KAMALA D. HARRIS
Attorney General of California
JANICE K. LACHMAN
Supervising Deputy Attorney General
LORRIE M. YOST
Deputy Attorney General
State Bar No. 119088
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-2271
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NORTH HIGHLANDS PHARMACY 5600 Watt Avenue North Highlands, CA 95660 Pharmacy Permit Number PHY 39917 and THOMAS OKIMOTO 5600 Watt Avenue North Highlands, CA 95660 Pharmacist License Number RPH 24559 Respondents.	Case No. 3428 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Virginia Herold (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.

2. On or about August 30, 1994, the Board of Pharmacy (Board) issued Pharmacy Permit Number PHY 39917 to North Highlands Pharmacy; Thomas Okimoto, Pharmacist-In-Charge, (Respondent North Highlands). Thomas Okimoto has been the Pharmacist-In-Charge since

///

August 30, 1994. The pharmacy permit was in full force and effect at all times relevant to the charges brought herein and will expire on August 1, 2012, unless renewed.

3. On or about July 25, 1966, the Board of Pharmacy issued Pharmacist License Number RPH 24559 to Thomas Okimoto (Respondent Okimito). The pharmacist license was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2014, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board of Pharmacy (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

5. Section 4063 of the Code states:

"No prescription for any dangerous drug or dangerous device may be refilled except upon authorization of the prescriber. The authorization may be given orally or at the time of giving the original prescription. No prescription for any dangerous drug that is a controlled substance may be designated refillable as needed."

6. Section 4076 of the Code states in pertinent part:

"(a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(11)(A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules . . . .

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container."

7. Section 4077 of the Code states in pertinent part:

(a) Except as provided in subdivisions (b) and (c), no person shall dispense any dangerous drug upon prescription except in a container correctly labeled with the information required by Section 4076."

8. Section 4081 of the Code states in pertinent part:

"(a) All records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices."

9. Section 4105 of the Code states in pertinent part:

"(a) All records or other documentation of the acquisition and disposition of dangerous drugs and dangerous devices by any entity licensed by the board shall be retained on the licensed premises in a readily retrievable form."

10. Section 4113 of the Code states in pertinent part:

"(c) The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

11. Section 4300 of the Code states in pertinent part:

"(a) Every license issued may be suspended or revoked.

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding one year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper.

"(e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure."

12. Section 4301 of the Code states in pertinent part:

"The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

(j) The violation of any of the statutes of this state, or any other state, or of the United States regulating controlled substances and dangerous drugs.

(o) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate any provision or term of this chapter or of the applicable federal and state laws and regulations governing pharmacy, including regulations established by the board or by any other state or federal regulatory agency."

13. Section 4342 of the Code states in pertinent part:

"(a) The board may institute any action or actions as may be provided by law and that, in its discretion, are necessary, to prevent the sale of pharmaceutical preparations and drugs that do not conform to the standard and tests as to quality and strength, provided in the latest edition of the United States Pharmacopoeia or the National Formulary, or that violate any provision of the Sherman Food, Drug and Cosmetic Law (Part 5 (commencing with Section 109875) of Division 104 of the Health and Safety Code)."

14. California Code of Regulations, Title 16 (16 CCR), section 1714 states in pertinent part:

"(b) Each pharmacy licensed by the board shall maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The pharmacy shall be of sufficient size and unobstructed area to accommodate the safe practice of pharmacy.

(c) The pharmacy and fixtures and equipment shall be maintained in a clean and orderly condition. The pharmacy shall be dry, well-ventilated, free from rodents and insects, and properly lighted. The pharmacy shall be equipped with a sink with hot and cold running water for pharmaceutical purposes."

15. 16 CCR section 1715 states in pertinent part:

"(a) The pharmacist-in-charge of each pharmacy as defined under section 4029 or section 4037 of the Business and Professions Code shall complete a self-assessment of the pharmacy's compliance with federal and state pharmacy law. The assessment shall be performed before July 1 of every odd-numbered year. The primary purpose of the self-assessment is to promote compliance through self-examination and education.

(d) Each self-assessment shall be kept on file in the pharmacy for three years after it is performed."

16. 16 CCR section 1716 states in pertinent part:

"Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code."

