Board.**
- Licensees must submit a copy of their actual CE certificates **or** an official CE report/printout from the CPE monitor administered by the National Association of Boards of Pharmacy (NABP).
- CE certificates must show the pharmacist's name, name and date of program, number of CE hours/units earned and provider's name.
- CPE monitor reports should show the licensee's name and hours earned during the audit period (Sept. 1, 2012, to Oct. 31, 2014).
Note: The CPE monitor was implemented by NABP in the middle of the 2012-2014

renewal period and may not include CE earned prior to the implementation date. Licensees should verify the accuracy of hours and submit supplemental proof of CE hours, if necessary.

- **CE for college credits: 20 CSR 2220-7.080(6)** allows CE credit for college credits earned at an accredited pharmacy, medical or dental educational institution of higher learning. The college credit must be related to the practice of pharmacy and must have been earned during the CE renewal period (Sept. 1, 2012, to Oct. 31, 2014). **See the regulation for specific details.** Licensees should submit a transcript or other official documentation from the school showing the course and program name, date and semester completed, and grade earned (if applicable).
- Licensees who do **not** have the required 30 CE hours must pay the **\$1,000 delinquent CE fee**. Checks or money orders should be made payable to the Missouri Board of Pharmacy and mailed to:

Missouri Board of Pharmacy
P.O. Box 625
Jefferson City, MO 65102

The delinquent CE fee is mandatory under state law and cannot be waived.

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System-based causes of vaccine errors

This column was prepared by the Institute for Safe Medication Practices. ISMP is an independent nonprofit agency and federally certified patient safety organization that analyzes medication errors, near misses, and potentially hazardous conditions as reported by pharmacists and other practitioners. ISMP then makes appropriate contacts with companies and regulators, gathers expert opinion about prevention measures, and publishes its recommendations.



To read about the risk reduction strategies that you can put into practice today, subscribe to ISMP Medication Safety Alert!® Community/Ambulatory

Care Edition by visiting www.ismp.org. ISMP provides legal protection and confidentiality for submitted patient safety data and error reports. Help others by reporting actual and potential medication errors to the **ISMP National Medication Errors Reporting Program Report**. Email: ismpinfo@ismp.org.

Immunizations are widely recognized as one of the most successful and cost-effective health interventions ever introduced worldwide. However, errors with vaccines can result in an unintended and unrecognized source of vulnerability.



In September 2012, ISMP (in cooperation with the California Department of Public Health) established the ISMP National Vaccine Errors Reporting Program (VERP) to collect data about the type of vaccine errors occurring and the reasons they occur. In **ISMP's November 28, 2013, newsletter**, ISMP provided a summary analysis of error reports submitted to the

While the immediate impact of a vaccine-related error on a patient may not be serious, such errors may render the vaccine ineffective or reduce its effectiveness, leaving patients unprotected against serious diseases such as hepatitis A, hepatitis B, diphtheria, tetanus, measles, cervical cancer, and many others.

ISMP VERP during its first year.

The vaccinations that are most frequently associated with errors included:

- Haemophilus influenzae type b conjugate (Hib);

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System-based causes of vaccine errors:

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- Diphtheria and tetanus toxoids, acellular pertussis adsorbed, and inactivated poliovirus (DTaP-IPV);
- Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis adsorbed (Tdap);
- Diphtheria, tetanus toxoid, and acellular pertussis adsorbed (DTaP);
- Hepatitis A (HepA);
- Hepatitis B (HepB);
- Human papillomavirus quadrivalent (types 6, 11, 16, and 18), recombinant (HPV4);
- Zoster; and
- Measles, mumps, rubella, and varicella (MMRV).

