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

In the Matter of the Accusation Against: **TWIN PHARMACY, INC. dba DABNEY PHARMACY,** **SHLOMO RECHNITZ, President, et al,** 11115 S. Main Street Los Angeles, CA 90061 Pharmacy Permit No. PHY 46745 **AND** **ROBERT ROTHMAN** 4682 Warner Avenue #C-115 Huntington Beach, CA 92649 Pharmacist License No. RPH 30759 Respondents.	Case No. 4445 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about December 20, 1976, the Board of Pharmacy issued Pharmacist License Number RPH 30759 to Robert Rothman (Respondent Rothman). The Pharmacist License was in full force and effect at all times relevant to the charges herein and will expire on May 31, 2016, unless renewed.

3. On or about June 14, 2004, the Board of Pharmacy issued Pharmacy Permit Number PHY 46745 to Twin Pharmacy, Inc. dba Dabney Pharmacy; Robert Rothman, Pharmacist-in-Charge; Shlomo Rechnitz, President; Denise Wilson-Ruane, Secretary (Respondent Pharmacy). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on June 1, 2016, unless renewed.

JURISDICTION

4. The original Accusation in this matter was filed on December 2, 2013, and duly served to Respondents, each of whom then filed a timely Notice of Defense. This First Amended 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.

5. Section **118**, subdivision (b), provides in pertinent part that the suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

6. Section **4300** 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."

7. Business and Professions Code section **4301** states:

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.

. . .

8. Section **4306.5** states:

"Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

. . .

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function."

9. Section **4040** provides in pertinent part:

"(a) 'Prescription' means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either Section 4052.1 or 4052.2.

. . .

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily

retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail."

10. Section **4063** 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."

11. Section **4059** subdivision (a) states:

"A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

12. Section **4081** provides 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 ... 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.

(b) The owner, officer, and partner of a pharmacy ... shall be jointly responsible, with the pharmacist-in-charge or designated representative-in-charge, for maintaining the records and inventory described in this section."

13. Section **4104** provides in pertinent part:

"(a) Every pharmacy shall have in place procedures for taking action to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice

the profession or occupation authorized by his or her license, or is discovered or known to have engaged in the theft, diversion, or self-use of dangerous drugs.

(b) Every pharmacy shall have written policies and procedures for addressing chemical, mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among licensed individuals employed by or with the pharmacy."

14. Section **4115** provides in pertinent part:

(a) A pharmacy technician may perform packaging, manipulative, repetitive, or other nondiscretionary tasks only while assisting, and under the direct supervision and control of a pharmacists. The pharmacist shall be responsible for the duties performed under his or her supervision by a technician.

. . .

(f)(1) A pharmacy with only one pharmacist shall have no more than one pharmacy technician performing the tasks specified in subdivision (a). The ratio of pharmacy technicians performing the tasks specified in subdivision (a) to any additional pharmacists shall not exceed 2:1, except that this ratio shall not apply to personnel performing clerical functions pursuant to Section 4116 or 4117.

15. Section **4342** provides at subdivision (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 Sherman, Drug and Cosmetic Law (Part 5 (commencing with Section 109875) of Division 104 of the Health and Safety Code).

16. Health and Safety Code section **11153** provides at subsection (a):

(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1)

an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use.

. . .

17. Health and Safety Code section **11208** provides:

"In a prosecution under this division, proof that a defendant received or has had in his possession at any time a greater amount of controlled substances than is accounted for by any record required by law or that the amount of controlled substances possessed by the defendant is a lesser amount than is accounted for by any record required by law is prima facie evidence of guilt."

18. Civil Code section **56.10** requires in pertinent part, that a provider of health case, health care service plan, or contractor shall not disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization.

19. California Code of Regulations, Title 16, section **1718** states:

"Current Inventory" as used in Sections 4081 and 4332 of the Business and Professions Code shall be considered to include complete accountability for all dangerous drugs handled by every licensee enumerated in Sections 4081 and 4332.

The controlled substances inventories required by Title 21, CFR, Section 1304 shall be available for inspection upon request for at least 3 years after the date of the inventory."

20. California Code of Regulations, Title 16, section **1714** provides 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.

. . .

(d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist."

21. California Code of Regulations, Title 16, section **1717** provides in pertinent part:

"(b) In addition to the requirements of Business and Professions Code section 4040, the following information shall be maintained for each prescription on file and shall be readily retrievable:

(1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed.

(2) The brand name of the drug or device; or if a generic drug or device is dispensed, the distributor's name which appears on the commercial package label; and

(3) If a prescription for a drug or device is refilled, a record of each refill, quantity dispensed, if different, and the initials or name of the dispensing pharmacist.

(4) A new prescription must be created if there is a change in the drug, strength, prescriber or directions for use, unless a complete record of all such changes is otherwise maintained.

(c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the prescription to identify him or herself. All orally transmitted prescriptions shall be received and transcribed by a pharmacist prior to compounding, filling, dispensing, or furnishing. Chart orders as defined in section 4019 of the Business and Professions Code are not subject to the provisions of this subsection."

22. California Code of Regulations, Title 16, 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.

COST RECOVERY

23. Business and Professions Code section **125.3** 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, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUG DEFINITIONS

24. **Hydrocodone with acetaminophen ("apap")**, trade name **Vicodin ES**, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business and Professions Code Section 4022.

25. **Acetaminophen with codeine**, trade name **Tylenol #3**, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business and Professions Code Section 4022.

26. **Promethazine with codeine**, trade name **Phenergan with Codeine**, is a Schedule V controlled substance pursuant to Health and Safety Code Section 11058 and a dangerous drug per Business and Professions Code Section 4022.

FACTS COMMON TO ALL CAUSES FOR DISCIPLINE

27. The following allegations are common to all causes for discipline in this matter:

28. At all times relevant herein, Respondent Robert Rothman was Pharmacist-in-Charge of Respondent Twin Pharmacy, Inc. dba Dabney Pharmacy (Respondent Pharmacy), a retail pharmacy located at 11115 S. Main Street, in the city of Los Angeles..

Background

29. In or prior to April of 2011 a San Diego pharmacist informant led law enforcement authorities to Milton Farmer, who was suspected of smuggling prescription drugs. A search of Farmer's trashcan at his residence in Oceanside, CA revealed empty prescription bottles from Respondent Pharmacy. Investigators subsequently concluded that Dr. Tyron Reece wrote prescriptions for patients that he did not actually examine and that Anthony "Sam" Wright would have these prescriptions filled at Respondent Pharmacy. Mr. Wright would then transport the prescription medication from Los Angeles to San Diego and deliver them to couriers like Milton Farmer. Mr. Farmer and other couriers would cross the border with the prescription medication strapped to their body and sell the drugs to pharmacies in Mexico.