17. 16 CCR section 1745 states in pertinent part:

"(a) A prescription for a Schedule II controlled substance (as defined in Health and Safety Code section 11055) may be partially filled, as defined in paragraph (b), if:

(1) The prescription is for an inpatient of a skilled nursing facility as defined in Health and Safety Code section 1250; or

(2) The prescription is for a terminally ill patient. "Terminally ill" as used herein means a patient for whom a licensed physician and surgeon has made and documented a diagnosis of illness or disease that will result in death.

(b) A "partially filled" prescription is a prescription from which only a portion of the amount for which the prescription is written is filled at any one time; provided that regardless of how many times the prescription is partially filled, the total amount dispensed shall not exceed that written on the face of the prescription.

(d) A pharmacist may partially fill a prescription for a controlled substance listed in Schedule II, if the pharmacist is unable to supply the full quantity ordered by the prescriber. The pharmacist shall make a notation of the quantity supplied on the face of the written prescription. The remaining portion of the prescription may be filled within 72 hours of the first partial filling. If the remaining portion is not filled within the 72-hour period, the pharmacist shall notify the prescriber. The pharmacist may not supply the drug after 72 hour period has expired without a new prescription."

18. 16 CCR section 1761 states:

"(a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.

(b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense a controlled substance prescription where the pharmacist knows or has objective reason to know that said prescription was not issued for a legitimate medical purpose."

19. Health and Safety Code section 11165, subdivision (d) provides in pertinent part:

"(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, the dispensing pharmacy or clinic shall provide the following information to the Department of Justice on a weekly basis and in a format specified by the Department of Justice:

(1) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, and federal controlled substance registration number.

(4) NDC (National Drug Code) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) ICD-9 (diagnosis code), if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription."

20. 16 CCR section 1793.7 states in pertinent part:

"(d) Any pharmacy employing or using a pharmacy technician shall develop a job description and written policies and procedures adequate to ensure compliance with the provisions of Article 11 of this Chapter, and shall maintain, for at least three years from the time of making, records adequate to establish compliance with these sections and written policies and procedures."

21. Section 118, subdivision (b), of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

22. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES/DANGEROUS DRUGS AT ISSUE

23. Hydrocodone with acetaminophen (HC/AP) is a pain medication classified as a Schedule III controlled substance pursuant to Health and Safety Code section 11506, subdivision (e)(4), and as a dangerous drug pursuant to Business and Professions Code section 4022.

24. OxyContin contains oxycodone which is an opioid agonist and a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(N), as well as a dangerous drug pursuant to Business and Professions Code section 4022.

25. Fentanyl is a synthetic narcotic analgesic and a Schedule II controlled substance under Health and Safety Code section 11055 subdivision (c)(8), as well as a dangerous drug

pursuant to Business and Professions Code section 4022. The Fentanyl transdermal patch is used in chronic pain management.

FIRST CAUSE FOR DISCIPLINE

(Erroneous Or Uncertain Prescriptions)

26. Respondents Highlands and Okimoto are subject to disciplinary action under 16 CCR section 1761, subdivisions (a) and (b) as that section interacts with Code section 4301, subdivision (o) in that Respondent PIC Okimoto dispensed uncertain or ambiguous prescriptions for a controlled substance when Respondent PIC Okimoto knew or should have known that the prescriptions were not issued for a legitimate medical purpose. The circumstances are as that Respondent PIC Okimoto filled prescriptions for patients who were consuming the prescribed drugs at a rate significantly higher than that which was prescribed and/or the maximum recommended dose, without questioning the medical purpose or directions for proper use of these drugs, as follows:

a. From approximately November 4, 2007 to July 04, 2009, PIC Okimoto furnished 11,727 tablets of HC/AP 10/325 to Patient S.D. The average number of tablets consumed per day was 19.3, approximately 60% more than the 12 tablets a day that had been prescribed by the patient's physician. The daily average of 19 tablets also equaled 6.3 grams of HC/AP per day, approximately 58% more than the maximum recommended dosage.

b. From approximately December 5, 2007 to June 25, 2009, with regard to 17 out of 33 prescriptions, PIC Okimoto furnished 8430 HC/AP 10/325 tablets to Patient L.F. The average number of tablets consumed per day was 14.8, approximately 23% more than the maximum of the 6 to 12 tablets a day that had been prescribed by the patient's physician. Furthermore, with respect to 21 prescriptions filled for Patient LF, the average daily usage of HC/AP 10/325 was 6.2 grams, approximately 55% more than the maximum recommended dosage.

c. From approximately September 26, 2007 to June 23, 2009, PIC Okimoto furnished 48 prescriptions totaling 4,950 HC/AP 10/325 tablets to Patient W.H. The average daily consumption was 7.8 tablets per day, approximately 95% more than the prescribed maximum of 4 tablets a day.

d. From approximately November 20, 2007 to October 23, 2008, PIC Okimoto furnished 25 prescriptions for HC/AP 10/325, a total of 4,340 tablets, to Patient M.W. This averaged 13.2 tablets per day, approximately 10% more than the prescribed 12 tablets a day. This also equaled 4.29 grams of HC/AP 10/325 per day, approximately 7% more than the maximum recommended dosage and 10% more than prescribed.

