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

In the Matter of the Second Amended Accusation Against:	Case No. 4828
PHARMACY CARE NETWORK, INC., DBA KANAN PHARMACY & MEDICAL SUPPLIES; ANTHONY JOHN CASSAR	OAH No. 2017090986
Pharmacy Permit No. PHY 46707,	
ANTHONY JOHN CASSAR,	
Pharmacist License No. RPH 49326	
Respondents.	

DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on July 2, 2019.

It is so ORDERED on June 3, 2019.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By

Victor Law, R.Ph.
Board President

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PROPOSED DECISION

This matter was heard by Eric Sawyer, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California, on April 16 through 20, 2018, and October 29 through November 2, 2018, in Los Angeles.

Morgan Malek, Deputy Attorney General, represented Virginia K. Herold (complainant), Executive Officer of the Board of Pharmacy (Board).

Armond Marcarian, Esq., represented respondents Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies, and Anthony Cassar, who was present each day.

The record was held open after the conclusion of the hearing for the parties to submit closing briefs, which were timely received and marked as follows: complainant's brief (ex. 26), respondents' brief (ex. Y), and complainant's rebuttal (ex. 27). The record was closed and the matter submitted for decision upon receipt of the last brief on February 15, 2019.

SUMMARY

This country's opioid crisis has produced many victims.

The victims include those addicted to the drugs they are prescribed and some who have died from overdose, their families, and the physicians and pharmacists involved in the delicate struggle to find the right balance between helping and harming their patients. Regulating agencies have been slow to respond and have also struggled. This crisis has evolved over time, tracing back to its initiation in the 2000s as a dull pain, but becoming increasingly acute with the passage of each year until the present time. Yet, the current standards cannot be fairly applied to the events transpiring when the crisis began and was evolving. In a sense, that is what happened in this case.

Complainant portrays respondents as being complicit in the overdose death of one of their patients, who sought drugs from several doctors and numerous pharmacies, and that respondents were reckless in violating their corresponding responsibility in refilling early 65 prescriptions for four patients. As for two other drug-seeking patients who forged prescriptions while seeking non-opioids, respondents are accused of again failing in their corresponding responsibility by prescribing to them drugs from the forged prescriptions, even though respondents were ultimately the only ones among many involved pharmacies and pharmacists to detect the drug-seeking and stop it. Respondents are also accused of various regulatory violations in how they documented and dispensed drugs, as well as altering three prescriptions in an attempt to foil the investigation underlying this case.

Although it was not established that respondents were responsible for the overdose death of the one patient, they did violate their corresponding responsibility by refilling 65 prescriptions early for four of their patients, including the one who overdosed. As for the two other drug-seeking patients who forged prescriptions while seeking non-opioids, respondents also failed to exercise their corresponding responsibility by missing two red flags and still prescribing to them drugs from the forged prescriptions, albeit with significant mitigating facts. Complainant failed to establish many of the regulatory violations alleged against respondents, but did prove Anthony Cassar altered three prescriptions by adding to them, after the fact, information not contained on the originals, though it was not established the added information was false. Respondents established significant evidence of mitigation and rehabilitation. Under these circumstances, moderate discipline is warranted. Moreover, some of the investigation and prosecution costs sought by complainant are unreasonable and unnecessary and therefore are reduced accordingly.

FACTUAL FINDINGS

Parties and Jurisdiction

1. On a date not established, an Accusation was filed against respondents by complainant in her official capacity.

2. On January 12, 2017, a Notice of Defense was filed on behalf of respondents, which requested a hearing to challenge the allegations of the Accusation.

3. On July 16, 2017, a First Amended Accusation was filed against respondents. By operation of Government Code section 11507, respondents were not "entitled to file a further pleading unless the agency in its discretion so orders." The Board did not so order.

4. On May 21, 2018 (after the first week of the hearing but before the second week commenced), the Second Amended Accusation was filed against respondents. Pursuant to Government Code section 11507, respondents were not required to file any pleading in response.

5. On May 18, 2004, the Board issued Pharmacy Permit Number PHY 46707 (or permit) to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies (respondent Kanan Pharmacy). Anthony John Cassar (respondent Cassar), who owns half of the business, is, and has been, the President and Pharmacist-In-Charge (or PIC) of respondent Kanan Pharmacy since May 18, 2004. Maria Cassar, respondent Cassar's wife, is, and has been, Secretary/Treasurer of respondent Kanan Pharmacy since May 18, 2004, and she owns the other half of the business. The permit was in force at all times relevant to the Second Amended Accusation and will expire on May 1, 2019, unless renewed.

6. On March 25, 1997, the Board issued Pharmacist License Number RPH 49326 (or license) to respondent Cassar. The license was in force at all times relevant to the Second Amended Accusation and will expire on May 31, 2020, unless renewed.

Respondents' Background and Record with the Board

7. Respondent Cassar received a bachelor degree from Loyola Marymount University and then married Maria, who he met in college. He graduated from the USC School of Pharmacy and was issued his pharmacy license from the Board. The Cassars have been married over 28 years and have two children, one in college and one in high school.

8. In March 2004, the Cassars purchased respondent Kanan Pharmacy, which is a moderate sized, independent pharmacy, open seven days a week, serving the areas of Calabasas to Westlake. Respondent Cassar is the PIC and manages the business; Mrs. Cassar does the bookkeeping.

9. Respondents have no prior disciplinary record with the Board.

10. On February 27, 2004, the Board issued Citation Number CI 2002 25346 in the amount of $1,850 to respondent Cassar for the violations described below, which occurred on or about May 1 and 6, 2003. The citation was not appealed and became final.[1]

- Business and Professions Code section 4116, subdivision (a) [failure to secure area where controlled substances are stored];[2]

[1] Citations are not considered discipline.

• California Code of Regulations, title 16, sections 1751.5, 1751.7, subdivisions (a), (d), and (e), and 1751.8, subdivision (f) [quality assurance/training of staff, patient and caregiver/policies and procedures for parenteral products];

• California Code of Regulations, title 16, section (Regulation) 1716.2, subdivision (a)(l), (2), (3), (4), (6), and (8) [records requirement- compounding for future furnishing];

• Section 4116, subdivision (b), and Regulation 1714.1, subdivision (f) [pharmacy operations during the temporary absence of a pharmacist];

• Regulation 1714, subdivision (d) [improper pharmacy security];

• Regulation 1715, subdivisions (a) and (b)(1) [self-assessment of a pharmacy by the pharmacist-in-charge]; and

• Regulation 1793.7, subdivision (b) [requirements for pharmacies employing pharmacy technicians].

The CURES Program

11. The Controlled Substance Utilization Review and Evaluation System (CURES) is a database that contains over 100 million entries of controlled substance drugs that were dispensed in California. CURES is part of a program developed by the California Department of Justice, Bureau of Narcotic Enforcement, which allows access to the Prescription Drug Monitoring Program (PDMP) system. The PDMP allows pre-registered users, including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information.

12. The CURES program started in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances and was amended in January 2005 to include mandatory weekly reporting of Schedule II through IV controlled substances. The data is sent to a data collection company, which sends the pharmacy confirmation that the data was received and lets the pharmacy know whether any data was rejected. The data is collected statewide and can be used by health care professionals such as pharmacists and prescribers to evaluate and determine whether their patients are utilizing their controlled substances correctly.

13. Board Inspector Valerie Sakamura and Supervising Inspector Janice Dang generally discussed in their testimony the evolution and significance of the CURES program to pharmacists. However, Inspector Sakamura has no prior experience as a retail pharmacist, and Supervising Inspector Dang has limited experience that predated the start of the CURES

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[2] Undesignated statutory references are to the Business and Professions Code.

program. For that reason, their collective testimony on CURES was of limited value. On the other hand, two of respondents' witnesses, licensed pharmacist and character witness Ira Freeman, as well as pharmacist and pharmacy practices expert witness Jeb Sydejko, provided detailed and credible testimony concerning the evolution of CURES from its inception to the present. Both Freeman and Sydejko have significant retail pharmacy experience. In addition, Mr. Freeman was involved in the testing of the early versions of CURES. The testimony of Mssrs. Freeman and Sydejko, as well as the corroborating testimony of respondent Cassar concerning his experience with CURES at the times in question, established the following facts concerning the evolution of CURES and standard of care for using it.[3]

14. When first implemented in 2008, CURES did not generate live data online. Instead, it operated as a fax response system, where a fax request would be made by a health care provider and a response would be received from the Department of Justice approximately 7-10 days later. Dr. Freeman testified that even though he was registered with CURES in 2008, he did not regularly make requests for information through CURES; he would only do so if he had a question about a particular prescription or if a prescriber had a question regarding a patient.

15. In 2010, CURES 1.0 became available as an online system. According to Mssrs. Freeman and Sydejko, CURES 1.0 was better, but it still had limited use. It also had significant flaws. For example, the system was hard to access, logging in was difficult, many times the system locked up, frequent password changes were required, and there was little technical support available to users who were unable to access the system. According to Mr. Sydejko, by 2013 still less than half of licensed pharmacists used the system, because of the flaws and the Board's lack of aggressively promoting the system. In fact, the Legislature was required to increase funding for the system to address the operational flaws.

16. In May 2015, Dr. Freeman completed testing of CURES 2.0, and it was launched approximately three months later. CURES 2.0 is completely online and easy to access. Mr. Sydejko persuasively testified it was after the introduction of CURES 2.0 that it became the standard of care for pharmacists to run a CURES search on all prescriptions involving controlled substances, including opioids. There has never been a statute, regulation, or rule promulgated by the Board mandating the use of CURES.

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[3] As discussed in Legal Conclusions 1 through 3, two different standards of proof apply in this case. A finding will note when neither standard has been met. If only the lower standard has been met, the higher standard will not be mentioned. If a finding does not otherwise specify, both standards have been met.

The Board's Investigation of the BK Complaint

17. On January 12, 2010, BK[4] died. He was 26 years old at the time. His mother found him in his room unresponsive, apparently having overdosed. The cause of his death was later determined to be Oxycodone intoxication. (Exs. 9-11.)

18. BK's mother, who is a registered nurse, found a significant number of prescription bottles in BK's room when she found him on the day he died. (Exs. 13 & 18.) The prescription bottles were for medications that had been filled by respondents from September 10, 2009, to November 12, 2009.

19. On August 31, 2011, the Board received a complaint from BK's mother. The Board assigned the investigation to Inspector Sakamura. She discovered that most of the medications in question had been prescribed for BK by Lawrence Glass, Doctor of Osteopathic. Dr. Glass had been investigated by the Osteopathic Medical Board of California and disciplinary charges had been filed against his license on March 4, 2011. Dr. Glass committed suicide before the matter could be resolved.

20. In preparation for an inspection of respondents' pharmacy premises, Inspector Sakamura reviewed CURES data for respondent Kanan Pharmacy for the time period of October 1, 2008, through January 1, 2010. Inspector Sakamura learned from the data that there were 283 Schedules II through IV prescriptions filled during that period for 23 patients. Inspector Sakamura selected three of the 23 patients to review their controlled substance dispensing by respondents, i.e., KC, MS, and SM. Due to the complaint filed by BK's mother, Inspector Sakamura also requested and reviewed the same documentation for BK.

21. On March 15, 2013, Inspector Sakamura visited the Kanan Pharmacy premises. Respondent Cassar was acting as the PIC at that time and was present. Inspector Sakamura gave respondent Cassar the names of the three patients she had chosen from the CURES data and asked for their patient profiles, as well as the same information for BK. Respondent Cassar had the profiles printed. Inspector Sakamura also gave him a list of questions to answer for each of the four patients, as well as questions about Dr. Glass. Inspector Sakamura also asked how respondents dealt with forged prescriptions, prescriptions from drug seekers, and what tools were used to decide whether to fill a prescription.

22. On April 6, 2013, Inspector Sakamura received a statement from respondent Cassar responding to some of her questions. On April 22, 2013, Inspector Sakamura received copies of the patient profiles and prescriptions for the four patients in question and respondent Cassar's responses to Inspector Sakamura's remaining questions. Inspector Sakamura correlated the information she received from respondents and arrived at a number of conclusions concerning the prescriptions for each of the four patients.

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[4] Initials are used to protect the privacy of the involved patients.

EARLY REFILLS

23. In their testimony, Inspector Sakamura and Supervising Inspector Dang established that prescriptions are filled based on the number of "day supply" in the prescription. The primary reason the controlled substance drug fills are regulated is to prevent the abuse and misuse of controlled substances, like opioids or other addictive medications. If those substances are not closely regulated, a patient could theoretically visit multiple pharmacies asking for "early refills" simply to feed their addiction or to trade the drugs on the black market. As used in this case, an "early refill" is when a patient seeks a refill of the prescription before the day supply has ended. For example, if a patient is prescribed a medication in pill form, and is told by the prescribing physician to take one pill a day for 30 days, the pharmacist will dispense 30 pills, and the day supply is 30 days. If the patient seeks a refill before 30 days has elapsed from the time the initial prescription is filled (or dispensed), this means that either she has taken more than one pill a day, has lost one or more, is travelling when the prescription's day supply ends, or is seeking more medication than should be consumed, etc.