The most common contributing factors associated with the reported vaccine errors included:

- Mistakes in choosing age-dependent formulations of vaccines intended to prevent the same diseases;
- Unfamiliarity with the vaccine, particularly its dose, dosing schedule, age specifications, route of administration, and the vaccine's various components (e.g., combination vaccines, diluents, and powder);
- Failure to check or verify the patient's age, health record, or state registry;
- Similar vaccine names and abbreviations;
- Similar and confusing vaccine labeling and packaging;
- Unsafe storage conditions (e.g., stored near other similar vaccines or unwanted temperature fluctuations); and
- Expiration dates not noticed or misunderstood.

Practice recommendations

Involve the patient or parent(s)/caregiver(s) in a vaccine verification process by:

1. Documenting the vaccine name, formulation (pediatric or adult, if applicable), lot number, and expiration date on the patient's vaccine record **prior to** preparation/administration of the vaccine,
2. Bringing the vial and syringe or the prefilled syringe along with the immunization record into the exam room,
3. Asking the patient or parent/caregiver to simultaneously verify the information on the immunization record while a health care provider reads the information on the label aloud,
4. Asking the patient or parent/caregiver if the verified vaccine is what he or she expected to be administered (based on an immunization schedule provided to the patient or parent/caregiver previously),
5. Preparing and administering the vaccine immediately after verification, and
6. Documenting the vaccine on the patient's medical record.

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FDA warns of growing network of rogue wholesale drug distributors

Through a new educational program called **Know Your Source**, Food and Drug Administration is warning pharmacists and other health care providers to watch for counterfeit and unapproved drugs.

Aimed at protecting patients from unsafe and ineffective drugs, the program advises providers to only purchase drugs from wholesale drug distributors licensed in their state. Further, FDA offers tips to providers to protect patients, including being wary of offers too good to be true, and ensuring that all drugs received are FDA-approved medications.

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, as well as NABP’s VAWD criteria.

Wholesale distributors that display the VAWD Seal as part of their accreditation have undergone a criteria compliance review, including a rigorous review of their operating policies and procedures, licensure verification, survey of facility and operations, background checks, and screening through the NABP Clearinghouse. Accredited facilities are reviewed annually and undergo a site survey every three years. Created in 2004, the accreditation program plays a pivotal role in preventing counterfeit drugs from entering the United States drug supply.

Additional information about the VAWD program is available in the Programs section of the NABP website.

DEA finalizes rule on CS prescription drug disposal

In September 2014, Drug Enforcement Administration (DEA) published its final rule, titled the Disposal of Controlled Substances, that allows some DEA registrants to modify their registration to become authorized collectors.



Under the new rule, some DEA registrants, including retail pharmacies, hospitals/clinics with an on-site pharmacy, manufacturers, distributors, reverse distributors, and narcotic treatment programs, may modify their registration with DEA to become authorized collectors.

The final rule implements the Secure and Responsible Drug Disposal Act of 2010, which authorized DEA to develop and implement regulations that would allow authorized entities other than law enforcement to collect unused and unwanted prescription drugs, including controlled substances (CS), for disposal purposes.

Proper disposal of unused prescription medication is a key method of preventing and reducing prescription drug abuse. The final rule took effect on October 9, 2014.

The full rule is available on the [Federal Register website](#).

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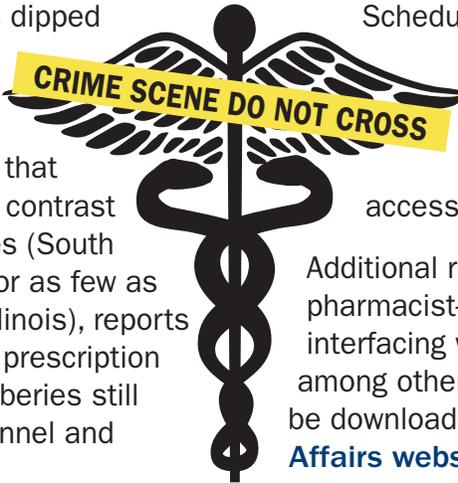
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Security guidelines available as rate of pharmacy robberies still a concern

Nationally, pharmacy robberies dipped slightly from 745 in 2012, to 713 in 2013, according to a report compiled by Drug Topics using DEA statistics. The 10 states that had the most robberies are in stark contrast to other states that had no robberies (South Dakota, North Dakota, and Alaska) or as few as one or two (such as Montana and Illinois), reports Drug Topics. However, fueled by the prescription drug abuse epidemic, pharmacy robberies still pose a threat to the safety of personnel and customers.