27. Respondents Highlands and Okimoto are subject to disciplinary action under section 16 CCR section 1761, subdivisions (a) and (b) as that section interacts with Code section 4301, subdivision (o) in that Respondent PIC Okimoto dispensed uncertain or ambiguous prescriptions for a controlled substance when Respondent PIC Okimoto knew or should have known that the prescriptions were not issued for a legitimate medical purpose. The circumstances are as that Respondent PIC Okimoto furnished duplicate prescriptions less than 30 days apart, frequently for two different strengths of HC/AP, to patients who simultaneously held an older refill prescription for HC/AP and a new prescription for HC/AP, without questioning which prescription was the appropriate one, as follows:

a. From approximately January 19, 2007 to November, 15, 2008, PIC Charge Okimoto furnished the following erroneous or uncertain duplicitous prescriptions for HC/AP to Patient LF:

i. On January 19, 2008, PIC Okimoto furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from refill prescription number 1233896, which he should have known to be erroneous or uncertain because on that same day he already furnished to Patient L.F. 360 tablets of HC/AP 10/325 from new prescription number 1236926.

ii. On February 11, 2008, PIC Okimoto furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from refill prescription number 1233896 which he should have known to be erroneous or uncertain because on that same day he already furnished to Patient L.F. 360 tablets of HC/AP 10/325 from refill prescription number 1236926 for 360 tablets of HC/AP 10/325.

iii. On April 24, 2008, PIC Okimoto furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from refill prescription number 1240670, which he should have known to be

erroneous or uncertain because on April 8, 2008, PIC Okimoto had already furnished to Patient L.F. 360 tablets of HC/AP 10/325 from new prescription number 1242692.

iv. On May 16, 2008, PIC Okimoto furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from refill prescription number 1240670, which he should have known to be erroneous or uncertain because on May 5, 2008, PIC Okimoto had already furnished to Patient L.F. 360 tablets of HC/AP 10/325 from new prescription number 1242692.

v. On July 1, 2008, PIC Okimoto furnished to Patient L.F. 360 tablets of HC/AP 10/325 from refill prescription number 1242692, which he should have known to be erroneous or uncertain because on June 24, 2008, he had already furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from new prescription number 1247740.

vi. On August 13, 2008, PIC Okimoto furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from refill prescription number 1247740, which he should have known to be erroneous or uncertain because on July 31, 2008, he had already furnished to Patient L.F. 360 tablets of HC/AP 10/325 from new prescription number 1249897.

vii. On September 12, 2008, PIC Okimoto furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from refill prescription number 1247740, which he should have known to be erroneous or uncertain because on August 30, 2008, he had already furnished to Patient L.F. 360 tablets of HC/AP 10/325 from refill prescription number 1249897.

viii. On October 28, 2008, PIC Okimoto furnished to Patient L.F. 360 tablets of HC/AP 10/325 from refill prescription number 1252983, which he should have known to be erroneous or uncertain because on October 2, 2008, he had already furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from new prescription number 1253608.

///

ix. On November 15, 2008, PIC Okimoto furnished to Patient L.F. 360 tablets of HC/AP 10/325 from refill prescription number 1252983, which he should have known to be erroneous or uncertain because on October 2, 2008, he had already furnished to Patient L.F. 150 tablets of HC/AP 7.5/750 from new prescription number 1253608.

b. From approximately September 26, 2007 to June 23, 2009, PIC Charge Okimoto furnished erroneous or uncertain duplicate prescriptions for HC/AP to Patient W.H. as follows:

i. On October 23, 2007, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325 from refill prescription number 1229475, which he should have known to be erroneous or uncertain because on October 10, 2007, he had already furnished to Patient W.H. 90 tablets of HC/AP 5/325, from new prescription number 1230291.