Board Investigation

30. On or about April 8, 2011, Board Inspectors reviewed the Controlled Substances Utilization Review and Evaluation System (CURES)[1] data for Respondent Pharmacy. The CURES data revealed that Respondents were 18 months late in filing CURES reporting.

31. On April 11, 2011, Board inspectors were present when a search warrant was served at Respondent Pharmacy, pursuant to investigation of the Anthony "Sam" Wright/Milton Farmer prescription drug smuggling operation by several cooperating law enforcement agencies, including the California Department of Justice, the Federal Bureau of Investigation, and the Drug Enforcement Administration.

32. On April 11, 2011, Board Inspectors interviewed Charles Dabney III, a pharmacy technician who had worked at Respondent Pharmacy for seven (7) years.[2] Dabney stated that

[1] The CURES program started in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances and was since amended in January 2005 to include mandatory weekly reporting of Schedule II-IV controlled substances. The data is sent to a data collection company, who sends the pharmacy confirmation that the data was received and informs the pharmacy if the data was rejected. The data is collected statewide and can be used by health care professionals to evaluate and determine whether their patients are utilizing controlled substances correctly.

"Sam" Wright had been a frequent customer at the pharmacy for 4-5 years, and that he brought in prescriptions written by **Dr. Carlos Estiandan** or **Dr. Tyron Reece**. Dabney additionally stated that during this time, at Sam's request, he routinely compiled special lists with patient prescription data, which he provided to Sam "every 2-3-weeks." Dabney stated that Respondent Rothman knew of and/or saw him creating these lists for Sam.

Audit Shows Massive Quantity of "Missing" Drugs

33. On or about April 11, 2011, Board Inspectors requested that Respondent Rothman inventory the three most frequently dispensed controlled substances at Respondent Pharmacy: Vicodin ES, Tylenol #3 and Phenergan with Codeine. This "stock on hand" data was the basis for an audit of these three controlled substances, completed on or about June 15, 2011. Dates chosen for the audit were August 4, 2009 through April 11, 2011(approximately 20 months).

34. The audit revealed that massive quantities of each drug were "missing" from pharmacy inventory, and could not be located or accounted for. Audit results are summarized as follows:

	hydrocodone /apap (Vicodin ES)	acetaminophen with codeine (Tylenol #3)	promethazine with codeine (Phenergan with Codeine)
Staring Amount	2,800	1,100	10,560
Total Purchased	287,400	226,300	1,944,000
Total Dispensed	271,028	221,724	1,793,255
Amount in inventory (on hand)as of 4/11/11	613	1767	25,920
Total Unaccounted For/Missing	**18,559** tablets	**3,909** tablets	**135,385** ml (about 282 pints)

35. Failure to Produce Policy - On or around November 10, 2011, Board Inspectors

[2] In a sworn statement dated April 25, 2011, submitted later to Board Inspectors, Mr. Dabney's position with the pharmacy was described as " Pharmacy Manager/Data Entry Typist/Compliance Officer." Mr. Dabney was licensed by the Board as a pharmacy technician (TCH 9600) from September 20,1993 to July 31, 2013.

requested that Respondents produce a copy of its office policy relating to employee impairment and theft in the workplace.

36. Verbal Orders –Respondent Rothman received a "large number of verbal orders" When asked to produce written records of telephone orders, Respondent failed to produce compliant documentation which requires name of patient, date of request, name, address, telephone number, license number and DEA number of the prescriber, drug name, quantity and directions for use.

37. Prescriptions for Patient SJ - Records of Respondent Pharmacy showed that Patient SJ had medications dispensed pursuant to at least 15 prescriptions purportedly written by Dr. Ayodele on dates between approximately November 27, 2000 and August 7, 2001. Pursuant to Board investigation, Dr. Ayodele reported that SJ was first seen as a patient in his office in **May 2009** – and that he (Avodele) had not authorized any prescriptions for SJ prior to May, 2009.

Empty Prescription Bottles in an Oceanside Trashcan

38. Board Inspectors reviewed patient profiles for 40 patients of Respondent Pharmacy whose names were found on empty prescription bottles which had been discarded in the trashcan at the Oceanside residence of known drug smuggler, Milton Farmer (*See* paragraph 24, above). Analysis of the 40 patient profiles revealed the following:

a. **Dr. Carlos Estiandan** [3] and **Dr. Tyron Reece** wrote a combined **94.2%** of all prescriptions attributed to the 40 patient prescriptions found in the trashcan and identified as having received prescription drugs filled by Respondents Pharmacy and Rothman.

[3] Dr. Carlos Estiandan, was arrested and found guilty on March 15, 2010 of 13 counts of unlawfully writing controlled substance prescriptions without a legitimate medical purpose and outside the usual scope of practice in *The People of the State of California v. Carlos Estiandan*, Los Angeles County Superior Court Case No. BA34703 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). On or around September 9, 2009, Dr. Estiandan surrendered his license to practice medicine the state of California.

b. Respondents routinely refilled several duplicate prescriptions for the same patient on the same day.

c. Respondents refilled three prescriptions for one patient when there was no authorization from the prescriber.

d. Prescription records show treatment for the same medical conditions (cough, anxiety and pain) with no prescription treatment for any other diagnosis (i.e. blood pressure, diabetes, cholesterol, etc.).

e. Dr. Estiandan wrote prescriptions for 24 of the 40 patients (approximately 66.1% of the prescriptions; 866 total prescriptions).

(1) Of all prescriptions written by Dr. Carlos Estiandan (Dr. Estiandan), 283 prescriptions were for promethazine with codeine and 276 were for hydrocodone/apap.

(2) Prescriptions written by Dr. Estiandan were filled on 221 different days, many of which were filled by Respondents on the same day, in bulk.

(3) On or about February 10, 2009, the Medical Board of California, Department of Consumer Affairs filed an Accusation against Dr. Estiandan alleging among other things, repeated acts of negligence, violation of drug laws, prescribing without appropriate examination of medical condition and prescribing to an addict.[4] Dr. Estiandan was subsequently arrested and eventually surrendered his license to practice medicine in September, 2009. In Fall, 2009, Dr. Tyron Reece began writing prescriptions for Dr. Estiandan's former "patients."

f. **Dr. Tyron Reece** wrote approximately 369 prescriptions for **38 of the 40** patients

[4] Administrative action was brought in The Matter of the Accusation Against Carlos Estiandan, M.D., Before the Medical Board of California Department of Consumer Affairs State of California, File No. 17-2004-162750, OAH No. 2009020501 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). Dr. Estiandan surrendered his license to practice medicine in the state of California on or around September 9, 2009.

during the period between October 2, 2009 – April 11, 2011.