Schedule II and III controlled substances be stored in a “safe or substantially constructed steel cabinet that is locked at all times,” with only licensed pharmacists having access.

Additional recommendations include annual pharmacist-in-charge self-assessments and interfacing with prescribers and customers, among others. The best practices document can be downloaded from the [New Jersey Consumer Affairs website](#).

The report lists the top 10 states that had the most pharmacy thefts in 2013. Arizona experienced the most pharmacy robberies in 2013 with 77 incidents, and Indiana took second place with 71 robberies.

The report, titled “Top 10 States for Pharmacy Robberies,” can be found online.

NABP partnered with DEA to create an **educational pamphlet identifying key strategies** pharmacists can take to secure their stores against robberies.

In addition, some boards of pharmacy have identified best practices for preventing pharmacy theft, and have supported these practices through regulations or recommendations for their licensees. For example, the New Jersey State Board of Pharmacy’s Pharmacy Security Best Practices document recommends that all

Private organizations have also developed resources to assist pharmacies in improving security. One such resource is the RxPATROL program, which works with law enforcement, the pharmacy community, and security professionals to maintain a database containing detailed information about pharmacy robberies and other losses. In addition, the **RxPATROL website** provides training videos and a pharmacy security checklist.

Further, NABP members directed the Association to convene a task force to review strategies that states have taken to prevent theft and drug diversion. The Task Force to Examine Strategies for Preventing and Reacting to Pharmacy Robberies and Thefts met on October 22–23, 2014, to discuss these issues.

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PTCB implements changes to CE requirements

In 2015, the Pharmacy Technician Certification Board (PTCB) will implement two changes in recertification requirements for certified pharmacy technicians (CPhTs) in accordance with its certification program changes announced in 2013.

First, any continuing education (CE) hours earned by a CPhT will need to be pharmacy technician-specific in order to qualify toward recertification. Second, PTCB will reduce the number of allowable “in-service” CE hours from 10 to five. PTCB’s certification program changes are intended to support and advance improved patient care and safety throughout pharmacy practice, a PTCB press release indicates. The changes are the result of a PTCB initiative that began with a 2011 summit on future directions for pharmacy technicians.

Additional information can be accessed on the [PTCB website](#).

Assured brand naproxen tablets recalled due to packaging error

In October 2014, Contract Packaging Resources of Greensboro, NC, a drug repackaging company, issued a voluntary recall of nearly 12,000 boxes of Assured brand naproxen sodium tablets because some cartons contain bottles of 200 mg ibuprofen softgels instead, a press release posted to the FDA website indicates.

The packaging error affected boxes of Assured brand naproxen sodium tablets 220 mg, 15 count (Lot Number FH4102A), which were distributed to

and sold at Dollar Tree stores and on the Dollar Tree website. Contract Packaging Resources is contacting customers to arrange for replacement of all recalled products. Adverse reactions or quality problems experienced with the use of this product may be reported to FDA’s MedWatch Adverse Event Reporting Program.

More information is available on the [FDA website](#).

Martin Avenue Pharmacy issues voluntary recall for all sterile compounded preparations

Martin Avenue Pharmacy Inc., of Naperville, IL, issued a voluntary recall for all in-date compounded sterile preparations due to a lack of sterility assurance in August 2014. Following a recent FDA inspection that revealed “quality control procedures that present a risk to sterility assurance,” the company issued the recall out of an abundance of caution, indicates a news release posted to the FDA website.

Martin Avenue Pharmacy supplied compounded sterile preparations to offices of licensed medical professionals and individuals in multiple states including Illinois, Wisconsin, Ohio, Michigan, Florida, Alabama and Texas until August 20, 2014.