24. Inspectors Sakamura and Dang also established through their testimony that early refills can pose a potential red flag for abuse of narcotic prescriptions. An early refill of less than five days is not especially concerning, particularly where a pattern of such is not evident. However, a prudent pharmacist should notice a pattern of refills earlier than five days or any early refill of five days or more and require the patient to provide an explanation before refilling the prescription. The standard of care at the time required documentation of the excuse the patient offered in the event that the situation continued or the excuse was invalidated or both. By contrast, on this point, respondents' pharmacy practices expert, Mr. Sydejko, provided vague and conclusory testimony, which was not helpful and contrary to common sense.

Patient BK

25. Inspector Sakamura conducted a drug audit of the patient profile and prescriptions respondents produced for patient BK and she documented her findings in a spreadsheet.[5] The audit of those records revealed that from March 26, 2009, through November 27, 2009, respondents filled 11 prescriptions (Oxycontin, Amphetamine/Adderall, Carisprodol [Soma] and Norco) early by five or more days for patient BK.

26. A. As part of her investigation, Inspector Sakamura ran a CURES search on BK, which revealed that in 2009 BK had prescriptions filled by respondent Kanan Pharmacy and five other pharmacies (West Val Pharmacy, Longs Drugs, Costco, CVS and Rite Aid), and that Dr. Glass and three other physicians had prescribed medications for him. The data and evidence clearly established that, in 2009, BK was what is known as a "doctor shopper,"

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[5] A copy of Inspector Sakamura's spreadsheet documenting early refills for all four patients is on pages 42-44 of the Second Amended Accusation, and is incorporated herein by this reference. (Gov. Code, § 11425.50, subd. (b).)

in that he used multiple pharmacies and doctors to get more drugs than he needed for a legitimate medical purpose. For this reason, it was not established by either applicable evidentiary standard that BK's overdose death was attributable to respondents.

B. It is true that, had respondents used CURES information for BK during 2009, this activity would likely have been discovered. However, and as discussed in more detail above in the section entitled "The CURES Program," complainant failed to establish by either applicable evidentiary standard in this case that the law or standard of care in 2009 required respondents to use CURES in this way.

Patient KC

27. Inspector Sakamura conducted a drug audit of respondents' records for patient KC. The audit revealed that from February 6, 2009, through September 6, 2012, respondents filled 13 prescriptions (Methodone and Fentanyl) early by five or more days for patient KC.

Patient SM

28. Inspector Sakamura similarly conducted a drug audit of respondents' documents for patient SM. The audit of those records revealed that from January 2, 2009, through March 20, 2012, respondents filled 33 prescriptions (Alprazolam, Morphine, Methylphenidate, Methodone and Oxycodone) early by five or more days for patient SM.

Patient MS

29. Inspector Sakamura similarly conducted a drug audit of respondents' documents for patient MS. The audit of those records revealed that from January 16, 2009, through December 10, 2012, respondents filled eight prescriptions (Fentanyl, Morphine, Oxycodone and Diazepam) early by five or more days for MS.

Overall Early Refills Findings

30. Respondent Cassar failed to exercise or implement his best professional judgment and corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose when respondents filled the above-described 65 prescriptions early by five days or more for patients KC, SM, MS, and BK, between April 6, 2009, and December 10, 2012. The early refills for the prescriptions led to these patients receiving more medications than they were prescribed for the given time periods. For each of these four patients, a pattern of early refills emerged. Yet, respondent Cassar did not establish that he either interceded in the situation or documented efforts to do so. Under these circumstances, the 65 prescriptions in question were not for a legitimate medical purpose, in that no patient should consume or have access to more medication during a particular time period than recommended by the prescriber.

31. Respondents argued but failed to establish that complainant was unable to prove any of the above-described prescriptions were filled early because complainant failed to prove when the drugs were actually dispensed to the patients. The argument rests largely on the cross-examination testimony of Inspector Sakamura that she saw no documentation showing when the four patients in question actually picked up their prescriptions from respondent Kanan Pharmacy. However, Inspector Sakamura based her early refill computations solely on the documentation provided by respondents, who in turn failed to present any documentation showing the four patients picked up the 65 prescriptions in question on any other dates. As respondents were requested to provide all documentation concerning the four patients' prescriptions, complainant was entitled to rely on what was produced. Moreover, Inspector Sakamura persuasively testified it would be a violation of the standard of care and contrary to insurance reimbursement policies to fill a prescription but have it sit in the pharmacy for days until the patient picks it up at a later time. If such had happened, respondents should have documentation explaining the gap in timing.

32. Respondents also failed to establish that the 65 prescriptions in question were not early, but instead late. This argument is based on computations of respondent Cassar. However, Supervising Inspector Dang's testimony was persuasive that respondent Cassar's methodology of calculating the times between prescriptions was suspect. Moreover, respondent Cassar's testimony on this point was vague and not supported by documentation, unlike Inspector Sakamura. Finally, Mr. Sydejko's testimony was vague, unsubstantiated, and not persuasive.

PATIENT MS'S FENTANYL PATCHES

33. MS has been respondents' patient since 2003. In that year, he had micro surgery on his back that went badly, leading to physical deformity and constant pain. Dr. Glass, who did not perform the back surgery, managed MS's pain and prescribed "1-2 [Fentanyl] patches every 2 days" for MS, which were dispensed by respondent Kanan Pharmacy.

34. Inspector Sakamura opined that respondents' documentation for MS's Fentanyl patches was deficient, and that the prescription was problematic, because "the patient should not be guessing if they need one or two patches, in that the absorption rate of the patch takes a while, so the patient will not feel instant relief." Inspector Sakamura also testified the documentation was deficient because it contained no mention of respondent Cassar clarifying the prescription or talking to MS about how to use the patches. Inspector Sakamura's testimony on this point was brief and uncertain, in that she testified "it looked like MS was guessing," and she was vague concerning the standard of care in this area.

35. MS testified in this matter. He is highly complementary of respondents' service. He remains a patient. MS testified that respondent Cassar consulted with him about the Fentanyl patches, reviewed his medical records, and has always been concerned about his health. MS did not voice any concern about how to use the patches or uncertainty in instructions provided by respondents about them. He used the patches until one exploded

and released all the medication at once, which led to symptoms resembling a heart attack. At that time, MS was still experiencing pain in his back, so Dr. Stark, who had replaced Dr. Glass after his suicide, decided to replace the Fentanyl patches with Oxycontin.

36. Respondent Cassar documented that he discussed with Dr. Glass a Fentanyl dosage of one to two patches every two days (ex. 24, p. 574) and the dosage change to only one patch every two days (*Id.* at p. 575). On January 8, 2011, respondent Cassar noted a contact with the doctor concerning an absorption issue. Respondent Cassar noted another dosage verification on May 23, 2011.

37. Respondent's pain management expert, Dr. Paul Choi, testified without contradiction that many pain management physicians use Fentanyl patches for a shorter duration than 72 hours because of what Dr. Choi described as "end-dose-failure," i.e., the patch not lasting 72 hours as it is designed. Respondent's pharmacy practices expert, Mr. Sydejko, testified without contradiction that the standard of care permits pharmacists to dispense Fentanyl patches dosed every two days. Mr. Sydejko also testified without contradiction that his research revealed approximately 25 percent of patients apply the Fentanyl patch every two days instead of every 72 hours. He also testified without contradiction that the standard of care does not require a pharmacist to question the dosage of a two-day Fentanyl application, but does allow the pharmacist to simply discuss the dosage with the patient, which respondent Cassar did with MS.

38. Under these circumstances, complainant failed to establish under either evidentiary standard that respondent Cassar committed acts or omissions that involved an inappropriate exercise of his education by filling the Fentanyl prescription to MS as he did.

RETAINING PRESCRIPTION RECORDS

39. As discussed above, on March 15, 2013, Inspector Sakamura requested respondents produce documentation concerning prescriptions for the four patients in question. On April 22, 2013, respondents produced documents in response. After reviewing those documents, Inspector Sakamura concluded records for six prescriptions were missing. She issued a notice of deficiency concerning the records she believed were missing. As a result, respondents produced another set of documents on September 3, 2013.

40. By the end of the first week of hearing, Inspector Sakamura conceded on cross-examination that, as a result of respondents' two document productions, she had received five of the six prescriptions in question. She testified that the only prescription still missing was RX 2208439, for a 10-day supply of "dext/amp," prescribed by Dr. Glass. However, the evidence established that respondents processed RX 2208439 on July 21, 2009, which was well more than three years before Inspector Sakamura requested a copy of it; and that respondents ultimately produced a copy of that prescription to Inspector Sakamura after receiving the notice of deficiency. On cross-examination during the second week of hearing, Inspector Sakamura admitted, "It seems they [respondents] kept long—records longer than

three years." She also conceded she had received copies of all of the six prescriptions in question, including RX 2208439.

PRESCRIPTION DEVIATIONS

41. A. RX 2211845 for patient MS was written for a quantity of 300 morphine sulfate tablets, but it was filled by respondents with only 240 tablets, without an explanation for the discrepancy. Inspector Sakamura opined that if a pharmacist fills a prescription with less tablets than prescribed, the standard of care requires the pharmacist to "talk to the prescriber and change the prescription" before dispensing a quantity that is different from the amount listed on the face of the prescription.

B. Respondent Cassar explained that, according to the prescription label, the day supply allowed by MS's insurance plan was only a 30-day supply which, in this case, amounted to 240 tablets. Respondent Cassar and Mr. Sydejko both testified that the way this prescription was filled conformed with the standard of care and is a commonly accepted way of handling the situation. Respondent Cassar also testified that today's managed care practice generally limits the quantity of most prescriptions billed to drug insurance plans to a 30-day supply, and that for this reason, it was not necessary to contact the prescriber.

C. Under these circumstances, respondent Cassar and Mr. Sydejko provided a more reasonable, practical explanation for handling a situation like this, and therefore, their opinions were more credible than Inspector Sakamura's opinion.

42. A. RX 2209222 for patient KC was written for a quantity of 220 milliliters of oxycodone liquid, but was filled with only 210 milliliters, with no documented explanation why the quantity was changed. Inspector Sakamura opined "the fact that it's less is not a good thing," and that "if you're going to deviate from it [the prescription] you should write that you spoke to somebody and you have a reason and you changed a prescription."

B. On the other hand, respondent Cassar and Mr. Sydejko testified that oxycodone liquid is supplied in 30-milliliter size bottles with express instruction from the manufacturer mandating the use of original bottles and the calibrated dropper that is supplied with each original bottle. The solution therefore should not be transferred to a different container. In this case, respondents used seven of the 30-milliliter size bottles, for a total of 210 milliliters; they could not have filled 220 milliliters with these constraints. For this reason, there was no need to contact the prescriber.

C. Under these circumstances, respondent Cassar and Mr. Sydejko provided a reasonable, practical explanation for handling a situation like this. Inspector Sakamura's opinion did not take into account the practical realities and constraints of this situation.

43. A. RX numbers 2213046, 2213044, 2213043, and 4425972 for patient SM were to be dispensed on March 29, 2011, but were filled by respondents on March 18, 2011, and actually dispensed by respondents on March 28, 2011. Inspector Sakamura testified

there should have been documentation explaining why the prescriptions were provided one day earlier than ordered by the prescriber.

B. Respondent Cassar offered a convoluted explanation for this situation, involving his contention that the prescription had been placed "on hold," that he mistakenly read the fill date to be "3/27/2011," and that notations for the prescriptions had been filed away by staff before he could review them. Regardless, the medication was provided to the patient one day earlier than ordered by the prescriber and respondents' documentation for these prescriptions does not provide an explanation for the discrepant dates. Mr. Sydejko did not opine on this situation.

C. In light of these circumstances, it was clearly and convincingly established that there was a deviation between the prescription fill date and when the prescriptions were actually dispensed to patient SM without documentation indicating the prescriber's consent for such deviation.

Complaint by Dr. KT[6] Concerning Forged Prescriptions

44. CB and JC are sisters. They were existing patients of respondent Kanan Pharmacy by no later than 2014.

45. On September 22, 2015, the Board received an e-mail from Dr. KT, a cosmetic surgeon, explaining that a patient (CB) stole her prescription pad, forged her signature, and used the stolen prescription forms to fill prescriptions for herself and her sister JC at various pharmacies. Dr. KT had agreed to prescribe a limited amount of amphetamine to CB only because she was told CB's psychiatrist was out of town. Dr. KT had not agreed to provide any prescription for JC.

46. A. Inspector Noelle Randall was assigned to investigate Dr. KT's complaint. As part of her investigation, Inspector Randall reviewed CURES Patient Activity Reports, which showed controlled substance dispensing histories for CB and JC.

B. The CURES reports indicated CB and JC received prescriptions for amphetamine tablets under the prescribing authority of Dr. KT from several pharmacies, including: (1) CVS Pharmacy; (2) Pavilions Pharmacy; (3) respondent Kanan Pharmacy; (4) Medallion Pharmacy; (5) Super Care Drugs Malibu; (6) Save On Pharmacy; and (7) Rite Aid Pharmacy.

C. For example, CB had prescriptions for amphetamines filled by respondent Kanan Pharmacy on August 13, 2014; seven days later, on August 20, 2014, at CVS Pharmacy; five days later, on August 25, 2014, at Pavilions Pharmacy; two days later, on August 27, 2014, at Rite Aid Pharmacy; ten days later, on September 6, 2014, at Save On Pharmacy; and seven days later, on September 13, 2014, at respondent Kanan Pharmacy.

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[6] The physician's name is omitted to protect her privacy.