(1) 100% of Dr. Reece's prescriptions were written for either promethazine with codeine, hydrocodone/apap or ahydrocodonelprazolam (Xanax).[5]

39. **Corresponding Responsibility Analysis** - Dr. Estiandan and Dr. Reece wrote a combined **94.2%** of all prescriptions attributed to the 40 patients whose prescriptions were found in the trashcan and identified as having received prescription drugs dispensed by Respondents. Prescriptions of Dr. Estiandan and Dr. Reece for the 40 patients were filled by Respondents *despite key objective factors* indicating the prescriptions were not legitimate, including but not limited to:

1. The patients all had similar diagnosis and saw the same two doctors;

2. The patients received the same drug combinations in the same quantities/amounts irrespective of age;

3. The drugs prescribed are highly abused and have high street value;

4. In many instances, the patient did not reside in close proximity to Respondent Pharmacy or to either physician;

5. All patients were prescribed controlled substances for chronic conditions (cough/anxiety/pain) - but were not submitting prescriptions for medications to treat other common health issues (e.g. blood pressure, diabetes);

6. The patients purportedly all had the same medical condition (cough/anxiety/pain) although neither physician specialized in treatment of these conditions (e.g. pulmonologists (chronic bronchitis) or psychiatrist (anxiety));

7. The patients did not drop off their own prescriptions to be filled;

8. All prescriptions were paid for in cash, and not by insurance;

[5] Dr. Reece surrendered his DEA registration on July 8, 2011 in lieu of disciplinary action.

9. Dr. Estiandan was arrested and charged with crimes relating to unlawfully prescribing medication;

10. After Dr. Estiandan was arrested – all of his patients were transferred to Dr. Reece, although the physicians' respective offices are approximately 20 miles apart.

40. When interviewed in April and May of 2012 by Board Inspectors regarding the 40 patient profiles, Respondent Rothman admitted that he did not know anything about the patients and failed to provide any specific information.

41. Respondent Rothman admitted that he defers to the doctor's judgment exclusively in lieu of personally verifying patient prescriptions. Respondent Rothman also admitted that he permits his pharmacy staff to make conclusive determinations regarding the legitimacy of patient prescriptions.

42. Respondent Rothman admitted that he did not use CURES reports or his own professional judgment when filling patient prescriptions.

43. Respondent Rothman admitted that he did not know about or act according to his corresponding responsibility when filling patient prescriptions.

Analysis of CURES Patient Records (2007-2009)

44. To investigate controlled substance dispensing practices of Respondents, Board Inspectors obtained a CURES report for controlled substances dispensed by Respondent Pharmacy between 2007 and 2009.

a. Refills Without Authorization – In reviewing a sample group of 13 patient profiles, Inspectors found that Respondents had refilled at least *119 prescriptions* on dates between approximately January 2007 and September, 2009, without authorization by a prescribing physician.

/ / /

Corresponding Responsibility Analysis

45. In closely analyzing the controlled substance drug treatment and therapy regiment for a sample group of six (6) patients, using CURES data, Board Inspectors found that Respondents routinely filled prescriptions despite key objective factors indicating the prescriptions were not legitimate, or circumstances that should have caused Respondents to question and investigate the prescription's legitimacy:

a. **PATIENT #41 ZA**[6]

DRUG	AMOUNT	DATE OF FILL
hydrocodone/apap ES	60	3/13/09
hydrocodone/apap ES	60	4/6/09
hydrocodone/apap ES	60	4/23/09
hydrocodone/apap ES	60	5/8/09
hydrocodone/apap ES	60	6/3/09
hydrocodone/apap ES	60	6/22/09
hydrocodone/apap ES	100	12/10/10
hydrocodone/apap ES	100	1/10/11
hydrocodone/apap ES	100	2/10/11
hydrocodone/apap ES	100	3/14/11

Summary of Findings: Patient received a quantity of 60 hydrocodone/apap within quick succession during the time period between 4/6/09 and 5/8/09 for a total of 180 tablets in just over 30 days.

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/ / /

[6] Patient initials are used to protect confidentiality throughout the Accusation.

b. **PATIENT #43 EA**

DATE	DRUG	PRESCRIBING PHYSICIAN
4/2005	Tylenol #3	Habbestad[7]
6/2005	promethazine/codeine	Reece
7/2005	Tylenol #3	Habbestad
7/2005	promethazine/codeine	Apusen
7/2005	Vicodin ES	Ayodele
8/2005	Vicodin ES	Apusen
8/2005	Vicodin ES	Ayodele
9/2005	Vicodin ES	Apusen
9/2005	promethazine/codeine	Rojas
10/2005	promethazine/codeine	Habbestad
10/2005	Vicodin ES	Ayodele
11/2005	promethazine/codeine	Rojas
11/2005	Vicodin ES	Rojas
12/2005	promethazine/codeine	Rojas
12/2005	Vicodin ES	Rojas
1/2006	Vicodin ES	Christian
3/2006	Vicodin ES	Apusen
3/2006	promethazine/codeine	Rojas
4/2006	Vicodin ES	Ware

[7] On or around October 10, 2008, Robert Habbestad received a Public Reprimand for failing to maintain adequate and accurate medical records and failing to record information relating to patient examinations in The Matter of the Accusation Against Robert Habbestad, M.D., OAH No. L2006120274.

6/2006	promethazine/codeine	Estiandan
8/2006	Vicodin ES	Rojas
8/2006	promethazine/codeine	Rojas
8/2006	Vicodin ES	Estiandan
10/2007	Vicodin ES	Chickey[8]
10/2007	promethazine/codeine	Chickey
1/2008	Vicodin ES	Chickey
3/2008	Vicodin ES	Chickey
3/2008	promethazine/codeine	Chickey
5/2008	Vicodin ES	Ware
5/2008	promethazine/codeine	Chickey
6/2008	promethazine/codeine	Chickey
8/2008	promethazine/codeine	Reece
8/2008	Vicodin ES	Reece
9/2008	promethazine/codeine	Reece
9/2008	Vicodin ES	Habbestad
9/2008	Vicodin ES	Ayodele
10/2008	promethazine/codeine	Reece
10/2008	Vicodin ES	Reece
11/2008	Vicodin ES	Reece
1/2009	promethazine/codeine	Chickey
1/2009	Vicodin ES	Chickey

[8] Anna Lourdes Armada Chickey, M.D. DEA Registration is currently under investigation by DEA, Los Angeles Region.