A full list of recalled products is available on the Martin Avenue Pharmacy website (registration required). FDA urges consumers and health care providers to report adverse events or side effects related to the use of these products to FDA’s MedWatch Safety Information Adverse Event Reporting Program.

More information is available on the [FDA website](#).

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PHARMACISTS

Bruce W. Cameron

License No. 2007036318
Cassville, MO

Voluntary surrender of pharmacist license, cannot reapply for seven years.

Dispensed fraudulent controlled substance prescriptions for himself, and misappropriated controlled substances for himself. Section 338.055.2(5), (13), (15) and (17).

Donald R. Dougan

License No. 042101
Springfield, MO

One-year probation.

As pharmacist-in-charge, removed a return-to-stock bottle from pharmacy that was labeled for a different patient, and diverted a prescription medication without a valid patient-specific prescription. Section 338.055.2(5), (6), (13) and (15).

Robert H. Garrett

License No. 029085
Chesterfield, MO

Voluntary surrender of license, cannot reapply for seven years.

Removed controlled substances from employer pharmacy for himself without a valid, patient-specific prescription and without paying for them. Section 338.055.2(5), (13), (15) and (17).

Catherine Seiler

License No. 040008
Springfield, MO

Voluntary surrender of pharmacist license.

Dispensed legend and controlled substances to herself without valid prescriptions and without paying for them; misbranding. Section 338.055.2(1), (5), (13), (15) and (17).

PHARMACIES

Lexi's Medicine Inc.

Permit No. 2015001480
Winona, MO

Restricted pharmacy permit issued on probation for five years.

President/pharmacist-in-charge of prior permit pleaded guilty to knowingly selling pseudoephedrine at retail without possessing a valid self-certification from the U.S. Attorney General. Section 338.055.2(2) and (15).

Missouri Baptist Sullivan Hospital

Permit No. 005038
Sullivan, MO

Probation for three years with credit given for two years' probation previously served under a BNDD settlement agreement.

Failure to provide adequate security and controls to detect/prevent diversion of controlled substances, and failure to maintain complete, current and accurate controlled substance records. Section 338.055.2(15).

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Uvanta Pharmacy-Southern Missouri

Permit No. 2009000059
Springfield, MO

Censure of permit.

Failed to obtain original, signed CII prescriptions prior to dispensing to patients and OPUS unit dose cassettes dispensed from pharmacy without verification by a pharmacist. Section 338.055.2(6).

Walgreens

Permit No. 004809
St. Louis

Censure of permit.

Losses of controlled substances, security not sufficient to deter drug diversion, and was unable to maintain accurate controlled substance records. Section 338.055.2(6) and (15).

Walgreens #03338

Permit No. 005725
Cape Girardeau, MO

Censure of permit.

Loss of controlled and non-controlled medications, security not sufficient to deter drug diversion, and was unable to maintain accurate controlled substance records. Section 338.055.2(6) and (15).

Walgreens #10153

Permit No. 2006027140
Poplar Bluff, MO

Probation until Aug. 30, 2015.

Employee theft of pseudoephedrine products, losses of controlled substances, security not sufficient to deter drug diversion, unable to maintain accurate controlled substance records. Section 338.055.2(6) and (15).

Walgreens #04970

Permit No. 006515
St. Charles, MO

Probation for one year.

Diversion of controlled substances, security not sufficient to deter drug diversion, unable to maintain accurate controlled substance records. Section 338.055.2(6) and (15).

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ABOUT THE NEWSLETTER

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Jay Nixon, Governor

John M. Huff, DIFP Director

Sherry Hess, Acting Director of Division of Professional Registration

Kimberly Grinston, Newsletter Editor and Board of Pharmacy Executive Director

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CONTACT US Missouri Board of Pharmacy • PO Box 625 • Jefferson City, MO 65109 • 3605 Missouri Blvd.
573-751-0091 **Email the Board of Pharmacy**