D. CB continued to get forged prescriptions filled by respondent Kanan Pharmacy from August 13, 2014, through September 3, 2015.

47. Inspector Randall verified that respondent Kanan Pharmacy had filled a total of nine forged prescriptions for CB and two for JC. Inspector Randall noted that the heading at the top of the prescription forms was, "Dr. [KT] Cosmetic & Reproductive Surgery." As part of her investigation, Inspector Randall asked respondent Cassar about respondent Kanan Pharmacy's policies for evaluating and filling controlled substance prescriptions in general. Respondent Cassar provided a copy of a document titled, "Kanan Pharmacy Diversion Initiative Program" (Diversion Program). (Ex. 5, pp. 287-293.)

48. A. As a result of her investigation, Inspector Randall determined the following facts.

B. All of the 11 forged prescriptions were written for amphetamine 10 milligram tablets, to treat attention-deficit disorder, and the preprinted prescriber information on the prescription document indicated the prescriber, Dr. KT, was a cosmetic and reconstructive surgeon. Inspector Randall opined it would not be typical for a surgeon to prescribe amphetamine 10 milligram tablets, as it is not typically used during surgery or recovery. Inspector Randall opined this was a red flag for potential drug diversion.

C. Nine of the eleven prescriptions in question were purchased with cash, not prescription insurance. Inspector Randall opined this payment method was also a red flag for potential diversion, since CB and/or JC had prescription insurance that would have covered the amphetamines, which had been used for two of the prescriptions in question.

49. Respondents did not produce any documentation indicating a pharmacist of respondent Kanan Pharmacy contacted Dr. KT to gain information needed to validate the prescriptions described above prior to dispensing.

50. When asked during the hearing why CURES reports were not run for CB and JC, respondent Cassar testified the Diversion Program only addressed the opiate prescriptions, and that amphetamine is not an opiate. Complainant contends respondents' Diversion Program specifically required running a CURES check for each controlled substance prescription, but a review of the entire document tends to show such a requirement was, in fact, for opioids and not a controlled substance like amphetamines. (See, e.g., ex. 5, pp. 287-290.)

51. Inspector Randall testified that because of the two red flag factors described above, the standard of care required respondents to notify the prescriber, Dr. KT, and verify the validity of the prescriptions. Respondents failed to do so. As discussed in more detail below, a pharmacist employed by respondents ultimately became suspicious of CB, leading that pharmacist to contact respondent Cassar, who in turn ran a CURES check and contacted Dr. KT with his suspicion that CB was drug-seeking and forging Dr. KT's prescriptions. That action supports Inspector Randall's opinions. Under these circumstances, it was clearly

and convincingly established that respondents failed to exercise their corresponding responsibility by filling forged prescriptions passed by CB.

52. Mr. Sydejko did not opine that respondents acted in accordance with the standard of care. In fact, Mr. Sydejko testified that, under the circumstances as he knew them, including the presence of the two red flag factors, respondents' failure to discover that the prescriptions were forged "was an issue."

53. However, there is significant mitigation involved in this situation. Respondent Cassar was the only pharmacist to discover the prescriptions were forged and he advised Dr. KT what happened, essentially putting a stop to CB's forgeries. None of the other involved pharmacies or pharmacists did so, all of whom received a citation and fine from the Board. After he discovered CB was forging prescriptions, Dr. Cassar contacted pharmacies in his area, as well as the doctors who had written prescriptions for CB and JC, and notified them of the situation. Respondent Cassar also documented CB and JC's patient profiles with a warning not to fill any more prescriptions for them. Inspector Randall also testified that none of the other pharmacies had a written policy like respondents' Diversion Program.

Altered Prescription Forms

54. As discussed above, Inspector Sakamura requested respondents produce documentation concerning prescriptions for patients KC, SM, MS, and BK. On April 22, 2013, respondents produced hundreds of pages of documents in response. Respondents produced another set of documents on September 3, 2013, approximately five months after the first production of documents. Inspector Sakamura apparently did not compare the two produced sets of documents with each other, but she did conclude her request for missing documents had been satisfied by the second document production.

55. During the first week of the hearing of this matter, Inspector Sakamura was vigorously cross-examined about her initial contention that respondents had not produced all responsive documents in the April 2013 production. Prompted by that questioning, Inspector Sakamura compared the two productions of documents and noticed that the two versions of the same three prescriptions she received for patients KC and MS were different. Specifically, the version of those prescriptions produced in September 2013 had additional notations written on them which were not on the first version of the documents produced in April 2013. Inspector Sakamura concluded that respondents had altered the prescriptions in question before sending copies of them to her in September 2013.

56. As for two of the prescriptions in question, the original version of prescriptions RX 2213183 and RX 2213184 (Methadone and Oxycodone) for patient KC were signed by Dr. Glass on April 11, 2011. However, the second version of those prescriptions received by Inspector Sakamura in September 2013 included the additional notation, "OK to dispense 4/11/12 per MD," with initials next to the notation, which was not on the original version of the two prescriptions.

57. The other prescription in question was RX 4416591 (Diazepam 10 mg tablets) for patient MS. The original version of this prescription sent to Inspector Sakamura had a date of "5/ /09." The second version of this prescription provided to her in September 2013 had the date of "5/08/09" and the following handwritten note, "Date Rx 5/8/09 per MD," with initials next to the notation, none of which was on the original version.

58. A. Because these discrepancies were not noticed until after the hearing began, respondent Cassar's explanation for them was not offered until he testified during the second week of the hearing, which was approximately six months later. Respondent Cassar testified as follows.

B. He assigned the task of gathering all of the requested prescriptions and the copying of those records to his staff. Copies were sent to Inspector Sakamura. Respondent Cassar did not retain a set of the copies for himself. The staff gradually returned the original prescriptions to the original prescription books.

C. As staff were returning the original prescriptions back to their files, one staff member told respondent Cassar there were notes attached to the three prescriptions in question that had been copied and sent to Inspector Sakamura. Respondent Cassar decided to transfer the substantive parts of the notes onto the prescriptions and then he discarded the notes; the original prescriptions were filed away. Respondent Cassar did not believe it would be necessary to keep the notes anymore because he thought copies of all of the prescriptions, including the notes, had already been sent to Inspector Sakamura. He discarded the notes because he did not believe the notes had further clinical significance.

D. Respondent Cassar testified the note related to KC's prescriptions contained references to his pharmacy's multiple attempts to contact Dr. Glass to find out if he would agree to allow KC to receive the two prescriptions in question on April 11, 2011, because KC wanted her prescription filled on that date, even though the doctor had a clear notation on the prescription not to dispense until the following day, April 12, 2011. The second version of the prescription has the wrong date of April 12, 2012, because respondent Cassar mistakenly wrote the year the prescription expired, one year later, or 2012, as opposed to when the prescription was filled in 2011.

E. Respondent Cassar testified the same process happened with MS's prescription, though he was not as specific in his discussion as he was regarding KC's prescriptions. However, the evidence established that MS's prescription was processed on the same date as that written by respondent Cassar, i.e., May 8, 2009.

59. Respondent Cassar's testimony is not credited because it is self-serving, uncorroborated, and not persuasive. Although he testified his staff was involved in the situation, respondent Cassar failed to identify any particular employee or offer evidence from any employee as corroboration. He failed to offer a satisfactory explanation why he did not attempt to confirm with his staff whether the notes he threw away had been copied and sent to Inspector Sakamura. He failed to offer a satisfactory explanation why he did not contact

Inspector Sakamura after he discovered the notes and transferred the information to the original prescriptions. It is hard to understand why respondent Cassar would knowingly alter original documentation by adding to them additional information, and then after doing so destroy the notes with the information on them. This is especially so given that respondent Cassar was under investigation by the Board at the time. More importantly, the information allegedly on the notes and transferred to the prescription forms was material and added missing information one would want to know. For example, KC's original prescriptions begged the question why they were filled one day earlier than authorized by Dr. Glass. The altered version of MS's prescription provided the authorization fill date missing in the original.

60. To be clear, it was not established by either applicable evidentiary standard that respondent Cassar failed to contact Dr. Glass's office and obtained authorization to fill KC's prescriptions one day earlier or to fill MS's prescription on May 8, 2009. Respondent Cassar or his staff probably did so and complainant presented insufficient evidence establishing otherwise. Under these circumstances, however, it was established that respondent Cassar altered the three prescriptions in question by adding additional information to them not contained in writing in his records when the first production of documents was sent to Inspector Sakamura.

61. In mitigation, it must be noted that of the hundreds of pages of prescription documents produced by respondents during the Board's investigation, only these three prescriptions were altered.

Respondents' Evidence

62. In mitigation, respondent Cassar fully cooperated with the Board at all times during the investigation. During the hearing, he was respectful and forthcoming in his testimony (with the lone exception of his testimony regarding the three altered prescriptions). He also expressed remorse for his shortcomings proven in this case, particularly in the area of documentation. He testified he has regrets in that area and will "try to do better in the future." The ALJ is also impressed with respondent Cassar's calm and cooperative demeanor during the hearing, in which his practices and character were vigorously, and at times unfairly, attacked by the prosecutor.

63. In further mitigation, respondent Cassar has tried to refine and restructure his practice since the events in question. He testified that his practice from 2008 through 2018 has evolved and has changed substantially, including more intensive documentation of all substantive communications. In addition, respondents created the Diversion Program, discussed above, which was launched in the first part of 2013 to address concerns about diversion and opioid use. Initially, the Diversion Program was designed to monitor patients' opioid prescriptions and used tools such as drug urine testing and toxicology reports. The program requires a valid form of identification for opioid prescriptions, and has a requirement that no controlled substance prescription may be filled more than three days

early. As of 2016, this policy was revised to disallow all opioid prescriptions from being filled early by more than one day.

64. In further mitigation, since mid-2013, respondent Kanan Pharmacy routinely uses CURES to monitor opioid prescriptions. Following Inspector Sakamura's March 2013 inspection, the level of documentation also has increased. In 2014, respondent Cassar also changed respondent Kanan Pharmacy's computers and operating system, which makes documentation of information and the pharmacist intervention related to dosing of medications, drug allergies, drug-to-drug interactions, and other relevant information easier and more efficient. After respondents exposed the forged prescriptions involved in this case, respondent Kanan Pharmacy's policy regarding CURES verification was expanded. Now respondents obtain a CURES report for all controlled substance prescriptions (opioids as well as non-opioids) and for all patients (new or existing) and for all prescription orders whether it is a new prescription order or a refill request.

65. In further mitigation, respondent Cassar has taken and completed two seminars on corresponding responsibility, one in May 2013 and the second in May 2018. He has completed additional educational courses related to opioids, pain management, pharmacy law, drug interactions, laws related to risks of reducing opioid overdose, and pharmacists' role in the management of opioid use disorder. (Ex. M.) Additionally, respondent Cassar has subscribed to the License Protection Handbook published by Mr. Sydejko as a way of staying compliant with the laws and regulations governing pharmacy practice.

66. A. Respondents presented the following persuasive character witnesses with excellent backgrounds and detailed knowledge of respondents' character and pharmacy practices:

B. LL has been respondents' patient for over 10 years and has continued to use their services even after moving to San Diego, because she trusts respondent Cassar's judgment. In fact, she testified about an incident in which she believes respondent Cassar saved her life by recognizing a potentially bad drug-to-drug interaction when LL was prescribed a drug for acid reflux; and another incident where she believes respondent Cassar's direct intervention prevented LL's son from experiencing a potentially adverse drug reaction. LL also praises respondent Cassar's other valuable services of frequently reviewing her medications and helping her choose a Medicare plan with the best coverage.

C. Dr. Freeman, who was discussed in great detail above concerning the CURES program, is a veteran pharmacist of 55 years who offered credible and persuasive testimony. He has known respondent Cassar since he was a pharmacy student and became active with the California Pharmacists Association. During his many visits to respondent Kanan Pharmacy's premises, Dr. Freeman has been impressed with the level of respondent Cassar's interactions with his patients. Dr. Freeman has no concerns regarding respondent Cassar's competence to practice pharmacy.

D. Dr. Robert Waldman has been a practicing physician since 1983, with approximately 50 percent of his practice devoted to addiction recovery. He has known respondent Cassar since 2004. Dr. Waldman frequently has interacted with respondent Cassar over the years. He describes respondent Cassar as "very compulsive" about verifying prescriptions with him and that he "always notified" him regarding potential medication side effects or when respondent Cassar suspected someone might be misusing his medications. Although Dr. Waldman found respondent Cassar's input valuable, he actually thought some of his input was "excessive," as he generally received at least one call daily to discuss patient care. Dr. Waldman believes respondent Cassar is extremely ethical and moral.

E. Dr. Bruce Lockwood is a psychiatrist who refers some of his patients to respondents for their prescriptions. Dr. Lockwood testified that he interacts with respondent Cassar frequently, sometimes as many as one to three times daily regarding various patient care issues. Dr. Lockwood believes respondent Cassar is very knowledgeable and he described respondent Cassar as a great pharmacist who is not a danger to the public. The patients he refers to respondents rave about the service they received.

F. Two other informative character witnesses testified on respondents' behalf. George Sanford is a retired police sergeant who knows respondent Cassar through the Boy Scouts program, and he regards respondent Cassar to be honest, ethical, and a good mentor to his sons. Maria Cassar, respondent Cassar's wife and part-owner of respondent Kanan Pharmacy, describes her husband as a good husband and father, who has integrity, and is "very detail oriented."