ii. On November 19, 2007, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325, from refill prescription number 1229475, which he should have known was erroneous or uncertain because on November 08, 2007, he had already furnished to Patient W.H. 90 tablets of HC/AP 5/325, from new prescription number 1230291.

iii. On January 7, 2008, and February 1, 2008, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325 from refill prescription number 1234646, which he should have known to be erroneous or uncertain because on January 3, 2008, he had already furnished to Patient W.H. 90 tablets of HC/AP 5/500 from new prescription number 1235692.

iv. On March 1, 2008, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325, from refill prescription number 1234646, which he should have known was erroneous or uncertain because on February 4, 2008, he had already furnished 90 tablets of HC/AP 5/325 to Patient W.H. from refill prescription number 1235692.

v. On May 5, 2008, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325 from refill prescription number 1234646, which he should have known was

erroneous or uncertain because on April 19, 2008, he had already furnished to Patient W.H. 90 tablets of HC/AP 5/500 from new prescription number 1241891.

vi. On May 30, 2008, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325 from refill prescription number 1234646, which he should have known was erroneous or uncertain because on May 16, 2008, he furnished to Patient W.H. 90 tablets of HC/AP 5/500 from refill prescription number 1241990.

vii. On July 14, 2008, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325 from refill prescription number 1247277, which he should have known was erroneous or uncertain because on June 27, 2008, he had already furnished to Patient W.H. 120 tablets of HC/AP 5/500 from new prescription number 1247972.

viii. On August 20, 2008, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1247972, which he should have known was erroneous or uncertain because on August 5, 2008, he had already furnished to Patient W.H. 90 tablets of HC/AP 5/325 from new prescription number 1250114.

ix. On September 19, 2008, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1247972, which he should have known was erroneous or uncertain because on September 2, 2008, he had already furnished to Patient W.H. 90 tablets from refill prescription number 1250114.

x. On October 13, 2008, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1247972, which he should have known was erroneous or uncertain because on October 1, 2008, he had already furnished to Patient W.H. 90 tablets of HC/AP 5/325 from refill prescription number 1250114.

xi. On December 2, 2008, PIC Okimoto furnished to Patient W.H. 90 tablets of HC/AP 5/325 from refill prescription number 1250114, which he should have known was erroneous or uncertain because on November 17, 2008, furnished to Patient W.H. 90 tablets of HC/AP 5/500 from new prescription number 1256539.

xii. On December 26, 2008, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/325 from refill prescription number 1256159, which he should have known was erroneous or uncertain because on December 09, 2008, he had already furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1256539.

xiii. On January 29, 2009, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/325 from refill prescription number 1256159, which he should have known was erroneous or uncertain because on January 13, 2009, he had already furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1256539.

xiv. On February 23, 2009, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/325 from refill prescription number 1256159, which he should have known was erroneous or uncertain because on February 12, 2009, he had already furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1256539.

xv. On March 20, 2009, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/325 from refill prescription number 1256159, which he should have known was erroneous or uncertain because on March 11, 2009, he had already furnished to Patient W.H. 120 tablets of HC/AP 5/500 from new prescription number 1264414.

xvi. On April 21, 2009, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/325 from refill prescription number 1256159, which he should have known was erroneous or uncertain because on April 7, 2009, he had already furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1264414.

xvii. On May 28, 2009, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1264414, which he should have known was erroneous or uncertain because on May 21, 2009, he had already

furnished to Patient W.H. 120 tablets of HC/AP 5/325 from new prescription number 1268675.

xviii. On June 23, 2009, PIC Okimoto furnished to Patient W.H. 120 tablets of HC/AP 5/500 from refill prescription number 1264414, which he should have known was erroneous or uncertain because on June 18, 2009, he had already furnished to Patient W.H. 120 tablets of HC/AP 5/500 from new prescription number 1271023.

c. From approximately November 3, 2007 to December 23, 2008, PIC Charge Okimoto furnished erroneous or uncertain duplicate prescriptions for HC/AP to Patient K.M. as follows:

i. On January 25, 2008, and on February 18, 2008, PIC Okimoto furnished to Patient K.M. 120 tablets of HC/AP 7.5/750 from refill prescription number 1231591, which he should have known was erroneous or uncertain because on January 15, 2008, he had already furnished to Patient W.H. 360 tablets of HC/AP 5/500 from new prescription number 1236584.