2/2009	promethazine/codeine	Chickey
7/2009	Vicodin ES	Chickey
7/2009	promethazine/codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	promethazine/codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	promethazine/codeine	Chickey
11/2009	promethazine/codeine	Reece
11/2009	Vicodin ES	Chickey

Summary of Findings: Patient doctor shopped by using several different prescribers to obtain the same medications. In 2005, the patient used 6 different doctors to obtain Vicodin ES and promethazine/codeine. In 2006, the patient used 4 different doctors to obtain Vicodin ES and promethazine/codeine. In 2008, the patient used 5 different doctors to obtain Vicodin ES and promethazine/codeine. Respondents failed to document why the patient was seeing multiple prescribers for the same drugs.

c. **PATIENT #44 JB**

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/2008	Tylenol #3	Habbestad
3/2008	Tylenol #3	Habbestad
5/2008	Tylenol #3	Habbestad
5/2008	Vicodin ES	Ayodele
7/2008	Tylenol #3	Habbestad
8/2008	Vicodin ES	Ayodele

9/2008	Tylenol #3	Ayodele
11/2008	Tylenol #3	Mays[9]
12/2008	Tylenol #3	Habbestad

Summary of Findings :Patient received both Vicodin ES and Tylenol #3, both for pain. There is no documentation showing that the pharmacist consulted with the prescribing physicians to determine if both medications were appropriate or correctly prescribed for pain. In addition, the patient used multiple prescribers to receive the same medications in the same month.

d. **PATIENT #46 YD**

Summary of Findings: During the time period between December 2004 and 2012, approximately 123 of a total of 151 prescriptions written for the patient were for controlled substances. The patient received promethazine/codeine, Vicodin ES, Soma, Xanax, Tylenol #3, Valium, ampicillin, Keflex, ibuprofen, Pepcid and methocarbamol. In 2009 and 2010, the patient received controlled substances prescriptions from Drs. Estiandan, Al-Bussam, and Chickey – all of whom have had actions taken against their medical licenses or are currently under investigation. Respondents Pharmacy and Rothman failed to inquire about why the patient has had a cough and pain for 8 years and why so many different doctors were sought for these prescriptions.

e. **PATIENT #50 YG**

Summary of Findings: On or around April 13, 2009, Respondents Pharmacy and Rothman filled a prescription for 240ml of promethazine/codeine for this patient. On or around April 20, 2009, Respondents Pharmacy and Rothman filled a second prescription for 240ml of promethazine/codeine for his patient. The patient would not have been able to complete one

[9] On or around July 23, 2006, James Arthur Mays received a Public Reprimand for failing to maintain adequate and accurate medical records and in The Matter of the Public Letter of Reprimand Issued to James Arthur Mays, M.D., Case No. 06-2003-147182.

prescription within seven days. There is no documentation indicating that Respondents contacted the prescribing physician or the patient regarding the patient's usage of the medication.

f. **PATIENT #53 TH**

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/8/07	promethazine/codeine	Fishman
1/17/07	promethazine/codeine	Ayodele
3/8/07	promethazine/codeine	Lin

Summary of Findings: Within two months, the patient received 3 prescriptions for promethazine/codeine from 3 different prescribing physicians, the second arriving merely 9 days after the first. The maximum recommended dose is 30ml/day. There is no documentation that Respondents Pharmacy and Rothman contacted the prescribing physicians regarding deviation from the recommended dosage or contacted the patient regarding use of the medication.

46. **Inspection - December, 2013 -** On or about December 23, 2013, a Board Inspector visited Respondent Pharmacy to investigate allegations made in an anonymous complaint. While at the pharmacy, the Inspector noticed outdated prescription medicines and diabetic supplies on pharmacy shelves, a violation of Business and Professions Code section 4342. Respondents were given notice of the violation and ordered to remove and inventory outdated product – and provide a disposal receipt to the Inspector, within thirty (30) days.

47. **Inspection – January, 2014 -** On or about January 22, 2014, a Board Inspector returned to Respondent Pharmacy to conduct a follow-up inspection. He observed that Respondent was the only pharmacist present in the pharmacy – along with four pharmacy technicians. During that inspection, the Inspector noted the following :

a. In random checks of pharmacy shelves, the Inspector found outdated medicines,

which he then quarantined.

b. He also observed dust and dirt on pharmacy shelves.

c. Although only one pharmacist was present, one technician (LL) was labeling diabetic supplies while - simultaneously - a second technician (RY) was filling prescriptions.

d. The Inspector observed that there was a locked storage area of the facility – and was told that confidential patient prescription records were stored in that area. A key to the locked area was stored in a drawer in the pharmacy.

48. At the conclusion of the inspection, Respondents were issued an Inspection Report citing multiple violations of pharmacy law, and ordered to correct violations, including removal of outdated drugs from pharmacy shelves. Pursuant to this order, Respondents removed hundreds of different types of expired medications from their shelves - with expiration dates as far back as June 30, 2011.

FIRST CAUSE FOR DISCIPLINE

(Failure to Assume Corresponding Responsibility to Assure Legitimacy of Prescriptions)

49. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with Health and Safety Code section 11153, subdivision (a) and Title 16 California Code of Regulations section 1761, in that, approximately between January 2007 and April 11, 2011, they failed to comply with their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose as follows:

a. Respondents furnished (and/or continued to furnish) prescriptions for controlled substances written by Dr. Carlos Estiandan and/or Dr. Tyron Reece to 40 patients despite key objective factors indicating prescriptions were not issued for a legitimate medical purpose, as described at paragraphs 38-43 above.

b. Respondents furnished (and/or continued to furnish) prescriptions for controlled substances to patients #41 ZA, #43 EA, #44 JB,# 46 YD, #50 YG and #53 TH, despite key

objective factors indicating prescriptions were not issued for a legitimate medical purpose, as described at paragraphs 44 – 45 above.

SECOND CAUSE FOR DISCIPLINE

(Failure of Pharmacist to Exercise or Implement Best Professional Judgment or Corresponding Responsibility when Dispensing Controlled Substances)

50. Respondent Rothman is subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with section 4306.5(a) and (b), in that he failed to exercise or implement his best professional judgment and/or corresponding responsibility when dispensing controlled substances, as more fully described at paragraph 49, incorporated herein by this reference.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Operational Standards and Security)

51. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with Title 16, California Code of Regulations section 1714 subdivision (b) and/or (d) and Health and Safety Code section 11208, in that pursuant to Board audit, between approximately August 4, 2009 and April 11, 2011, Respondents failed to maintain pharmacy security or provide effective controls against theft or diversion, resulting in substantial inventory losses, and no ability to account for the whereabouts or disposition of missing drug stock as follows:

a. hydrocodone/apap - 18,559 tablets missing/unaccounted for

b. acetaminophen with codeine - 3,909 tablets missing/unaccounted for

c. promethazine with codeine – 135,385 ml (282 pints) missing/unaccounted for

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Records of Acquisition and Disposition)

52. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4081, subdivisions (a) and (b) and Health and Safety Code section

11208, in that, per Board audit for dates between August 4, 2009 and April 11, 2011, Respondents had substantial inventory losses, with no records to account for the whereabouts or disposition of the missing drug stock as follows:

a. hydrocodone/apap - 18,559 tablets missing/unaccounted for

b. acetaminophen with codeine - 3,909 tablets missing/unaccounted for

c. promethazine with codeine – 135,385 ml (282 pints) missing/unaccounted for

FIFTH CAUSE FOR DISCIPLINE

(Failure to Timely Submit CURES Data)

53. Respondents Twin Pharmacy and Rothman are subject to subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with Health and Safety Code section 11165, in that during the 18 month period between October 2009 and April 2011, Respondents failed to comply with state law requirements for submission of CURES data on a weekly basis, as described at paragraph 30, above.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Comply with Prescription Refill Requirements)

54. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4063, in that in 119 instances between approximately January 2007 and September 2009, Respondents refilled prescriptions without requisite authorization of the prescriber, as more fully described at paragraph 44 above.