67. During the hearing, Inspector Sakamura testified on cross-examination that she had no opinion on whether respondents pose a threat to the public, which the ALJ construes to mean she does not believe respondents currently pose a threat to the public.

The Board's Costs

68. A. Complainant presented evidence of the following costs incurred in the investigation and prosecution of this case:

B. The total investigation costs of Board inspectors are $37,285.25[7], comprised of (1) $13,733.50 in costs charged by Inspector Randall; (2) $5,937.25 in costs charged by Supervising Inspector Dang; (3) and $17,614.00 in costs charged by Inspector Sakamura.

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[7] The Board's final statement of investigation costs, dated October 23, 2018, contains a total amount of $38,935.75 (ex. 3, p. 31), which is more than the sum of the three listed inspectors' charges. In their closing briefs, the parties refer to costs apparently charged by another Board inspector, Antony Ngondora, but the costs evidence (ex. 3) does not contain any documentation for charges by Inspector Ngondora.

C. According to the certification of prosecution costs and declaration of Morgan Malek, the total prosecution costs incurred by the Board were $43,777.50, based on charges by several deputy attorneys general working on this case in addition to Ms. Malek. (Ex. 3, p. 41.)

D. Based on the above, the total investigation and prosecution costs being sought against respondents are $81,062.75.

69. A. However, a number of those charges or their components are unreasonable, unnecessary, or worthy of reduction for the following reasons:

B. The $5,937.25 of charges by Supervising Inspector Dang are not warranted, as they were not investigation costs. Supervising Inspector Dang was not involved in the underlying investigation of this matter, unlike Inspectors Sakamura and Randall. Rather, she was used as a rebuttal expert witness to counter some opinions offered by respondent Cassar and Mr. Sydejko.

C. Inspector Sakamura was the lead investigator in this matter. She charged a total of 158.25 hours. However, only 28 hours of her time were spent on actual investigation work. She charged 44 hours for writing her two reports and 80 hours preparing for the hearing. The time spent preparing for the hearing is not reasonable, in that it is not investigation work. Under these circumstances, 50 percent (160 hours minus 80 hours) of Inspector Sakamura's charges of $17,614.00 should be reduced, i.e., $8,807.00.

D. Inspector Randall is based in San Diego. She charged 27.75 hours travelling to Los Angeles to conduct her investigation. The Board has inspectors based in Los Angeles County who could have handled that work. Respondents should not have to subsidize the Board's staffing and travel costs, so Inspector Randall's travel time should not be awarded. Inspector Randall also charged 40.25 hours for hearing preparation. As discussed above, hearing preparation time is not investigation work and therefore should not be awarded. Inspector Randall charged a total of 113.50 hours, 68 hours of which should be reduced, which is a reduction of approximately 60 percent. Therefore, Inspector Randall's total charges of $13,733.50 should be reduced by 60 percent, or $8,240.10.

E. In her rebuttal brief, Ms. Malek agrees her charges of $6,800 for the five days of hearing in April 2018 should be eliminated. Many other deputy attorneys general charged time for their work on this case in the total amount of $5,397.50, yet none of those other attorneys appeared in this case and it is not established that their work was reasonable or necessary. Respondents should not have to subsidize the Department of Justice's staffing and personnel turn-over. In their closing brief, respondents make a spirited attack on the efficiency and reasonableness of Ms. Malek's remaining charges. While the attack is not entirely off-base, it does not warrant further reduction. Therefore, the total reductions to the prosecution costs are $12,197.50.

F. The reductions discussed above total $35,181.85. When the reductions are subtracted from the total investigation and prosecution costs of $81,062.75, what remains is a new total cost amount of $45,880.90. Complainant alleged eight causes for discipline against respondents, but only succeeded with four of them, or 50 percent. Therefore, the remaining total costs of $45,880.90 should be reduced by 50 percent, leaving a final amount of $22,940.45.

70. Based on the above, it was established that the Board incurred reasonable costs of investigation and prosecution in the amount of $22,940.45.

LEGAL CONCLUSIONS

Burden and Standards of Proof

1. The burden of proof in a licensing disciplinary action is on the party bringing the charges in an accusation, here complainant. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 789 fn 9.)

2. Respondent Cassar's pharmacist license is a professional one. (*Murphy v. E. R. Squibb & Sons, Inc.* (1985) 40 Cal.3d 672, 678-679.) To impose discipline on a professional license, complainant must prove cause for discipline by clear and convincing evidence to a reasonable certainty. (*Sternberg v. California State Bd. of Pharmacy* (2015) 239 Cal.App.4th 1159, 1171 [*Sternberg*]; *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) Clear and convincing evidence "requires a finding of high probability," and has been described as "requiring that the evidence be ' "so clear as to leave no substantial doubt"; "sufficiently strong to command the unhesitating assent of every reasonable mind." ' [Citation.]" (*In re Angelia P.* (1981) 28 Cal.3d 908, 919.)

3. In contrast, respondent Kanan Pharmacy's permit is a nonprofessional license, because it does not have extensive educational, training, or testing requirements akin to a professional license. (See *Mann v. Department of Motor Vehicles* (1999) 76 Cal.App.4th 312, 319; *San Benito Foods v. Veneman* (1996) 50 Cal.App.4th 1889, 1894.) An applicant for a pharmacy permit need not be a pharmacist; instead, the applicant must designate a PIC with the requisite education, training, and licensure. (§§ 4110, subd. (a), 4113, subd. (a).) To impose discipline on respondent Kanan Pharmacy's nonprofessional pharmacy permit, complainant must prove cause for discipline by a preponderance of the evidence, which is a lower standard of proof than clear and convincing evidence. (*Imports Performance v. Dept. of Consumer Affairs, Bureau of Automotive Repair* (2011) 201 Cal.App.4th 911, 916-917; Evid. Code, §115.) A preponderance of the evidence means "'evidence that has more convincing force than that opposed to it.' [Citation.]" (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.)

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Cause for Discipline Against Respondents

FIRST CAUSE FOR DISCIPLINE: ALTERED DOCUMENTS

4. A. Section 4301, subdivision (f), defines unprofessional conduct to include the "commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not."

B. Section 4301, subdivision (g), also defines unprofessional conduct to include "[k]nowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts."

C. Section 4301, subdivision (q), also defines unprofessional conduct to include "[e]ngaging in any conduct that subverts or attempts to subvert an investigation of the board."

D. In this case, respondents are subject to disciplinary action under section 4301, subdivisions (f), (g), (q), on the grounds of unprofessional conduct, in that respondents presented three altered prescriptions to Inspector Sakamura. In doing so, respondents acted dishonestly by portraying to the Board a false version of original prescriptions which contained additional information not on the originals. (*Id.*, subd. (f).) Such conduct also constitutes respondents' knowingly making documents that falsely represented information which had not been written on the original versions. (*Id.*, subd. (g).) Finally, submitting altered documents subverted Inspector Sakamura's investigation. (*Id.*, subd. (q).) (Factual Findings 54-61.)

SECOND CAUSE FOR DISCIPLINE: CORRESPONDING RESPONSIBILITY

5. A. Section 4113, subdivision (c), provides that a PIC of a pharmacy "shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy." Section 4036.5 defines a PIC as a pharmacist proposed by a pharmacy and approved by the Board as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.

B. Section 4301 defines unprofessional conduct to include clearly excessive furnishing of controlled substances in violation of Health and Safety Code section 11153 (subd. (d)), violation of state or federal statutes regulating controlled substances and dangerous drugs (subd. (j)), and violating or attempting to violate state or federal law governing pharmacy (subd. (o)). Pursuant to Health and Safety Code section 11153, subdivision (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 professional practice. The statute also provides that, although the responsibility for the proper prescribing

and dispensing of controlled substances is upon the prescribing practitioner, "a corresponding responsibility rests with the pharmacist who fills the prescription."

C. In *Vermont & 110th Medical Arts Pharmacy v. Board of Pharmacy* (1981) 125 Cal.App.3d 19 (*Vermont*), the court held that the statutory scheme in place, including some of the statutes discussed above, "plainly calls upon pharmacists to use their common sense and professional judgment. When their suspicions are aroused as reasonable professional persons by either ambiguities in the prescriptions, the sheer volume of controlled substances prescribed by a single practitioner for a small number of persons or, as in this case, when the control inherent in the prescription process is blatantly mocked by its obvious abuse as a means to dispense inordinate and incredible large amounts of drugs under the color and protection of law, pharmacists are called upon to obey the law and refuse to dispense." (*Vermont, supra,* 125 Cal.App.3d at p. 25.)[8]

D. Respondents are subject to disciplinary action under sections 4113, 4036.5, 4301, subdivisions (d), (j), and (o), in conjunction with Health and Safety Code section 11153, subdivision (a), and pursuant to *Vermont*, on the grounds of unprofessional conduct, in that it was established by clear and convincing evidence that respondent Cassar failed to exercise or implement his best professional judgment or corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose when respondents filled 65 prescriptions early by five days or more for patients KC, SM, MS, and BK, between April 6, 2009, and December 10, 2012. The early refills for those prescriptions led to those patients receiving more medications than they were prescribed for the given time periods. (Factual Findings 17-32.)

E1. Respondent Kanan Pharmacy asserts a pharmacy is not subject to discipline under these statutes, because California's corresponding responsibility law only applies to pharmacists. "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." (Health & Saf. Code, § 11153, subd. (a).)

E2. However, *Vermont* upheld discipline of a pharmacy's permit for a pharmacist's violation of the corresponding responsibility law. (*Vermont, supra,* 125 Cal.App.3d at pp. 23-26.) As complainant points out, under general administrative law, the holder of a pharmacy permit can be subject to disciplinary action based solely on the actions or omissions of an employee who is a licensed pharmacist under the doctrine of respondeat superior. (*Randle v. California State Bd. of Pharmacy* (1966) 240 Cal.App.2d 254, 261.)

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[8] The Board's Precedential Decision No. 2013-01 (*Board of Pharmacy v. Pacifica Pharmacy Corporation, et al.,* Case No. 3802, OAH No. 2011010644 [*Pacifica*]) is not applicable to this cause for discipline, in that the Decision was not effective until 2013, which was after the events in question. The same is true of complainant's citation to *Sternberg*, which was published in 2015.

Furthermore, the Pharmacy Law authorizes the Board to "deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee." (§ 4302.) Respondent Kanan Pharmacy is a licensed pharmacy corporation, and respondent Cassar owns 50 percent of its stock, meaning complainant may discipline respondent Kanan Pharmacy's pharmacy permit for respondent Cassar's violations of the corresponding responsibility law.

THIRD CAUSE FOR DISCIPLINE: MISUSE OF EDUCATION

6. A. In addition to the statutes cited above in connection with the second cause for discipline, complainant also alleges that Regulation 1761, subdivision (a), as well as the cases of *Sternberg*, *Vermont*, and *Pacifica*,[9] support the third cause for discipline against respondents for misuse of education. Regulation 1761, subdivision (a), provides that "[n]o 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. It was not established that respondents are subject to disciplinary action for misuse of education under the authority cited above, in that it was not established that respondent Cassar committed acts or omissions involving the inappropriate exercise of his education. Specifically, it was not established by either standard that respondent Cassar failed to properly document or question patient MS's Fentanyl prescription, or that he violated the standard of care by not accessing CURES data for patient BK in 2009. (Factual Findings 11-22 & 33-38.)

FOURTH CAUSE FOR DISCIPLINE: RETAINING CONTROLLED SUBSTANCE PRESCRIPTIONS

7. A. Section 4081, subdivision (a), requires that all "records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be . . . preserved for at least three years from the date of making." Section 4105, subdivision (c), similarly requires, "[t]he records required by this section shall be retained on the licensed premises for a period of three years from the date of making." Section 4169, subdivision (a)(5), also requires licensees to maintain records of the acquisition or disposition of dangerous drugs or dangerous devices for at least three years. Finally, Health and Safety Code section 11179 requires a "person who fills a prescription shall keep it on file for at least three years from the date of filling it."

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[9] However, complainant has not argued how *Sternberg*, *Vermont*, or *Pacifica* support this cause for discipline, or even clarify the charging statutes. Nor is it clear how *Sternberg* and *Pacifica*, published after the events in question, are applicable.

B. It was not established that respondents are subject to disciplinary action under sections 4081, subdivision (a), 4105, subdivision (c), 4169, subdivision (a)(5), and/or Health and Safety Code section 11179, in that it was not established under either standard that respondents failed to retain one prescription (RX 2208439) filled by the pharmacy for a controlled substance for three years from the date of filling. The one prescription in question was filled more than three years from the date a copy of it was requested by Inspector Sakamura, who also conceded during the hearing that she ultimately received a copy of it. Under these circumstances, complainant's argument that cause for discipline is warranted was less than colorable and bordered on frivolous. (Factual Findings 39-40.)

FIFTH CAUSE FOR DISCIPLINE: RETAINING CONTROLLED SUBSTANCE PRESCRIPTIONS

8. A. In addition to the statutes cited above in connection with the fourth cause for discipline, the fifth cause for discipline also alleges that section 4105, subdivision (a), further requires that a pharmacy maintain three years of acquisition and disposition records "in a readily retrievable form."