ii. On June 10, 2008, PIC Okimoto furnished to Patient K.M. 360 tablets of HC/AP 10/325 from refill prescription number 1244901, which he should have known was erroneous or uncertain because on June 6, 2008, he had already furnished to Patient K.M. 120 tablets of HC/AP 7.5/700 from new prescription number 1246688 .

iii. On July 10, 2008, PIC Okimoto furnished to Patient K.M. 360 tablets of HC/AP 10/325 from refill prescription number 1244901, which he should have known was erroneous or uncertain because on July 6, 2008, he had already furnished to Patient K.M. 120 tablets of HC/AP 7.5/750 from refill prescription number 1246688.

iv. On August, 9, 2008, PIC Okimoto furnished to Patient K.M. 360 tablets of HC/AP 10/325 from refill prescription number 1244901, which he should have known was erroneous or uncertain because on August 4, 2008, he had already furnished 120 tablets of HC/AP 7.5/750 to Patient K.M. from refill prescription number 1246688.

v. On October 1, 2008, PIC Okimoto furnished to Patient K.M. 120 tablets of HC/AP 7.5/750 from refill prescription number 1246688, which he should have know to be erroneous or uncertain because on September 8, 2008, he had already furnished 360 tablets of HC/AP 10/325 to Patient K.M. from new prescription number 1252056.

vi. On October 1, 2008, PIC Okimoto furnished to Patient K.M. 120 tablets of HC/AP 7.5/750 from refill prescription number 1252056, which he should have know to be erroneous or uncertain because on October 1, 2008, he had already furnished 360 tablets of HC/AP 10/325 to Patient K.M. from new prescription number 1246688.

vii. On October 27, 2008, PIC Okimoto furnished to Patient K.M. 120 tablets of HC/AP 7.5/750 from new prescription number 1255322, which he should have know to be erroneous or uncertain because on October 1, 2008, he had already furnished 360 tablets of HC/AP 10/325 from refill prescription number 1252056.

viii. On October 31, 2008, November 29, 2008, and December 23, 2008, PIC Okimoto furnished to Patient K.M. 360 tablets of HC/AP 10/325 from prescription number 1254729, which he should have know was erroneous or uncertain because on October 27, 2008, he had already furnished to Patient K.M. 120 tablets of HC/AP 7.5/750 from prescription number 1255322.

SECOND CAUSE FOR DISCIPLINE

(Partial Filing of Schedule II Controlled Substances Prescriptions)

28. Respondents Highlands and Okimoto are subject to disciplinary action under 16 CCR section 1745, subdivisions (a) and (d), as that section interacts with Code section 4301, subdivision (o), in that Respondent PIC Okimoto partially filled 22 Schedule II controlled substance prescriptions as described below for patients who were not terminally ill or residing in a skilled nursing facility, despite having sufficient quantities on hand to completely fill the prescription. The partially filled prescriptions are as follows:

///

#	Date Dispensed	RX #	Drug	Patient Initials	Quantity Provided	Authorized Quantity
1	12/19/07	1234891	OxyContin 80 mg.	MW	180	270
2	12/20/07	1234891	OxyContin 80 mg.	MW	90	
3	05/21/08	1245640	OxyContin 80 mg.	DW	100	270
4	05/22/08	1245640	OxyContin 80 mg.	DW	100	
5	05/23/08	1245640	OxyContin 80 mg.	DW	70	
6	07/12/08	1248802	OxyContin 80 mg.	MW	90	270
7	07/13/08	1248802	OxyContin 80 mg.	MW	90	
8	07/14/08	1248802	OxyContin 80 mg.	MW	90	
9	07/14/08	1248905	OxyContin 80 mg.	LF	60	180
10	07/15/08	1248905	OxyContin 80 mg.	LF	60	
11	07/16/08	1248905	OxyContin 80 mg.	LF	60	
12	07/24/08	1249470	OxyContin 40 mg.	LF	60	180
13	07/26/08	1249470	OxyContin 40 mg.	LF	50	
14	08/04/08	1249470	OxyContin 40 mg.	LF	10	
15	08/05/08	1249470	OxyContin 40 mg.	LF	40	
16	08/05/08	1249470	OxyContin 40 mg.	LF	20	
17	08/19/08	1251006	OxyContin 80 mg.	KM	125	180
18	08/25/08	1251006	OxyContin 80 mg.	KM	20	
19	08/25/08	1251006	OxyContin 80 mg.	KM	20	
20	08/26/08	1251006	OxyContin 80 mg.	KM	15	
21	08/23/08	1251253	OxyContin 40 mg.	KM	40	180
22	08/25/08	1251253	OxyContin 40 mg.	KM	20	
23	08/26/08	1251253	OxyContin 40 mg.	KM	75	
24	08/27/08	1251253	OxyContin 40 mg.	KM	45	
25	08/27/08	1251458	OxyContin 40 mg.	LF	15	180
26	08/27/08	1251458	OxyContin 40 mg.	LF	30	
27	08/28/08	1251458	OxyContin 40 mg.	LF	30	
28	08/28/08	1251458	OxyContin 40 mg.	LF	20	