SEVENTH CAUSE FOR DISCIPLINE

(Disclosure of Confidential Patient Information)

55. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with Civil Code section 56.10 in that Respondents disclosed confidential medical information regarding multiple patients without first obtaining authorization, per admissions of

Charles Dabney to the effect that he compiled patient lists and distributed them to Sam Wright, as more fully described at paragraph 32 above.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Establish Policies and Procedures Regarding Employee Misconduct)

56. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4104, in that on or about November, 2011, Board Inspectors determined that Respondents had failed to comply with state law requirements to establish written policies and procedures addressing chemical, mental or physical impairment or diversion by licensed individuals employed by the pharmacy as more fully described in paragraph 35 above.

NINTH CAUSE FOR DISCIPLINE

(Failure to Comply with Requirements for Documenting Oral Prescriptions)

57. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4040, and Title 16 California Code of Regulations section 1717 (which requires that an orally transmitted prescription must be reduced to writing and initialed by a pharmacist, and that all prescriptions must have documentation with name of patient, date of request, name, address, telephone number, license number and DEA number of the prescriber, and drug name, quantity and directions for use) in that in or about April, 2011, Board Inspectors discovered that Respondents routinely filled oral prescriptions without compliant documentation as more fully described at paragraph 36 above.

TENTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Prescription)

58. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with 4059, in that Respondents furnished controlled substances dangerous drugs to

patient SJ pursuant to prescriptions purportedly issued by a Dr. A. In fact, SJ was not a patient of Dr. A prior to May 2009 – so that any prescriptions in his name prior to that date were unauthorized, as more fully described at paragraph 37 above.

ELEVENTH CAUSE FOR DISCIPLINE

(Drugs Lacking Quality of Strength – January 2014)

59. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with 4342, subdivision (a) in that during and following a Board Inspection on or about January 22, 2014, hundreds of different types of medication on the shelves of Respondent Pharmacy were identified as past the expiration date (thus failing to conform to the standard and tests as to quality and strength), as more fully described in paragraphs 44 - 48 above.

TWELFTH CAUSE FOR DISCIPLINE

(Failure to Adequately Supervise Technicians – January 2014)

60. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with 4115, subdivisions (a) and (f) in that during a Board Inspection on or about January 22, 2014, two pharmacy technicians were observed filling prescriptions, although only one pharmacist (Respondent Rothman) was present and working in Respondent Pharmacy, as more fully described in paragraph 47 above.

DISCIPLINARY CONSIDERATIONS

61. To determine the degree of discipline, if any, to be imposed on Respondents in this matter, Complainant alleges as follows:

Prior Discipline - Respondent Rothman

a. On or about January 31, 1987, in a prior disciplinary action entitled *In the Matter of the Accusation Against Robert Rothman* before the Board of Pharmacy, Case Number 1217 Respondent's license was revoked and revocation was stayed and Respondent Rothman was placed on three (3) years probation with terms and conditions. In

addition, Respondent's Pharmacist License Number RPH 30759 was suspended for ninety (90) days.

b. Charges in that matter stemmed from Respondent's conviction on or about November 28, 1983, on his guilty plea, of violating Business and Professions Code section 4227 [furnishing or dispensing drugs without a prescription] and Penal Code sections 664/496 [attempted receipt of stolen property] in the matter *The People of the State of California v. Robert Bruce Rothman et al.*, Orange County Superior Court, Case No. C-1554 (1983).

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 46745, issued to Respondent Twin Pharmacy, Inc. dba Dabney Pharmacy; Shlomo Rechnitz, and Denise Wilson-Ruane;

2. Revoking or suspending Pharmacist License Number RPH 30759, issued to Respondent Robert Rothman;

3. Ordering Respondents Dabney Pharmacy and Robert Rothman 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: July 24, 2015

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

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

In the Matter of the Accusation Against: **TWIN PHARMACY, INC. dba** **DABNEY PHARMACY** 11115 S. Main Street Los Angeles, CA 90061 Pharmacy Permit No. PHY 46745 and **Robert Rothman** 4682 Warner Avenue #C-115 Huntington Beach, CA 92649 Pharmacist License No. RPH 30759 Respondents.	Case No. 4445 **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 (Board), Department of Consumer Affairs.

2. On or about December 20, 1976, the Board of Pharmacy issued Pharmacist License Number RPH 30759 to Robert Rothman (Respondent Rothman). The Pharmacist License was in

full force and effect at all times relevant to the charges herein and will expire on May 31, 2014, unless renewed.

3. On or about June 14, 2004, the Board of Pharmacy issued Pharmacy Permit Number PHY 46745 to Twin Pharmacy, Inc. dba Dabney Pharmacy; Robert Rothman, Pharmacist-in-Charge; Shlomo Rechnitz, President; Denise Wilson-Ruane, Secretary (Respondent Dabney). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on June 1, 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.

5. Section 118, subdivision (b), provides in pertinent part that the suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

6. Section 4300 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."

STATUTORY PROVISIONS

7. Section 4306.5 states:

"Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function."

8. Section 4040 provides in pertinent part:

"(a) 'Prescription' means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either Section 4052.1 or 4052.2.

...

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail."

9. Section 4063 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."

10. Section 4059 subdivision (a) states:

"A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

11. Section 4081 provides 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 ... 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.

(b) The owner, officer, and partner of a pharmacy ... shall be jointly responsible, with the pharmacist-in-charge or designated representative-in-charge, for maintaining the records and inventory described in this section."

12. Section 4104 provides in pertinent part:

"(a) Every pharmacy shall have in place procedures for taking action to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice the profession or occupation authorized by his or her license, or is discovered or known to have engaged in the theft, diversion, or self-use of dangerous drugs.

(b) Every pharmacy shall have written policies and procedures for addressing chemical, mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among licensed individuals employed by or with the pharmacy."

13. Section 4169 states, in pertinent part:

"(a) A person or entity may not do any of the following:

...

(3) Purchase, trade, sell, or transfer dangerous drugs that the person knew or reasonably should have known were misbranded, as defined in Section 111335 of the Health and Safety Code."

REGULATORY PROVISIONS

14. California Code of Regulations, Title 16, section 1718 states:

"Current Inventory" as used in Sections 4081 and 4332 of the Business and Professions Code shall be considered to include complete accountability for all dangerous drugs handled by every licensee enumerated in Sections 4081 and 4332.