B. It was not established that respondents are subject to disciplinary action under section 4105, subdivision (a), in that it was not established under either standard that respondents failed to maintain in the pharmacy three years of acquisition and disposition records in a readily retrievable form. Liability here is premised on the same allegedly missing prescription (RX 2208439), but the evidence established that prescription was issued well more than three years before Inspector Sakamura requested a copy of it. Thus, the fact that respondents submitted a copy of this prescription several months after Inspector Sakamura first requested it is irrelevant. (Factual Findings 39-40.)

SIXTH CAUSE FOR DISCIPLINE: VARIATION FROM PRESCRIPTIONS

9. A. Regulation 1716, in conjunction with section 4301, subdivisions (j) and (o), provides that it can be unprofessional conduct for a pharmacist to "deviate from the requirements of a prescription except upon the prior consent of the prescriber. . . ."

B. Respondents are subject to disciplinary action under Regulation 1716, in conjunction with section 4301, subdivisions (j) and (o), on the grounds of unprofessional conduct, in that for RX numbers 2213046, 2213044, 2213043, and 4425972, respondents deviated from those prescriptions by providing the medication to the patient one day earlier than the date specified on the prescriptions without documenting the consent of the prescriber. (Factual Finding 43.) However, it was not established under either standard that there was such an improper deviation concerning RX numbers 2209222 or 2211845. (Factual Findings 41 & 42.)

SEVENTH CAUSE FOR DISCIPLINE: ERRONEOUS OR UNCERTAIN PRESCRIPTIONS

10. A. This cause for discipline is based on the 65 early refill prescriptions that are the basis of the second cause for discipline discussed above, except that the seventh cause

for discipline is premised solely on an alleged violation of Regulation 1761, subdivision (a), which was recited and discussed in Legal Conclusion number six above.[10]

B. It is alleged that, pursuant to Regulation 1761, subdivision (a), respondents were required to document calls they made to the four patients in question concerning the need to refill these prescriptions early. However, as recited above, Regulation 1761, subdivision (a), does not contain such a requirement vis-à-vis a patient, but rather focuses only on contacts with the prescriber. In that regard, the issue with these 65 prescriptions was that they were filled early, not that there was any error or irregularity with any of the prescriptions issued by the prescribers that required contact with the prescriber. Since respondents have already been held liable for refilling these prescriptions under the corresponding responsibility theory, liability here would be duplicative and gratuitous. Therefore, respondents were not required to contact the prescribers pursuant to Regulation 1761, subdivision (a).

C. Under these circumstances, no cause for discipline was established against respondents pursuant to Regulation 1761, subdivision (a). (Factual Findings 17-32.)

EIGHTH CAUSE FOR DISCIPLINE: ERRONEOUS OR UNCERTAIN PRESCRIPTIONS

11. A. Like the seventh cause for discipline above, this one is also based on an alleged violation of Regulation 1761, subdivision (a), in addition to unprofessional conduct pursuant to section 4301, subdivisions (j) and (o).

B. Respondents are subject to disciplinary action under section 4301, subdivisions (j) and (o), in conjunction with Regulation 1761, subdivision (a), for unprofessional conduct, in that respondents dispensed 11 prescriptions over a one-year period, which had been forged by a patient and therefore each contained a significant error, omission, irregularity, uncertainty, ambiguity, or alteration. Respondents failed to contact the prescriber, Dr. KT, to obtain the information needed to validate the prescriptions, despite having a corresponding responsibility to do so based on the presence of two red flag factors that should have made them suspicious of the validity of the prescriptions. (Factual Findings 44-53.)

C. Respondents' argument that a pharmacy is not subject to discipline for a violation of Regulation 1761, subdivision (a), is rejected for the same reasons explained above concerning the same argument made as to the second cause for discipline.

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[10] In her rebuttal brief, complainant also cites to Regulation 1761, subdivision (b), which was not alleged in the Second Amended Accusation. Therefore, subdivision (b) is not considered.

Imposition of Discipline

12. A. Rehabilitation is a "state of mind" and the law looks with favor upon rewarding with the opportunity to serve one who has achieved "reformation and regeneration." (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041, 1058.) Acknowledgement of the wrongfulness of one's actions is an essential step toward rehabilitation. (*Seide v. Committee of Bar Examiners* (1989) 49 Cal.3d 933.)

B. After having cited the two cases above, complainant argues respondents "fought tooth & nail during the 10 days of administrative hearing . . . and claimed that they have done nothing wrong." (Ex. 27, p. 12.) While respondents vigorously defended against the operative pleading, which was their right, respondent Cassar did not contend he did nothing wrong. As discussed in the Factual Findings, respondent Cassar admitted that he made mistakes and pledged to do better in the future. He has taken meaningful steps to evolve his practice and pharmacy over time, as the opioid crisis has become more acute. It is unlikely he will commit the same misconduct in the future. His actions are consistent with the general principles of rehabilitation articulated in the *Pacheco* and *Seide* cases cited by complainant.

C. Moreover, and contrary to complainant's arguments, respondents in this case are simply not like those respondents involved in the *Vermont* and *Pacifica* cases, whose actions were so egregious as to warrant revocation of their licenses. While the overdose death of BK is sad and troubling, for various reasons, and apparently was the operating animus for this action against respondents, his death cannot be fairly attributed to respondents.

D. Finally, respondent Cassar appears to be a pharmacist and business owner doing his best in troubling times for pharmacy professionals. The ALJ is convinced that most of the misconduct established in this case was endemic among the pharmacy community at the times in question and therefore is not as egregious as claimed by complainant, when viewed through the prism of the standards at those times and not through the current standards.

13. An administrative proceeding such as this is not meant to punish a licensee, but rather to protect the public. (*Camacho v. Youde* (1979) 95 Cal.App.3d 161, 165.) Since cause for discipline was established in this case, the level of discipline to be imposed on respondents must be determined. In reaching a decision on disciplining a licensee, the Board's Disciplinary Guidelines [Rev. 2/2017] (Guidelines) are to be considered. (Cal. Code Regs, tit. 16, § 1760.) The Guidelines divide the various types of violations into four categories, ranging from the least serious, Category I, to the most serious, Category IV. The Guidelines state "[t]hese categories assume a single violation. For multiple violations, the appropriate penalty shall increase accordingly." (Guidelines, p. 5.) If there are violations in more than one category, "the minimum and maximum penalties shall be those recommended in the highest category." (*Ibid.*)

14. A. In this case, the gravity of respondents' violations emanates from Category II. While the sixth cause for discipline (variation of four prescriptions by filling them one day early) is deemed to be a Category I violation, and the first cause for discipline (three altered

prescriptions given to Inspector Sakamura) is deemed to be a Category III violation, the bulk of respondents' remaining misconduct comes from their corresponding responsibility violations in connection with the 65 early refills (second cause for discipline) and filling 11 forged prescriptions (eighth cause for discipline), all of which are deemed to be Category II violations.

B. The Guidelines list corresponding responsibility violations to be in Category III. However, that category is described as those "where potential for harm is greater, more imminent, or more serious than it is for Category II violations, as well as for violations that involve knowingly or willfully violating laws or regulations pertaining to pharmacy. . . ." (Guidelines, p. 7.) In this case, it was not established that respondents' corresponding responsibility violations were willful or knowing, particularly remembering respondent Cassar was the only pharmacist who discovered and stopped the forged prescription scheme. Moreover, the potential for harm posed by respondents' corresponding responsibility violations was not proven to be serious, great, and certainly not imminent. Those violations are rooted in neglect, not malfeasance; the harm was potential and theoretical, not actual or imminent.

C. Since there are multiple violations in multiple categories, the Guidelines suggest treating the totality of the violations to be in the highest category, here Category III. Such treatment is not warranted, given the fact that the bulk of violations are in Category II. Moreover, the lone Category III violation is more the result of poor judgement than dishonesty. Although respondent Cassar exercised poor judgement in altering the three prescriptions, it is likely the information he added to the altered prescriptions was true. Therefore, discipline here should be from Category II. The suggested discipline for Category II violations ranges from a minimum of probation for three years under various terms and conditions to a maximum of revocation. (Guidelines, p. 6.)

15. A. The Guidelines list 17 factors to be considered in determining the appropriate level of discipline to be imposed. These factors are applied to respondents as follows:

1. *Actual or potential harm to the public*. No actual or potential harm to the public was established.

2. *Actual or potential harm to any consumer*. Some potential harm to consumers was demonstrated by the two sets of corresponding responsibility violations, but no actual harm was established. Namely, it was not proven that respondents are responsible for the overdose death of BK or that any of the other involved customers suffered any harm. In fact, one of the involved patients, MS, testified in glowing terms about respondents.

3. *Prior disciplinary record, including level of compliance with disciplinary order(s)*. Respondents have no prior disciplinary record with the Board.

4. *Prior warnings of record(s), including citation(s) and fine(s)*. Respondents received one citation in 2004 for minor violations.

5. *Number and/or variety of current violations*. There were three core violations (two sets of similar corresponding responsibility violations, one set of four prescription variations, and one set of three prescription alterations), which is deemed to be a moderate amount.

6. *Nature and severity of the act(s), offense(s) or crime(s) under consideration*. Notwithstanding the three altered prescriptions given to Inspector Sakamura, the totality of the misconduct established in this case is deemed to be of moderate severity.

7. *Aggravating evidence*. In aggravation, respondent Cassar was not fully candid about his alteration of the three prescriptions given to Inspector Sakamura.

8. *Mitigating evidence*. Respondents presented significant mitigating evidence which lessened the seriousness of their violations. For example, respondents cooperated with Board investigative efforts at all times. For the most part, respondent Cassar was candid and forthright in his testimony. Respondent Cassar essentially stopped the forged prescription scheme. The alteration problem was limited to only three of hundreds of prescriptions analyzed in this case, and the information added to the altered prescriptions was probably true.

9. *Rehabilitation evidence*. Respondents have established meaningful rehabilitation. Respondent Cassar demonstrated contrition and remorse in his testimony. Respondents have evolved their pharmacy practice to address the shortcomings established in this case, including creating and upgrading their Diversion Program, using CURES when required, upgrading their computer and operating systems, as well as respondent Cassar's completion of two corresponding responsibility seminars and his subscription to Mr. Sydejko's license protection program. Respondents also are supported by a number of impressive and thoughtful character witnesses, who portray respondent Cassar as an ethical, hard-working, and, at times, compulsively detailed pharmacist, who is dedicated to his family, career, and practice. Even the Board's primary investigator, Inspector Sakamura, could not opine during the hearing that respondents currently pose a threat to the public.

10. *Compliance with terms of any criminal sentence*. This factor is not applicable.

11. *Overall criminal record*. This factor is not applicable.

12. *If applicable, evidence of proceedings for case being set aside and dismissed pursuant to section 1203.4 of the Penal Code*. This factor is not applicable.

13. *Time passed since the act(s) or offense(s)*. Respondents' misconduct traces back to 2009 through 2012 for the set of 65 early refills and the four prescription variances; 2013 for the three altered prescriptions given to Inspector Sakamura; and 2014 through 2015 for the 11 forged prescriptions that respondents filled. While the misconduct therefore covers a continuous period of six years, it has been well over three

years since it concluded. Thus, the violations can be described as having moderate duration and proximity.

14. *Whether the conduct was intentional or negligent, demonstrated incompetence, or, if the respondent is being held to account for conduct committed by another, the respondent had knowledge of or knowingly participated in such conduct.* Most of the misconduct was rooted in negligence, though respondent Cassar's submission of three altered prescriptions was intentional.

15. *Financial benefit to the respondent from the misconduct.* Respondents did not financially benefit from any of their misconduct.

16. *Other licenses held by the respondent and license history of those licenses.* This factor is not applicable.

17. *Uniform Standards Regarding Substance-Abusing Healing Arts Licensees.* This factor is not applicable.

B. The 17 factors demonstrate sufficient mitigation and rehabilitation to warrant imposing the minimum discipline suggested for Category II violations, namely three years of probation with standard terms. None of the optional terms is warranted, including suspension, the imposition of which would be punitive and would not serve public protection. The standard term imposing supervising restrictions on respondent Cassar (term no. 8) has been relaxed, such that Option 2 has been selected and only a yearly review required of the retained independent consultant. Respondent Cassar has demonstrated sufficient competence and rehabilitation to warrant no more frequent review of his practices. (Factual Findings 1-67.)

Other Disciplinary Considerations

16. A. Section 4307, subdivision (a), provides, in pertinent part, that any person whose license has been revoked or is under suspension shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate or partner of a licensee. In this case, respondent Cassar's license has not been revoked or suspended.

B. Section 4307, subdivision (a), also provides that if discipline is imposed on respondent Kanan Pharmacy's permit, and respondent Cassar, while acting as the manager, administrator, owner, member, officer, director, associate, or partner of respondent Kanan Pharmacy, "had knowledge of or knowingly participated in any conduct for which" the permit is disciplined, respondent Cassar "shall" be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for no longer than five years, if the pharmacy permit is placed on probation.

C. In this case, neither party addressed section 4307 in their briefs. While respondent Cassar's personal involvement in most of the violations is unclear but results at least from his status as respondent Kanan Pharmacy's PIC, it is clear respondent Cassar altered the

three prescriptions in question that are the basis of the first cause for discipline. Therefore, he "had knowledge of and knowingly participated" in at least some of the conduct for which respondent Kanan Pharmacy is being disciplined.