29	09/02/08	1251458	OxyContin 40 mg.	LF	85	
30	08/29/08	1251660	OxyContin 80 mg.	LF	70	180
31	09/02/08	1251660	OxyContin 80 mg.	LF	110	

THIRD CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substances to CURES)

29. Respondents Highlands and Okimoto are subject to disciplinary action under Health and Safety Code section 11165, subdivision (d) as that section interacts with Code section 4301, subdivisions (j) and (o), in that from June 2, 2008 to January 16, 2009, Respondent PIC Okimoto failed to report dispensing 46 controlled substance prescriptions to CURES (Controlled Substance Utilization Review and Evaluation System) as follows:

#	Date Dispensed	RX#	New or Refill	Drug	Patient Initials	Quan -tity
1	06/23/08	1247699	New	Hydrocodone w/Acetaminophen 10/325	DH	30
2	06/25/08	1247699	Refill	Hydrocodone w/Acetaminophen 10/325	DH	30
3	07/11/08	1248768	New	Hydrocodone w/Acetaminophen 10/325	DH	60
4	10/28/08	1252481	New	Hydrocodone w/Acetaminophen 10/325	DH	60
5	07/09/08	1247143	Refill	Hydrocodone w/Acetaminophen 10/325	DW	120
6	07/11/08	1247143	Refill	Hydrocodone w/Acetaminophen 10/325	DW	120
7	07/12/08	1247143	Refill	Hydrocodone w/Acetaminophen 10/325	DW	120
8	06/06/08	1246688	New	Hydrocodone w/Acetaminophen 7.5/750	KM	120
9	07/06/08	1246688	Refill	Hydrocodone w/Acetaminophen 7.5/750	KM	120
10	07/07/08	1248489	New	OxyContin 40 mg.	KM	120
11	07/07/08	1248489	New	OxyContin 40 mg.	KM	60
12	07/10/08	1244901	Refill	Hydrocodone w/Acetaminophen 10/325	KM	360
13	06/02/08	1242692	Refill	Hydrocodone w/Acetaminophen 10/325	LF	360
14	06/04/08	1246585	New	OxyContin 40 mg.	LF	180
15	06/24/08	1247740	New	Hydrocodone w/Acetaminophen 7.5/750	LF	150
16	06/24/08	1247741	New	OxyContin 40 mg.	LF	10
17	06/24/08	1247742	New	Fentanyl 25 mcg. Patch	LF	360

18	01/09/09	1256020	Refill	Hydrocodone w/Acetaminophen 10/325	RR	360
19	06/02/08	1245850	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
20	06/03/08	1245850	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
21	06/04/08	1245850	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
22	06/05/08	1246669	New	Hydrocodone w/Acetaminophen 10/325	SD	20
23	06/06/08	1246669	Refill	Hydrocodone w/Acetaminophen 10/325	SD	55
24	06/21/08	1247324	Refill	Hydrocodone w/Acetaminophen 10/325	SD	30
25	06/24/08	1247792	New	Hydrocodone w/Acetaminophen 10/325	SD	15
26	06/25/08	1247792	Refill	Hydrocodone w/Acetaminophen 10/325	SD	15
27	06/26/08	1247792	Refill	Hydrocodone w/Acetaminophen 10/325	SD	15
28	06/27/08	1247792	Refill	Hydrocodone w/Acetaminophen 10/325	SD	55
29	07/05/08	1248347	Refill	Hydrocodone w/Acetaminophen 10/325	SD	35
30	07/07/08	1248347	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
31	07/08/08	1248347	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
32	07/10/08	1248347	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
33	07/11/08	1248761	New	Hydrocodone w/Acetaminophen 10/325	SD	20
34	01/03/09	1259274	Refill	Hydrocodone w/Acetaminophen 10/325	SD	30
35	01/05/09	1259274	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
36	01/07/09	1259846	New	Hydrocodone w/Acetaminophen 10/325	SD	20
37	01/08/09	1259846	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
39	01/09/09	1259846	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
40	01/10/09	1259846	Refill	Hydrocodone w/Acetaminophen 10/325	SD	45
41	01/12/09	1259846	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
42	01/13/09	1259846	Refill	Hydrocodone w/Acetaminophen 10/325	SD	25
43	01/14/09	1260405	New	Hydrocodone w/Acetaminophen 10/325	SD	20
44	01/15/09	1260405	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
45	01/16/09	1260405	Refill	Hydrocodone w/Acetaminophen 10/325	SD	20
46	06/27/08	1247972	New	Hydrocodone w/Acetaminophen 5/500	WH	120
47	01/13/09	1256539	Refill	Hydrocodone w/Acetaminophen 5/500	WH	120
	TOTAL	**46 RXs**	**16 New RXs, 30 Refill RXs**			3,666