The controlled substances inventories required by Title 21, CFR, Section 1304 shall be available for inspection upon request for at least 3 years after the date of the inventory."

15. California Code of Regulations, Title 16, section 1714 provides 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.

...

(d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist."

16. California Code of Regulations, Title 16, section 1717 provides in pertinent part:

"(b) In addition to the requirements of Business and Professions Code section 4040, the following information shall be maintained for each prescription on file and shall be readily retrievable:

(1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed.

(2) The brand name of the drug or device; or if a generic drug or device is dispensed, the distributor's name which appears on the commercial package label; and

(3) If a prescription for a drug or device is refilled, a record of each refill, quantity dispensed, if different, and the initials or name of the dispensing pharmacist.

(4) A new prescription must be created if there is a change in the drug, strength, prescriber or directions for use, unless a complete record of all such changes is otherwise maintained.

(c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the prescription to identify him or herself. All orally transmitted prescriptions shall be received and transcribed by a pharmacist prior to compounding, filling, dispensing, or furnishing. Chart orders as defined in section 4019 of the Business and Professions Code are not subject to the provisions of this subsection."

COST RECOVERY

17. Business and Professions Code section 125.3 provides in pertinent part, except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board upon request of the entity bringing the proceedings, the administrative law judge may 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. Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

DRUG DEFINITIONS

18. Hydrocodone with acetaminophen, trade name **Vicodin ES**, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business and Professions Code Section 4022.

19. Acetaminophen with codeine, trade name **Tylenol #3**, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business

and Professions Code Section 4022.

20. Promethazine with codeine, trade name **Phenergan with Codeine**, is a Schedule V controlled substance pursuant to Health and Safety Code Section 11058 and a dangerous drug per Business and Professions Code Section 4022.

BACKGROUND FACTS

21. On or around April 8, 2011, Board Inspectors reviewed the Controlled Substances Utilization Review and Evaluation System (CURES)[1] data for Respondent Dabney, located at 11115 S. Main Street, Los Angeles, CA 90061. The CURES data revealed that Respondents Dabney and Rothman were 18 months late in filing CURES reporting.

22. On or around April 11, 2011, a search warrant was performed at Respondent Dabney's location based on information that prescription drugs being dispensed by Respondents Dabney and Rothman were found to be unlawfully taken into Mexico and sold.[2]

23. On or around June 15, 2011, Board Inspectors performed an audit of the three most frequently filled prescriptions at Respondents Dabney and Rothman during the time period between 8/4/09 and 4/11/11: Vicodin ES, Tylenol #3 and Promethazine with Codeine.

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[1] The CURES program started in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances and was since amended in January 2005 to include mandatory weekly reporting of Schedule II-IV controlled substances. The data is sent to a data collection company, who sends the pharmacy confirmation that the data was received and informs the pharmacy if the data was rejected. The data is collected statewide and can be used by health care professionals to evaluate and determine whether their patients are utilizing controlled substances correctly.

[2] In 2011, a San Diego pharmacist informant led law enforcement authorities to Milton Farmer, who officials suspected of smuggling prescription drugs. A search of Farmer's trashcan in Oceanside, CA revealed empty prescription bottles from Respondent Dabney. Investigations concluded that Dr. Tyron Reece wrote prescriptions for patients that he did not actually examine and that Anthony "Sam" Wright would get these prescriptions filled at Respondent Dabney. Mr. Wright would then transport the prescription medication from Los Angeles to San Diego and deliver them to couriers like Milton Farmer. Mr. Farmer and other couriers would cross the border with the prescription medication strapped to their body and sell the drugs to pharmacies in Mexico.

24. An audit of Respondent Dabney revealed the following during that time period:

	VICODIN ES	TYLENOL #3	PROMETHAZINE with Codeine
Total Purchased	290,200	227,400	1,954,560
Total Dispensed	271,028	221,724	1,793,255
Amount on hand as of 4/11/11	613	1767	25,920
Total Missing (Loss)	18,559 tablets	3909 tablets	135,385 ml

25. On or around June 2011, Board Inspectors obtained an older CURES report submitted by Respondents Dabney and Rothman to review 13 patients' controlled substance drug treatment and therapy regime during the time period between 2007 and 2009.

26. Based on the 13 patient profiles reviewed (CURES patients), Board Inspectors learned that Respondents Dabney and Rothman filled a total of 119 prescriptions during that time period, without authorization by a prescribing physician.

27. The Board subsequently attempted to obtain additional information from the 13 patients relating to services they received from Respondents Dabney and Rothman. The Board received no responses from any of the 13 patients.

28. However, a review of 6 patient profiles revealed the following:

a. PATIENT #41 ZA[3]

DRUG	AMOUNT	DATE OF FILL
Hydrocodone/APAP ES	60	3/13/09
Hydrocodone/APAP ES	60	4/6/09
Hydrocodone/APAP ES	60	4/23/09
Hydrocodone/APAP ES	60	5/8/09

[3] Patient initials are used to protect confidentiality here, and in each instance throughout the Accusation.

Hydrocodone/APAP ES	60	6/3/09
Hydrocodone/APAP ES	60	6/22/09
Hydrocodone/APAP ES	100	12/10/10
Hydrocodone/APAP ES	100	1/10/11
Hydrocodone/APAP ES	100	2/10/11
Hydrocodone/APAP ES	100	3/14/11

Summary: Patient received a quantity of 60 Hydrocodone/APAP ES within quick succession during the time period between 4/6/09 and 5/9/09 for a total of 180 tablets in just over 30 days.

b. PATIENT #43 EA

DATE	DRUG	PRESCRIBING PHYSICIAN
4/2005	Tylenol #3	Habbestad[4]
6/2005	Promethazine/Codeine	Reece
7/2005	Tylenol #3	Habbestad
7/2005	Promethazine/Codeine	Apusen
7/2005	Vicodin ES	Ayodele
8/2005	Vicodin ES	Apusen
8/2005	Vicodin ES	Ayodele
9/2005	Vicodin ES	Apusen
9/2005	Promethazine/Codeine	Rojas

[4] On or around October 10, 2008, Robert Habbestad received a Public Reprimand for failing to maintain adequate and accurate medical records and failing to record information relating to patient examinations in The Matter of the Accusation Against Robert Habbestad, M.D., OAH No. L2006120274.