D. Since the word "shall" is prominent in section 4307, subdivision (a), the prohibition provided in the statute is not optional. However, imposing that level of discipline in this case would be unwarranted and punitive, given the moderate level of misconduct coupled with the significant mitigation and rehabilitation. Moreover, Government Code section 11519, subdivision (b), provides that "a stay of execution may be included in the decision or if not included therein may be granted by the agency at any time before the decision becomes effective." Since a revocation can be stayed under Government Code section 11519, there is no reason to conclude that less severe discipline, such as the prohibition provided by section 4307, cannot also be stayed. Therefore, while the prohibition provided by section 4307, subdivision (a), is mandatory, it shall be subject to the same stay as the remaining discipline imposed.

Costs

17. A. Section 125.3 provides that an administrative law judge may order a licentiate who has violated a licensing law to pay the reasonable costs of the investigation and enforcement of the case. Respondents violated provisions of the Pharmacy Law. It was established that the Board incurred reasonable costs in the amount of $22,940.45. (Factual Findings 68-70.)

B. As the employing entity, respondent Kanan Pharmacy is responsible for all of the violations established in this case. So too for respondent Cassar, as the PIC, though he was also personally involved in some of the underlying misconduct. Under these circumstances, respondents shall be jointly and severally responsible for the Board's costs, and they may determine who shall pay the costs. The standard cost term has been removed from the respondents' individual probations and replaced by one term covering both of them.

ORDER

Respondent Cassar

Pharmacist License Number RPH 49326, issued to respondent Anthony John Cassar (respondent), is revoked; however, the revocation is stayed and respondent is placed on probation for three years upon the following terms and conditions:

1. Obey All Laws

Respondent shall obey all state and federal laws and regulations.

Respondent shall report any of the following occurrences to the Board, in writing, within seventy-two (72) hours of such occurrence:

- an arrest or issuance of a criminal complaint for violation of any provision of the Pharmacy Law, state and federal food and drug laws, or state and federal controlled substances laws;

- a plea of guilty, or nolo contendere, no contest, or similar, in any state or federal criminal proceeding to any criminal complaint, information or indictment;

- a conviction of any crime; or

- the filing of a disciplinary pleading, issuance of a citation, or initiation of another administrative action filed by any state or federal agency which involves respondent's license or which is related to the practice of pharmacy or the manufacturing, obtaining, handling, distributing, billing, or charging for any drug, device or controlled substance.

Failure to timely report such occurrence shall be considered a violation of probation.

2. Report to the Board

Respondent shall report to the Board quarterly, on a schedule as directed by the Board or its designee. The report shall be made either in person or in writing, as directed. Among other requirements, respondent shall state in each report under penalty of perjury whether there has been compliance with all the terms and conditions of probation.

Failure to submit timely reports in a form as directed shall be considered a violation of probation. Any period(s) of delinquency in submission of reports as directed may be added to the total period of probation. Moreover, if the final probation report is not made as directed, probation shall be automatically extended until such time as the final report is made and accepted by the Board.

3. Interview with the Board

Upon receipt of reasonable prior notice, respondent shall appear in person for interviews with the Board or its designee, at such intervals and locations as are determined by the Board or its designee. Failure to appear for any scheduled interview without prior notification to Board staff, or failure to appear for two (2) or more scheduled interviews with the Board or its designee during the period of probation, shall be considered a violation of probation.

4. Cooperate with Board Staff

Respondent shall timely cooperate with the Board's inspection program and with the Board's monitoring and investigation of respondent's compliance with the terms and conditions of his probation, including but not limited to: timely responses to requests for information by Board staff; timely compliance with directives from Board staff regarding requirements of any term or condition of probation; and timely completion of documentation pertaining to a term or condition of probation. Failure to timely cooperate shall be considered a violation of probation.

5. Continuing Education

Respondent shall provide evidence of efforts to maintain skill and knowledge as a pharmacist as directed by the Board or its designee.

6. Reporting of Employment and Notice to Employers

During the period of probation, respondent shall notify all present and prospective employers of the decision in case number 4828 and the terms, conditions and restrictions imposed on respondent by the decision, as follows:

Within thirty (30) days of the effective date of this decision, and within ten (10) days of undertaking any new employment, respondent shall report to the Board in writing the name, physical address, and mailing address of each of his employer(s), if any, and the name(s) and telephone number(s) of all of his direct supervisor(s), if any, as well as any pharmacist(s)-in-charge, designated representative(s)-in-charge, responsible manager, or other compliance supervisor(s) and the work schedule, if known. Respondent shall also include the reason(s) for leaving the prior employment. Respondent shall sign and return to the Board a written consent authorizing the Board or its designee to communicate with all of respondent's employer(s) and supervisor(s), and authorizing those employer(s) or supervisor(s) to communicate with the Board or its designee, concerning respondent's work status, performance, and monitoring. Failure to comply with the requirements or deadlines of this condition shall be considered a violation of probation.

Within thirty (30) days of the effective date of this decision, and within fifteen (15) days of respondent undertaking any new employment, if any, respondent shall cause (a) his direct supervisor, (b) his pharmacist-in-charge, designated representative-in-charge, responsible manager, or other compliance supervisor, and (c) the owner or owner representative of his employer, to report to the Board in writing acknowledging that the listed individual(s) has/have read the decision in case number 4828, and terms and conditions imposed thereby. If one person serves in more than one role described in (a), (b), or (c), the acknowledgment shall so state. It shall be the respondent's responsibility to ensure that these acknowledgment(s) are timely submitted to the Board. In the event of a change in the person(s) serving the role(s) described in (a), (b), or (c) during the term of probation, respondent shall cause the person(s) taking over the role(s) to report to the Board in writing within fifteen (15) days of the change acknowledging that he or she has read the decision in case number 4828, and the terms and conditions imposed thereby.

If respondent works for or is employed by or through an employment service, respondent must notify the person(s) described in (a), (b), and (c) above at every entity licensed by the Board of the decision in case number 4828, and the terms and conditions imposed thereby in advance of respondent commencing work at such licensed entity. A record of this notification must be provided to the Board upon request.

Furthermore, within thirty (30) days of the effective date of this decision, and within fifteen (15) days of respondent undertaking any new employment by or through an employment service, respondent shall cause the person(s) described in (a), (b), and (c) above

at the employment service to report to the Board in writing acknowledging that he or she has read the decision in case number 4828, and the terms and conditions imposed thereby. It shall be respondent's responsibility to ensure that these acknowledgment(s) are timely submitted to the Board.

Failure to timely notify present or prospective employer(s) or failure to cause the identified person(s) with that/those employer(s) to submit timely written acknowledgments to the Board shall be considered a violation of probation.

Employment within the meaning of this provision includes any full-time, part-time, temporary, relief, or employment/management service position as a pharmacist, or any position for which a pharmacist license is a requirement or criterion for employment, whether the respondent is an employee, independent contractor or volunteer.

7. Notification of Change(s) in Name, Address(es), or Phone Number(s)

Respondent shall further notify the Board in writing within ten (10) days of any change in name, residence address, mailing address, e-mail address or phone number.

Failure to timely notify the Board of any change in employer, name, address, or phone number shall be considered a violation of probation.

8. Restrictions on Supervision and Oversight of Licensed Facilities

During the period of probation, respondent shall not supervise any intern pharmacist or serve as a consultant to any entity licensed by the Board. Respondent may be a pharmacist-in-charge, designated representative-in-charge, responsible manager or other compliance supervisor of any single entity licensed by the Board, but only if respondent or that entity retains, at his expense, an independent consultant who shall be responsible for reviewing the operations of the entity *once per year* for compliance by respondent and the entity with state and federal laws and regulations governing the practice of the entity, and compliance by respondent with the obligations of his supervisory position. Respondent may serve in such a position at only one entity licensed by the Board, only upon approval by the Board or its designee. Any such approval shall be site specific.

The consultant shall be a pharmacist licensed by and not on probation with the Board, who has been approved by the Board or its designee to serve in this position. Respondent shall submit the name of the proposed consultant to the Board or its designee for approval within thirty (30) days of the effective date of the decision or prior to assumption of duties allowed in this term.

Assumption of any unauthorized supervision responsibilities shall be considered a violation of probation. In addition, failure to timely seek approval for, timely retain, or ensure timely reporting by the consultant shall be considered a violation of probation.

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9. Probation Monitoring Costs

Respondent shall pay any costs associated with probation monitoring as determined by the Board each and every year of probation. Such costs shall be payable to the Board on a schedule as directed by the Board or its designee. Failure to pay such costs by the deadline(s) as directed shall be considered a violation of probation.

10. Status of License

Respondent shall, at all times while on probation, maintain an active, current pharmacist license with the Board, including any period during which suspension or probation is tolled.

Failure to maintain an active, current pharmacist license shall be considered a violation of probation.

If respondent's pharmacist license expires or is cancelled by operation of law or otherwise at any time during the period of probation, including any extensions thereof due to tolling or otherwise, upon renewal or reapplication respondent's license shall be subject to all terms and conditions of this probation not previously satisfied.

11. License Surrender While on Probation

Following the effective date of this decision, should respondent cease practice due to retirement or health, or be otherwise unable to satisfy the terms and conditions of probation, respondent may relinquish his license, including any indicia of licensure issued by the Board, along with a request to surrender the license. The Board or its designee shall have the discretion whether to accept the surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance of the surrender of the license, respondent will no longer be subject to the terms and conditions of probation. This surrender constitutes a record of discipline and shall become a part of the respondent's license history with the Board.

Upon acceptance of the surrender, respondent shall relinquish his pocket and/or wall license, including any indicia of licensure not previously provided to the Board within ten (10) days of notification by the Board that the surrender is accepted if not already provided.

Respondent may not reapply for any license from the Board for three (3) years from the effective date of the surrender. Respondent shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the Board, including any outstanding costs.

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12. Practice Requirement – Extension of Probation

Except during periods of suspension, respondent shall, at all times while on probation, be employed as a pharmacist in California for a minimum of 80 hours per calendar month. Any month during which this minimum is not met shall extend the period of probation by one month. During any such period of insufficient employment, respondent must nonetheless comply with all terms and conditions of probation, unless respondent receives a waiver in writing from the Board or its designee.

If respondent does not practice as a pharmacist in California for the minimum number of hours in any calendar month, for any reason (including vacation), respondent shall notify the Board in writing within ten (10) days of the conclusion of that calendar month. This notification shall include at least: the date(s), location(s), and hours of last practice; the reason(s) for the interruption or reduction in practice; and the anticipated date(s) on which respondent will resume practice at the required level. Respondent shall further notify the Board in writing within ten (10) days following the next calendar month during which respondent practices as a pharmacist in California for the minimum of hours. Any failure to timely provide such notification(s) shall be considered a violation of probation.

It is a violation of probation for respondent's probation to be extended pursuant to the provisions of this condition for a total period, counting consecutive and non-consecutive months, exceeding thirty-six (36) months. The Board or its designee may post a notice of the extended probation period on its website.

13. Violation of Probation

If respondent has not complied with any term or condition of probation, the Board shall have continuing jurisdiction over respondent, and the Board shall provide notice to respondent that probation shall automatically be extended, until all terms and conditions have been satisfied or the Board has taken other action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed. The Board or its designee may post a notice of the extended probation period on its website.

If respondent violates probation in any respect, the Board, after giving respondent notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If a petition to revoke probation or an accusation is filed against respondent during probation, or the preparation of an accusation or petition to revoke probation is requested from the Office of the Attorney General, the Board shall have continuing jurisdiction and the period of probation shall be automatically extended until the petition to revoke probation or accusation is heard and decided.

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14. Completion of Probation

Upon written notice by the Board or its designee indicating successful completion of probation, respondent's license will be fully restored.

Respondent Kanan Pharmacy

Pharmacy Permit Number PHY 46707, issued to respondent Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies, with Anthony John Cassar as the Pharmacist-in-Charge, is revoked; however, the revocation is stayed and respondent is placed on probation for three years upon the following terms and conditions:

1. Definition: Respondent

For the purposes of these terms and conditions, "respondent" shall refer to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies, with Anthony John Cassar as the Pharmacist-in-Charge. All terms and conditions stated herein shall bind and be applicable to the licensed premises and to all owners, managers, officers, administrators, members, directors, trustees, associates, or partners thereof. For purposes of compliance with any term or condition, any report, submission, filing, payment, or appearance required to be made by respondent to or before the board or its designee shall be made by an owner or executive officer with authority to act on behalf of and legally bind the licensed entity.

2. Obey All Laws

Respondent shall obey all state and federal laws and regulations.

Respondent shall report any of the following occurrences to the Board, in writing, within seventy-two (72) hours of such occurrence:

- an arrest or issuance of a criminal complaint for violation of any provision of the Pharmacy Law, state and federal food and drug laws, or state and federal controlled substances laws;

- a plea of guilty, or nolo contendere, no contest, or similar, in any state or federal criminal proceeding to any criminal complaint, information or indictment;

- a conviction of any crime; or

- discipline, citation, or other administrative action filed by any state or federal agency which involves respondent's license or which is related to the practice of pharmacy or the manufacturing, obtaining, handling or distributing, billing, or charging for any dangerous drug, and/or dangerous device or controlled substance.

Failure to timely report any such occurrence shall be considered a violation of probation.