FOURTH CAUSE FOR DISCIPLINE

(Refilling a Controlled Substances Prescription Without Provider Authorization)

30. Respondents Highlands and Okimoto are subject to disciplinary action under section 4063, as that section interacts with Code section 4301, subdivisions (j) and (o), in that from August 29, 2008 to May 13, 2009, Respondent PIC Okimoto furnished 792 HC/AP 10/325 tablets to Patient S.D. without prescriber authorization as follows. Prescription number 1251622 authorized a total of 1440 tablets by new and refill prescriptions and 1495 were furnished by Respondent PIC Okimoto, 55 doses more than authorized. Prescription number 1256225 authorized a total of 1440 tablets by new and refill prescriptions and 1810 were furnished by Respondent PIC Okimoto, 370 doses more than authorized. And prescription number 1262321 authorized a total of 1440 tablets by new and refill prescriptions and 1807 were furnished by Respondent PIC Okimoto, 367 doses more than authorized.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Keep Records of Disposition)

31. Respondents Highland and Okimoto are subject to disciplinary action under Code sections 4081, subdivision (a) and 4105, subdivision (a), as those sections relate to Code section 4301, subdivisions (j) and (o), in that Respondent PIC Okimoto, from October 8, 2008 to June 20, 2009, failed to make a record of disposition for the following 21 prescriptions, accounting for 570 tablets of HC/AP 10/325 furnished to Patient SD, as follows.

#	Date Dispensed	RX #	Quantity	Drug
1	10/08/08	1253928	15	Hydrocodone with Acetaminophen 10/325 tablets
2	10/10/08	1253928	65	Hydrocodone with Acetaminophen 10/325 tablets
3	11/11/08	1256225	20	Hydrocodone with Acetaminophen 10/325 tablets
4	12/05/08	1257365	65	Hydrocodone with Acetaminophen 10/325 tablets
5	12/11/08	1257947	20	Hydrocodone with Acetaminophen 10/325 tablets
6	12/13/08	1257947	45	Hydrocodone with Acetaminophen 10/325 tablets

7	12/26/08	1258923	20	Hydrocodone with Acetaminophen 10/325 tablets
8	12/29/08	1258923	15	Hydrocodone with Acetaminophen 10/325 tablets
9	01/19/09	1260405	20	Hydrocodone with Acetaminophen 10/325 tablets
10	01/26/09	1260923	20	Hydrocodone with Acetaminophen 10/325 tablets
11	02/26/09	1263073	20	Hydrocodone with Acetaminophen 10/325 tablets
12	03/26/09	1265194	20	Hydrocodone with Acetaminophen 10/325 tablets
13	03/31/09	1265731	20	Hydrocodone with Acetaminophen 10/325 tablets
14	04/17/09	1266766	20	Hydrocodone with Acetaminophen 10/325 tablets
15	05/02/09	1267970	45	Hydrocodone with Acetaminophen 10/325 tablets
16	05/05/09	1267970	20	Hydrocodone with Acetaminophen 10/325 tablets
17	05/11/09	1268401	20	Hydrocodone with Acetaminophen 10/325 tablets
18	05/13/09	1268401	20	Hydrocodone with Acetaminophen 10/325 tablets
19	05/19/09	1268916	20	Hydrocodone with Acetaminophen 10/325 tablets
20	06/02/09	1269579	20	Hydrocodone with Acetaminophen 10/325 tablets
21	06/20/09	1271217	40	Hydrocodone with Acetaminophen 10/325 tablets
	Total	**21** RX's	**570**	**Hydrocodone with Acetaminophen 10/325 Tablets**