10/2005	Promethazine/Codeine	Habbestad
10/2005	Vicodin ES	Ayodele
11/2005	Promethazine/Codeine	Rojas
11/2005	Vicodin ES	Rojas
12/2005	Promethazine/Codeine	Rojas
12/2005	Vicodin ES	Rojas
1/2006	Vicodin ES	Christian
3/2006	Vicodin ES	Apusen
3/2006	Promethazine/Codeine	Rojas
4/2006	Vicodin ES	Ware
6/2006	Promethazine/Codeine	Estiandan
8/2006	Vicodin ES	Rojas
8/2006	Promethazine/Codeine	Rojas
8/2006	Vicodin ES	Estiandan
10/2007	Vicodin ES	Chickey[5]
10/2007	Promethazine/Codeine	Chickey
1/2008	Vicodin ES	Chickey
3/2008	Vicodin ES	Chickey
3/2008	Promethazine/Codeine	Chickey
5/2008	Vicodin ES	Ware
5/2008	Promethazine/Codeine	Chickey
6/2008	Promethazine/Codeine	Chickey

[5] Anna Lourdes Armada Chickey, M.D. DEA Registration is currently under investigation by DEA, Los Angeles Region.

8/2008	Promethazine/Codeine	Reece
8/2008	Vicodin ES	Reece
9/2008	Promethazine/Codeine	Reece
9/2008	Vicodin ES	Habbestad
9/2008	Vicodin ES	Ayodele
10/2008	Promethazine/Codeine	Reece
10/2008	Vicodin ES	Reece
11/2008	Vicodin ES	Reece
1/2009	Promethazine/Codeine	Chickey
1/2009	Vicodin ES	Chickey
2/2009	Promethazine/Codeine	Chickey
7/2009	Vicodin ES	Chickey
7/2009	Promethazine/Codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	Promethazine/Codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	Promethazine/Codeine	Chickey
11/2009	Promethazine/Codeine	Reece
11/2009	Vicodin ES	Chickey

Summary: Patient doctor shopped by using several different prescribers to obtain the same medications. In 2006, the patient used 4 different doctors to obtain Vicodin ES and Promethazine/Codeine. In 2008, the patient used 5 different doctors to obtain Vicodin ES and Promethazine/Codeine. Respondents Dabney and Rothman failed to document why the patient

was seeing multiple prescribers for the same drugs.

c. PATIENT #44 JB

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/2008	Tylenol #3	Habbestad
3/2008	Tylenol #3	Habbestad
5/2008	Tylenol #3	Habbestad
5/2008	Vicodin ES	Ayodele
7/2008	Tylenol #3	Habbestad
8/2008	Vicodin ES	Ayodele
9/2008	Tylenol #3	Ayodele
11/2008	Tylenol #3	Mays[6]
12/2008	Tylenol #3	Habbestad

Summary: Patient received both Vicodin ES and Tylenol #3, both for pain. There is no documentation showing that the pharmacist consulted with the prescribing physicians to determine if both medications were appropriate or correctly prescribed for pain. In addition, the patient used multiple prescribers to receive the same medications in the same month.

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[6] On or around July 23, 2006, James Arthur Mays received a Public Reprimand for failing to maintain adequate and accurate medical records and in The Matter of the Public Letter of Reprimand Issued to James Arthur Mays, M.D., Case No. 06-2003-147182.

d. PATIENT #46 YD

Summary: During the time period between December 2004 and 2012, approximately 123 of a total of 151 prescriptions written for the patient were for controlled substances. The patient received Promethazine/Codeine, Vicodin ES, Soma, Xanax, Tylenol #3, Valium, ampicillin, Keflex, Ibuprofen, Pepcid and Methocarbamol. In 2009 and 2010, the patient obtained mostly controlled substance prescriptions from Drs. Estiandan, Al-Bussam, and Chickey – all of whom have had actions taken against their medical licenses or are currently under investigation. Respondents Dabney and Rothman failed to inquire about why the patient has had a cough and pain for 8 years and why so many different doctors were sought for these prescriptions.

e. PATIENT #50 YG

Summary: On or around April 13, 2009, Respondents Dabney and Rothman filled a prescription for 240ml of Promethazine/Codeine for this patient. On or around April 20, 2009, Respondents Dabney and Rothman filled a second prescription for 240ml of Promethazine/Codeine for his patient. The maximum recommended dose is 30ml/day. The patient would not have been able to complete one prescription within seven days. Respondents Dabney and Rothman failed to document that the patient was not receiving a benefit from the medication, nor did they document contacting the prescribing physician to inform him/her that the medication was not working.

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f. PATIENT #53 TH

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/8/07	Promethazine/Codeine	Fishman
1/17/07	Promethazine/Codeine	Ayodele
3/8/07	Promethazine/Codeine	Lin

Summary: Within two months, the patient received 3 prescriptions for Promethazine/Codeine from 3 different prescribing physicians, the second arriving merely 9 days after the first. The maximum recommended dose is 30ml/day. There is no documentation that Respondents Dabney and Rothman contacted the prescribing physicians regarding deviation from the recommended dosage or contacted the patient regarding use of the medication.

29. On or around November 10, 2011, Board Inspectors requested that Respondents Dabney and Rothman produce a copy of its office policy relating to employee impairment and theft in the workplace.

30. Respondents Dabney and Rothman failed to produce a policy pursuant to the Board's request.

31. Respondent Rothman admitted receiving a "large number of verbal orders and writing a large number of telephone prescription documents." When asked to produce written records of telephone orders, Respondent failed to produce compliant documentation which require name of patient, date of request, name, address, telephone number, license number and DEA number of the prescriber, and drug type, quantity and directions for use.

32. On or around August 2012, Board Inspectors reviewed the profiles of

approximately 40 patients whose names were found on empty prescription bottles in a trashcan and were identified as having received prescription drugs filled by Respondents Dabney and Rothman (*See* footnote 2, infra).

33. A review of the 40 patient profiles revealed that Respondents Dabney and Rothman refilled several duplicate prescriptions for the same patient on the same day.

34. The records also revealed that Respondents Dabney and Rothman refilled three prescriptions for the same patient, without authorization from the prescribing physician.

35. A review of the 40 patient profiles established that 94.2% of all prescriptions filled by Respondents Dabney and Rothman were for either one of three medications: hydrocodone/apap, Phenergan with codeine or alprazolam (Xanax) (34.9%, 35.5% and 24.6% respectively), all of which are controlled substances.

36. The records showed no prescription treatment for any other diagnosis (i.e. blood pressure, diabetes, cholesterol, etc.).

37. Dr. Carlos Estiandan (Dr. Estiandan) wrote approximately 66.1% of the prescriptions (866 total prescriptions) for 24 of the 40 patients identified.[7]

38. Of all prescriptions written by Dr. Estiandan, 283 prescriptions were for promethazine with codeine and 276 were for hydrocodone/apap.

39. Prescriptions written by Dr. Estiandan were filled on 221 different days, many of which were filled by Respondents Dabney and Rothman on the same day, in bulk.