3. Report to the Board

Respondent shall report to the Board quarterly, on a schedule as directed by the Board or its designee. The report shall be made either in person or in writing, as directed. Among other requirements, respondent shall state in each report under penalty of perjury whether there has been compliance with all the terms and conditions of probation. Failure to submit timely reports in a form as directed shall be considered a violation of probation. Any period(s) of delinquency in submission of reports as directed may be added to the total period of probation. Moreover, if the final probation report is not made as directed, probation shall be automatically extended until such time as the final report is made and accepted by the Board.

4. Interview with the Board

Upon receipt of reasonable prior notice, respondent shall appear in person for interviews with the Board or its designee, at such intervals and locations as are determined by the Board or its designee. Failure to appear for any scheduled interview without prior notification to Board staff, or failure to appear for two (2) or more scheduled interviews with the Board or its designee during the period of probation, shall be considered a violation of probation.

5. Cooperate with Board Staff

Respondent shall timely cooperate with the Board's inspection program and with the Board's monitoring and investigation of respondent's compliance with the terms and conditions of the probation, including but not limited to: timely responses to requests for information by Board staff; timely compliance with directives from Board staff regarding requirements of any term or condition of probation; and timely completion of documentation pertaining to a term or condition of probation. Failure to timely cooperate shall be considered a violation of probation.

6. Probation Monitoring Costs

Respondent shall pay any costs associated with probation monitoring as determined by the Board each and every year of probation. Such costs shall be payable to the Board on a schedule as directed by the Board or its designee. Failure to pay such costs by the deadline(s) as directed shall be considered a violation of probation.

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7. Status of License

Respondent shall, at all times while on probation, maintain current pharmacy permit with the Board. Failure to maintain current licensure shall be considered a violation of probation.

If respondent's license expires or is cancelled by operation of law or otherwise at any time during the period of probation, including any extensions thereof or otherwise, upon renewal or reapplication respondent's license shall be subject to all terms and conditions of this probation not previously satisfied.

8. License Surrender While on Probation

Following the effective date of this decision, should respondent wish to discontinue business, respondent may tender the premises license to the Board for surrender. The Board or its designee shall have the discretion whether to grant the request for surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance of the surrender of the license, respondent will no longer be subject to the terms and conditions of probation.

Respondent may not apply for any new license from the Board for three (3) years from the effective date of the surrender. Respondent shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the Board.

Respondent further stipulates that it shall reimburse the Board for its costs of investigation and prosecution prior to the acceptance of the surrender.

Upon acceptance of the surrender, respondent shall relinquish the premises wall and renewal license to the Board within ten (10) days of notification by the Board that the surrender is accepted. Respondent shall further submit a completed Discontinuance of Business form according to Board guidelines and shall notify the Board of the records inventory transfer within five (5) days. Respondent shall further arrange for the transfer of all records of acquisition and disposition of dangerous drugs and/or devices to premises licensed and approved by the Board.

Respondent shall also, by the effective date of this decision, arrange for the continuation of care for ongoing patients of the pharmacy by, at minimum, providing a written notice to ongoing patients that specifies the anticipated closing date of the pharmacy and that identifies one or more area pharmacies capable of taking up the patients' care, and by cooperating as may be necessary in the transfer of records or prescriptions for ongoing patients. Within five days of its provision to the pharmacy's ongoing patients, respondent shall provide a copy of the written notice to the Board. For the purposes of this provision, "ongoing patients" means those patients for whom the pharmacy has on file a prescription with one or more refills outstanding, or for whom the pharmacy has filled a prescription within the preceding sixty (60) days.

Respondent may not apply for any new license from the Board for three (3) years from the effective date of the surrender. Respondent shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the Board.

Respondent further stipulates that it shall reimburse the Board for its costs of investigation and prosecution prior to the acceptance of the surrender.

9. Sale or Discontinuance of Business

During the period of probation, should respondent sell, trade or transfer all or part of the ownership of the licensed entity, discontinue doing business under the license issued to respondent, or should practice at that location be assumed by another full or partial owner, person, firm, business, or entity, under the same or a different premises license number, the Board or its designee shall have the sole discretion to determine whether to exercise continuing jurisdiction over the licensed location, under the current or new premises license number, and/or carry the remaining period of probation forward to be applicable to the current or new premises license number of the new owner.

10. Notice to Employees

Respondent shall, upon or before the effective date of this decision, ensure that all employees involved in permit operations are made aware of all the terms and conditions of probation, either by posting a notice of the terms and conditions, circulating such notice, or both. If the notice required by this provision is posted, it shall be posted in a prominent place and shall remain posted throughout the probation period. Respondent shall ensure that any employees hired or used after the effective date of this decision are made aware of the terms and conditions of probation by posting a notice, circulating a notice, or both. Additionally, respondent shall submit written notification to the Board, within fifteen (15) days of the effective date of this decision, that this term has been satisfied. Failure to timely provide such notification to employees, or to timely submit such notification to the Board shall be considered a violation of probation.

"Employees" as used in this provision includes all full-time, part-time, volunteer, temporary and relief employees and independent contractors employed or hired at any time during probation.

11. Owners and Officers: Knowledge of the Law

Respondent shall provide, within thirty (30) days after the effective date of this decision, signed and dated statements from its owners, including any owner or holder of ten percent (10%) or more of the interest in respondent or respondent's stock, and all of its officers, stating under penalty of perjury that said individuals have read and are familiar with state and federal laws and regulations governing the practice of pharmacy. The failure to timely provide said statements under penalty of perjury shall be considered a violation of probation.

12. Premises Open for Business

Respondent shall remain open and engaged in its ordinary business as a pharmacy permittee in California for a minimum of 80 hours per calendar month. Any month during which this minimum is not met shall toll the period of probation, i.e., the period of probation shall be extended by one month for each month during with this minimum is not met.

During any such period of tolling of probation, respondent must nonetheless comply with all terms and conditions of probation, unless respondent is informed otherwise in writing by the Board or its designee. If respondent is not open and engaged in its ordinary business as a pharmacy permittee for a minimum of 80 hours in any calendar month, for any reason (including vacation), respondent shall notify the Board in writing within ten (10) days of the conclusion of that calendar month. This notification shall include at minimum all of the following: the date(s) and hours respondent was open; the reason(s) for the interruption or why business was not conducted; and the anticipated date(s) on which respondent will resume business as required. Respondent shall further notify the Board in writing with ten (10) days following the next calendar month during which respondent is open and engaged in its ordinary business as a pharmacy permittee in California for a minimum of 80 hours. Any failure to timely provide such notification(s) shall be considered a violation of probation.

13. Posted Notice of Probation

Respondent shall prominently post a probation notice provided by the Board or its designee in a place conspicuous to and readable by the public within two (2) days of receipt thereof from the Board or its designee. Failure to timely post such notice, or to maintain the posting during the entire period of probation, shall be considered a violation of probation.

Respondent shall not, directly or indirectly, engage in any conduct or make any statement which is intended to mislead or is likely to have the effect of misleading any patient, customer, member of the public, or other person(s) as to the nature of and reason for the probation of the licensed entity.

14. Violation of Probation

If respondent has not complied with any term or condition of probation, the Board shall have continuing jurisdiction over respondent, and probation shall be automatically extended, until all terms and conditions have been satisfied or the Board has taken other action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed.

If respondent violates probation in any respect, the Board, after giving respondent notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If a petition to revoke probation or an accusation is filed against respondent during probation, the Board shall have continuing jurisdiction and the period of

probation shall be automatically extended until the petition to revoke probation or accusation is heard and decided.

15. Completion of Probation

Upon written notice by the Board or its designee indicating successful completion of probation, respondent's license will be fully restored.

Costs

Respondents Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies, and Anthony John Cassar, are jointly and severally liable to pay the Board its reasonable costs of this case's investigation and enforcement under Business and Professions Code section 125.3, in the amount of $22,940.45, pursuant to a reasonable payment plan approved by the Board.

Prohibition Under Section 4307

Respondent Anthony John Cassar is prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of Pharmacy Permit Number PHY 46707, issued to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies, for the period of time while Pharmacy Permit Number PHY 46707 is subject to the probation imposed in this case.

This prohibition is stayed while respondents Cassar and Kanan Pharmacy are on the probations specified above. If either respondent, or both, violates probation in any respect, the Board, after giving respondents notice and an opportunity to be heard, may petition to revoke this stay and impose the prohibition set forth in Business and Professions Code section 4307 against respondent Cassar.

DATED: March 18, 2019

DocuSigned by:
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ERIC SAWYER
Administrative Law Judge
Office of Administrative Hearings

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

In the Matter of the Accusation Against: **PHARMACY CARE NETWORK, INC., DBA KANAN PHARMACY & MEDICAL SUPPLIES; ANTHONY JOHN CASSAR** **5847 Kanan Rd.** **Agoura Hills, CA 91301** **Pharmacy Permit No. PHY 46707** **ANTHONY JOHN CASSAR** **7853 Valley Flores Dr.** **West Hills, CA 91304** **Pharmacist License No. RPH 49326** Respondents.	Case No. 4828 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On May 18, 2004, the Board issued Pharmacy Permit Number PHY 46707 to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies ("Respondent Pharmacy"). Anthony Cassar is and has been the President and Pharmacist-In-Charge of Respondent Pharmacy since May 18, 2004. Maria Cassar is and has been the Secretary/Treasurer of Respondent Pharmacy since May 18, 2004. This Permit was in force at all times relevant to this First Amended Accusation's charges and will expire on May 1, 2019 unless renewed.

3. On March 25, 1997, the Board issued Pharmacist License Number RPH 49326 to Anthony John Cassar ("Respondent Cassar"). The Pharmacist License was in force at all times relevant to this Accusation's charges and will expire on May 31, 2018 unless renewed.

JURISDICTION

4. This Second Amended Accusation is brought before the Board, Department of Consumer Affairs, under the authority of the following laws.

5. **Section 4300** of the Business and Professions Code provides, in pertinent part, that every license issued by the Board is subject to discipline, including suspension or revocation.

6. **Section 4300.1** of the Business and Professions Code states:

"The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license."

7. **Section 4302** of the Business and Professions Code states:

"The board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee."

BUSINESS AND PROFESSIONS CODE

8. **Section 4035** of the Business and Professions Code states:

"Person" includes, but is not limited to, firm, association, partnership, corporation, limited liability company, state governmental agency, trust, or political subdivision."

9. **Section 4059**, subdivision (a), of the Business and Professions Code 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. A person may not furnish any dangerous device, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

10. **Section 4063** of the Business and Professions 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."

11. **Section 4081** of the Business and Professions 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.

"(b) The owner, officer, and partner of any pharmacy, wholesaler, or veterinary food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge or representative-in-charge, for maintaining the records and inventory described in this section."

12. **Section 4105** of the Business and Professions Code states:

"(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.

"(b) The licensee may remove the original records or documentation from the licensed premises on a temporary basis for license-related purposes. However, a duplicate set of those records or other documentation shall be retained on the licensed premises.

"(c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.

"(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

"(e) (1) Notwithstanding subdivisions (a), (b), and (c), the board may, upon written request, grant to a licensee a waiver of the requirements that the records described in subdivisions (a), (b), and (c) be kept on the licensed premises.

(2) A waiver granted pursuant to this subdivision shall not affect the board's authority under this section or any other provision of this chapter.

. . . .

13. **Section 4113**, subdivision (c), of the Business and Professions Code states:

"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."

14. **Section 4156** of the Business and Professions Code states:

A pharmacy corporation shall not do, or fail to do, any act where doing or failing to do the act would constitute unprofessional conduct under any statute or regulation. In the conduct of its practice, a pharmacy corporation shall observe and be bound by the laws and regulations that apply to a person licensed under this chapter.

15. **Section 4169, subdivision (a)(5)** of the Business and Professions Code states:

A person or entity shall not do any of the following: Fail to maintain records of the acquisition or disposition of dangerous drugs or dangerous devices for at least three years.

16. **Section 4301** of the Business and Professions Code 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:

. . .

‘(d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.

…

“(f) the commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption

“(g) knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

…

"(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.

. . . .

“(q) engaging in any conduct that subverts or attempts to subvert an investigation of the Board.”.

17. **Section 4302** of the Business and Professions Code states:

The board may deny, suspend, or revoke any license where conditions exist in relation to any person holding 10 percent or more of the ownership interest or where conditions exist in relation to any officer, director, or other person with management or control of the license that would constitute grounds for disciplinary action against a licensee.

18. **Section 4306.5** of the Business and Professions Code 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."

19. **Section 4307** of the Business and Professions Code states:

(a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, or partner had knowledge of or knowingly participated in any conduct for which the license was denied, revoked, suspended, or placed on probation, shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee as follows:

(1)Where a probationary license is issued or where an existing license is placed on probation, this prohibition shall remain in effect for a period not to exceed five years.

(2)Where the license is denied or revoked, the prohibition shall continue until the license is issued or reinstated.

(b)"Manager, administrator, owner, member, officer, director, associate, or partner," as used in this section and Section 4308, may refer to a pharmacist or to any other person who serves in that capacity in or for a licensee.

(c)The provisions of subdivision (a) may be alleged in any pleading filed pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. However, no order may be issued in that case except as to a person who is named in the caption, as to whom the pleading alleges the applicability of this section, and where the person has been given notice of the proceeding as required by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. The authority to proceed as provided by this subdivision shall be in addition to the board's authority to proceed under Section 4339 or any other provision of law.