SIXTH CAUSE FOR DISCIPLINE

(Variation From Prescription)

32. Respondents Highland and Okimoto are subject to disciplinary action under section 16 CCR section 1716, as that section relates to Code section 4301, subdivisions (j) and (o), in that on October 13, 2008, Respondent PIC Okimoto dispensed prescription number 1247972 for 120 tablets of HC/AP 5/500 to Patient W.H. before receiving prescriber authorization for the refill. On October 15, 2008, Physicians Assistant Bantea returned the refill request, but changed the directions for use from "1 tablet four times a day" to "1 tablet three times a day" and reduced the quantity from 120 tablets to 90.

///

///

SEVENTH CAUSE FOR DISCIPLINE

33. Respondent Okimoto is subject to disciplinary action under 16 CCR section 1715, as that section relates to Code section 4301, subdivision (o), in that from on or about November 29, 2001, to December 26, 2006, PIC Okimoto failed to complete and maintain a pharmacy self-assessment form.

EIGHTH CAUSE FOR DISCIPLINE

34. Respondent Okimoto is subject to disciplinary action under 16 CCR section 1793.7, subdivision (d), as that section relates to Code section 4301, subdivision (o), in that on or about December 26, 2006, PIC Okimoto did not have written policies and procedures and a job description for pharmacy technicians available as required.

NINTH CAUSE FOR DISCIPLINE

35. Respondent Okimoto is subject to disciplinary action under 16 CCR section 1714, subdivisions (b) and (c), as that section relates to Code section 4301, subdivision (o), in that on or about December 26, 2006, Respondent failed to maintain the pharmacy area at North Highlands Pharmacy in a clean and orderly condition such that drugs could be safely prepared, maintained, secured and distributed. Specifically, the pharmacy counters were cluttered and obstructed to an extent that they were unable to accommodate the safe practice of pharmacy, large numbers of drug containers were on the floor, and expired drugs were kept on the shelves with the current drugs.

TENTH CAUSE FOR DISCIPLINE

36. Respondent Okimoto is subject to disciplinary action under Code section 4342, as that section relates to Code section 4301, subdivisions (j) and (o), in that on or about December 26, 2006, he maintained expired drugs in the pharmacy's current inventory area along side non-expired drugs, rather than properly quarantine or dispose of them. These drugs had expiration dates from January 2002 through 2004, and could not be relied upon to meet the standard of quality set forth in the United States Pharmacopoeia or the National Formulary.

///

///

ELEVENTH CAUSE FOR DISCIPLINE

37. Respondent Okimoto is subject to disciplinary action under Code section 4342; and under Title 21 Code of Federal Regulations sections 211.130, and 211.137, as these sections relate to Code section 4301, subdivisions (j) and (o), as follows. On or about December 26, 2006, Respondent Okimoto failed to ensure that all pre-counted or pre-poured medications were labeled in accordance with current good manufacturing practice requirements and with Health and Safety Code section 11480 of the Sherman Food, Drug and Cosmetic Law in that at the pharmacy there were several pre-counted and poured drugs (Naproxen 500 mg, Soma, Cimetidine 400 mg, Promethazine w/codeine syrup) without any label indicating the name of the drug, the strength of the drug, the dosage form, lot #, expiration date, quantity, or manufacturer's name.

TWELFTH CAUSE FOR DISCIPLINE

37. Respondent Okimoto is subject to disciplinary action under Code section 4076, subsection (a)(11), and Code section 4077, as those sections relate to Code section 4301, subdivisions (j) and (o), as follows: On or about December 26, 2006, Respondent Okimoto allowed prescription drugs that were ready for pick up to be in containers that did not have attached to them labels that included a physical description of the dispensed medication, including the medication's color, shape, and any identification code that appears on the tablets or capsules

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit Number PHY 39917, issued to North Highlands Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 24559, issued to Thomas Okimoto;

///

///

///

3. Ordering Respondents North Highlands Pharmacy and Thomas Okimoto to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

4. Taking such other and further action as deemed necessary and proper.

DATED: 4/9/12

VIRGINIA HEROLD
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

SA2009102211
10804840.doc