40. Sometime on or around February 10, 2009, the Medical Board of California, Department of Consumer Affairs filed an Accusation against Dr. Estiandan alleging among other

[7] Dr. Carlos Estiandan, was arrested and found guilty on March 15, 2010 of 13 counts of unlawfully writing controlled substance prescriptions without a legitimate medical purpose and outside the usual scope of practice in *The People of the State of California v. Carlos Estiandan*, Los Angeles County Superior Court Case No. BA34703 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). On or around September 9, 2009, Dr. Estiandan surrendered his license to practice medicine the state of California.

things, repeated acts of negligence, violation of drug laws, prescribing without appropriate examination of medical condition and prescribing to an addict.[8]

41. Shortly after Dr. Estiandan was arrested and ultimately surrendered his license to practice medicine, Dr. Tyron Reece (Dr. Reece) began writing prescriptions for Dr. Estiandan's patients.

42. Dr. Reece wrote approximately 369 prescriptions for 38 of the 40 patient during the period between October 2, 2009 – April 11, 2011.

43. One hundred percent of Dr. Reece's prescriptions were written for either promethazine with codeine, hydrocodone/apap or alprazolam (Xanax).[9]

44. Dr. Estiandan and Dr. Reece wrote a combined 94.2% of all prescriptions attributed to the 40 patient prescriptions found in the trashcan and identified as having received prescription drugs filled by Respondents Dabney and Rothman.

45. Dr. Estiandan's and Reece's prescriptions for the 40 patients were filled by Respondents Dabney and Rothman even though the following facts appeared to exist: The patients all had similar diagnosis and saw the same two doctors; The patients received the same drug combinations in the same quantities/amounts irrespective of age; The drugs prescribed are highly abused and have high street value; In many instances, the patient did not reside in close proximity to Respondent Dabney or to either physician; All patients were prescribed controlled substances and none received prescriptions for blood pressure, cholesterol or diabetes; The patients all had the same medical condition (cough, anxiety and pain) although neither Dr. Estiandan or Dr. Reece are pain specialists or pulmonologists (chronic bronchitis) or psychiatric

[8] Administrative action was brought in The Matter of the Accusation Against Carlos Estiandan, M.D., Before the Medical Board of California Department of Consumer Affairs State of California, File No. 17-2004-162750, OAH No. 2009020501 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). Dr. Estiandan surrendered his license to practice medicine in the state of California on or around September 9, 2009.

[9] Dr. Reece surrendered his DEA registration on July 8, 2011 in lieu of disciplinary action.

specialists (anxiety); The patients did not drop off their own prescriptions to be filled; All prescriptions were paid for in cash, and not by insurance; Dr. Estiandan was arrested and charged relating to unlawfully prescribing medication; All of Dr. Estiandan's patients were transferred to Dr. Reece after Dr. Estiandan was arrested, even though the physicians' respective offices are approximately 20 miles apart.

46. When interviewed by Board Inspectors relating to the 40 patients identified, Respondent Rothman admitted that he did not know anything about the patients and failed to provide any specific information.

47. Respondent Rothman admitted that he defers to the doctor's judgment exclusively in lieu of personally verifying patient prescriptions. Respondent Rothman also admitted that he permits his pharmacy staff makes conclusive determinations regarding the legitimacy of patient prescriptions.

48. Respondent Rothman admitted that did not use CURES reports or his own professional judgment when filling patient prescriptions.

49. Respondent Rothman admitted that he did not know about or act according to his corresponding responsibility when filling patient prescriptions.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Inappropriate Exercise of Education)

50. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (a) in that Respondent engaged in acts or omissions that involve the inappropriate exercise of his education, training or experience as a pharmacist. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

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SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Exercise Best Judgment)

51. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (b) in conjunction with California Code of Regulations, Title 16, sections 1714 and 1718 and Health and Safety Code sections 11056 and 11058 in that Respondent engaged in acts or omissions involving failure to exercise his best professional judgment or corresponding responsibility with regard to dispensing or furnishing controlled substances or dangerous drugs with regard to the provision of services. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Review Patient Records)

52. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (c) in that Respondent engaged in acts or omissions that involve failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Failure to Maintain Patient-Specific Information)

53. Respondent Rothman is subject to disciplinary action under sections 4300 and 4306.5 (d) in that Respondent engaged in acts or omissions that involve failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function. Complainant incorporates by reference paragraphs 21 – 22, as if fully set forth herein.

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FIFTH CAUSE FOR DISCIPLINE

(Failure to Comply with the Prescription Requirements)

54. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4040 in conjunction with California Code of Regulations, Title 16, section 1717 in that Respondent failed to comply with the requirements of orally transmitted prescriptions, which require, among other items, the name(s) and address(es) of patients, quantity of the drug prescribed and directions for use, date of issue. Complainant incorporates by reference paragraphs 31, as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Comply with the Prescription Refill Requirements)

55. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4063 in that Respondent failed to comply with the requirements of a prescription refill. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

SEVENTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Prescription)

56. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4059 in conjunction with Health and Safety Code sections 11056 and 11058 in that Respondent furnished controlled substances dangerous drugs without a prescription. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Maintain a Policy Relating to Theft or Impairment)

57. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4104 in that Respondent failed to have written policies and procedures for addressing chemical, mental or physical impairment as well as theft, diversion among licensed individuals

employed by the pharmacy. Complainant incorporates by reference paragraphs 29 – 30, as if fully set forth herein.

NINTH CAUSE FOR DISCIPLINE

(Trading, Selling and/or Transferring Misbranded Drugs)

58. Respondents Rothman and Dabney are subject to disciplinary action under sections 4300 and 4169 in that Respondents purchased, traded, sold or transferred dangerous drugs that Respondents knew or reasonably should have known were misbranded. Complainant incorporates by reference paragraphs 21 – 49 and all subparagraphs, as if fully set forth herein.

DISCIPLINE CONSIDERATIONS

59. To determine the degree of discipline, if any, to be imposed on Respondent Robert Rothman, Complainant alleges that on or about January 31, 1987, in a prior disciplinary action entitled In the Matter of the Accusation Against Robert Rothman before the Board of Pharmacy, in Case Number 1217 Respondent's license was revoked and revocation was stayed and Respondent Rothman was placed on three (3) years probation with terms and conditions. In addition, Respondent's Pharmacist License Number RPH 30759 was suspended for ninety (90) days.

60. The circumstances are that on or around November 28, 1983, Respondent was convicted on his guilty plea of violating Business and Professions Code § 4227 [furnishing or dispensing drugs without a prescription] Penal Code §§ 64/496 [attempted receipt of stolen property] in the matter *The People of the State of California v. Robert Bruce Rothman*, Orange Co. Super. Court, Case No. C-1554 (1983).

61. That decision is now final and is incorporated by reference as if fully set forth.

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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 46745, issued to Respondent Twin Pharmacy, Inc. dba Dabney Pharmacy; Shlomo Rechnitz; Denise Wilson-Ruane;

2. Revoking or suspending Pharmacist License Number RPH 30759, issued to Respondent Robert Rothman;

3. Ordering Respondents Dabney Pharmacy and Robert Rothman 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: 12/2/13

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

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