HEALTH AND SAFETY CODE

20. S**ection 11153**, subdivision (a) of Health and Safety Code states:

"(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."

21. **Section 11179** of the Health and Safety Code states:

"A person who fills a prescription shall keep it on file for at least three years from the date of filling it."

22. **Section 11200**, subdivision (c), of the Health and Safety Code states:

"No prescription for a Schedule II substance may be refilled."

CALIFORNIA CODE OF REGULATIONS

23. California Code of Regulations, title 16, **section 1707.1**, states:

"(a) A pharmacy shall maintain medication profiles on all patients who have prescriptions filled in that pharmacy except when the pharmacist has reasonable belief that the patient will not continue to obtain prescription medications from that pharmacy.

(1) A patient medication record shall be maintained in an automated data processing or manual record mode such that the following information is readily retrievable during the pharmacy's normal operating hours.

(A) The patient's full name and address, telephone number, date of birth (or age) and gender;

(B) For each prescription dispensed by the pharmacy:

1. The name, strength, dosage form, route of administration, if other than oral, quantity and directions for use of any drug dispensed;

2. The prescriber's name and where appropriate, license number, DEA registration number or other unique identifier;

3. The date on which a drug was dispensed or refilled;

4. The prescription number for each prescription; and

5. The information required by section 1717.

(C) Any of the following which may relate to drug therapy: patient allergies, idiosyncracies, current medications and relevant prior medications including nonprescription medications and relevant devices, or medical conditions which are communicated by the patient or the patient's agent.

(D) Any other information which the pharmacist, in his or her professional judgment, deems appropriate.

(2) The patient medication record shall be maintained for at least one year from the date when the last prescription was filled.

24. California Code of Regulations, title 16**, section 1715.6,** states:

"The owner shall report to the Board within thirty (30) days of discovery of any loss of the controlled substances, including their amounts and strengths."

25. California Code of Regulations, title 16, **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."

26. California Code of Regulations, title 16, **section 1761,** states in pertinent part:

(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.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

27. **Adderall,** also known as Amphetamine Salt Combo, is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(1) and is a dangerous drug under Business and Professions Code section 4022. It is used to treat Attention-Deficit Disorder.

28. **Alprazolam, a generic name for Xanax**, is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(1) and is a dangerous drug under Business and Professions Code section 4022.

29. **Carisprodol, a generic name for Soma**, is a Schedule IV controlled substance under 21 Code of Federal Register section 1308.14, subdivision (c)(5) and is a dangerous drug under Business and Professions Code section 4022. It became a Schedule IV controlled substance on January 1, 2012.

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30. **Diazepam, a generic name for Valium**, is a Schedule IV controlled substance under Health and Safety Code section 11057, subdivision (d)(9) and is a dangerous drug under Business and Professions Code section 4022.

31. **Dextroamphetamine/amphetamine, a generic name for Adderall**, is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(1) and is a dangerous drug under Business and Professions Code section 4022.

32. **Fentanyl** is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (c)(8) and is a dangerous drug under Business and Professions Code section 4022.

33. **Hydrocodone/acetaminophen, a generic name for Lortab, Vicodin, and Norco,** is a Schedule III controlled substance under Health and Safety Code section 11056(e)(4) and is a dangerous drug under Business and Professions Code section 4022.

34. **Methadone** is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (c)(14) and is a dangerous drug under Business and Professions Code section 4022.

35. **Methylphenidate**, **a generic name for Ritalin**, is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (d)(6) and is a dangerous drug under Business and Professions Code section 4022.

36. **Morphine** is a Schedule II controlled substance under Health and Safety Code section 11055(b)(1)(L) and is a dangerous drug under Business and Professions Code section 4022.

37. **Oxycodone, a generic name for Oxycontin**, is a Schedule II controlled substance under Health and Safety Code section 11055, subdivision (b)(1)(M) and is a dangerous drug under Business and Professions Code section 4022.

COST RECOVERY

38. **Section 125.3** of the Business and Professions Code states, 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.

COMPLAINT FILED BY W.K.

39. The Board received a complaint from a mother (W.K.) who stated that her son B.K. passed away of an overdose in January 2010. The physician, L.G., Doctor of Osteopathic, who prescribed the drugs had been investigated by the Medical Board and Attorney General's office, and L.G.'s hearings were scheduled for November 2011. There were six allegations against L.G., and one of the allegations was for over prescribing addictive medications. Respondent filled prescriptions for her son from September 10, 2009 to November 12, 2009 for 676 pills. The mother stated there were probably more, but those were the only bottles she and her husband found.

40. Dr. L.G., was the main prescriber of the prescriptions that Patient B.K filled at Respondent Pharmacy. On March 4, 2011, the Osteopathic Medical Board of California filed an Accusation against Dr. L.G. for repeated acts of negligence. However, Dr. L.G. committed suicide before the matter was resolved.

41. On March 15, 2013, Board Inspector V.S. conducted an inspection at the Respondent Pharmacy. In preparation for the inspection, the Board inspector reviewed CURES[1] data from October 1, 2008 to January 1, 2010 for the pharmacy and chose three patients in addition to B.K. to review for controlled substance dispensing.

42. The CURES program started in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances and was 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

[1] C.U.R.E.S. stands for "Controlled Substance Utilization Review and Evaluation System" and is a database that contains over 100 million entries of controlled substance drugs that were dispensed in California. CURES is part of a program developed by the California Department of Justice, Bureau of Narcotic Enforcement, which allows access to the Prescription Drug Monitoring Program (PDMP) system. The PDMP allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access patient controlled substance history information.

lets the pharmacy know if any data was rejected. The data is collected statewide and can be used by health care professionals such as pharmacists and prescribers to evaluate and determine whether their patients are utilizing their controlled substances correctly.

43. As the Board inspector reviewed the controlled substance prescribing data from October 1, 2008 to January 1, 2010 at Respondent Pharmacy, there were 283 prescriptions filled during that time, for 23 patients. The Board Inspector chose three of those patients to review their controlled substance dispensing.

44. On March 15, 2013, the Board inspector went to Respondent Pharmacy to investigate the complaint. Pharmacist in charge (PIC) Respondent Cassar was present. The Board inspector gave Respondent Cassar a list of the 3 patients the Board inspector got off the CURES report and asked for patient profiles, as well as one for Brady K.. Once Respondent Cassar printed the profiles, the Board inspector gave him a list of questions to answer for each of the patients, and several questions about Dr. L.G.. The Board inspector also asked about how Respondent Pharmacy dealt with forged prescriptions, prescriptions from drug seekers, and what tools were used to decide whether or not to fill a prescription. The deadline for his response was 14 days.

45. On March 21, 2013, the Board inspector received an email from Respondent Cassar stating he was working on gathering the information she asked for, as well as a copy of his updated policy and procedure on theft and impairment.

46. On April 3, 2013, the Board inspector received an email from Respondent Pharmacy's counsel requesting an extension to gather the requested prescriptions.

47. On April 6, 2013, the Board inspector received a statement from Respondent Cassar stating "My understanding was that Dr. [L.G.] was a pain specialist whose single office was located in Encino, California. I was not aware of any other office. When we started receiving prescriptions from his office, he explained to me personally of his specialty and assured me that any patient who was seen had first signed a contract agreeing that he would be the only physician from which they would obtain prescriptions for narcotic pain therapy. In addition, he told me that before a patient was seen, he would send a request to the CURES program for a fax of all current and recent dispensing history on the patient. If a patient was not honest regarding who they saw

and what they took, Dr. Glass would fire the patient. While I cannot recall the name of the patient, I know I had one patient who became concerned when they obtained a prescription for a small amount of hydrocodone/apap following a dental procedure. I had no reason to believe his prescribing practices were not legitimate. On occasion we would contact Dr. [L.G.]s' office regarding any prescriptions that I felt were too early to be filled or prescriptions that required clarification on directions, quantities, or strengths. His responses were always consistent with my understanding of his practice."

48. Respondent Cassar explained that he has become more cautious when filling Controlled Substances II prescriptions, he is in contact with the local Sheriff's department and obtains a list of suspect physicians, which he shares with his local CVS, he has contacted pharmacies near the physician to ask the nature of the physician's practice when he is not familiar with them. According to Respondent Cassar, when prescriptions are called in, he pays attention to whether the call is from an office or a cell phone, if the call is from a cell phone, he immediately calls the office to confirm the prescription. Respondent Cassar further explained that all patients must have a valid ID, and that he uses the CURES program while the patient is waiting. According to Respondent Cassar, if the patient uses multiple doctors, pharmacies, or drugs, he does not fill it. Respondent Cassar further explained that he also gets diagnosis information on his patients.

RESPONDENT CASSAR'S RESPONSES TO THE BOARD INVESTIGATOR'S INQUIRIES

49. On or about April 22, 2013, the Board inspector received the prescriptions for Respondent Pharmacy's four patients and Respondent Cassar's responses to the Board inspector's questions for each of the patients, several questions about Dr. L.G.. and questions as to how Respondent Pharmacy dealt with forged prescriptions, prescriptions from drug seekers, and what tools were used to decide whether or not to fill a prescription.

PATIENT K.C.

50. In response to the following question "What can you tell me about this patient-What is the patient being treated for?" Respondent Cassar replied "While we may find documentation

as to what the patient was being treated for, I believe the patient was being treated for a chronic pain condition".

51. In response to the following question "Have they tried any non-medication therapies, or alternative therapies for their condition before trying pain medications?" Respondent Cassar replied "I am not aware if she had tried any non-medication therapies or alternative therapies."

52. In response to the following question "What type of consultation have they received from you regarding their prescriptions? What is your consultation like when it comes to pain medication?" Respondent Cassar replied "Patients received consultation as required by OBRA-90[2] and California law which includes a review of the patient's profile. I review with the patient which medication is short vs. long acting. If they receive other non-narcotic or non-pain medications that causes sedation, I typically review that with them as well. In addition, I ask they be aware of the restrictions of alcohol and driving with this medication."

53. In response to the following question "Did the patient pick up their medications themselves, was it delivered, or was it picked up by someone else?" Respondent Cassar replied

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[2] Omnibus Budget Reconciliation Act of 1990: Federal lawmakers enacted Section 4401 of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) to ensure fiscally responsible spending of Federal funding while ensuring safe and effective therapeutic outcomes for Medicaid patients. OBRA '90 includes three key drug utilization review components that affect pharmacy practice: prospective drug utilization review, record-keeping requirements, and a requirement to offer counsel.[1] OBRA '90 further outlines specific information that the pharmacist, while exercising professional judgment, should discuss with the

patient when he or she accepts the offer to counsel, such as:

- Name of the drug (brand name, generic, or other descriptive information);
- Intended use and expected action;
- Route, dosage form, dosage, and administration schedule;
- Common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered, including how to avoid them and the action required if they occur;
- Techniques for self-monitoring of drug therapy;
- Proper storage;
- Potential drug-drug interactions or drug-disease contraindications;
- Prescription refill information; and
- Action to take in the event of a missed dose.[2]

OBRA '90 and regulations adopted by Centers for Medicare & Medicaid Services (CMS)[3] require States to establish standards regarding implementation of patient counseling requirements to participate in and to receive continued Federal funding for State Medicaid programs. Although the original Federal requirements of OBRA '90 were intended to apply only to Medicaid beneficiaries, States established unique patient counseling regulations for both Medicaid and non-Medicaid beneficiaries. As a result, all patients are entitled to the benefits associated with

patient counseling standards of care. For links to State Boards of Pharmacy and their rules and regulations regarding patient counseling, refer to http://www.nabp.net/boards-of-pharmacy on the National Association of Boards of Pharmacy website.

"As I recall, Ms. C. picked up her own medication, though I believe on an occasion or two she had her mother pick-up her medication. In those cases, I believe she called us in advance."

54. In response to the following question "Did you talk to the prescriber about any of the prescriptions for this patient in order to clarify or make therapy adjustments?" Respondent Cassar replied "If something required clarification we would contact the doctor. As we pull prescriptions, examples of that communication may turn up."

55. In response to the following question "Did you feel any of these patient's therapies may have been excessive?" Respondent Cassar replied "Based on her total treatment history, there was nothing that in my professional judgment indicated her therapy was excessive. The patient initially used a combination of short acting and long acting narcotic pain medications. I recall her telling me of issues she had with her intestinal tract which is why she switched to liquid forms of narcotic pain medication. She was stable for some time and would fill her medication a few days early but nothing that would cause me concern in my professional judgment. Later she switched back to tablets, I believe due to a cost/insurance issue. Her daily dose increased over the five years she was treated by Dr. L.G., I assume due to tolerance. Still, in my professional judgment, I did not see a reason to be concerned as she never present in the pharmacy as being intoxicated. In addition, Ms. [K.C.] has insurance and if a prescription is early, or duplicative we will be notified when the claim is processed. In any such case, we typically try to determine from the patient why and, if appropriate, call the doctor to discuss the situation."

56. In response to the following question "How do you document any conversations you have with doctor or patient?" Respondent Cassar replied "I would typically document any conversations with doctors or patients on their prescriptions."

57. In response to the following question "Did you use CURES at the time this patient was at your pharmacy?" Respondent Cassar replied "No, not that I can recall. There was no clear reason to consult CURES for this patient.

58. The Board investigator entered the information for [K.C.] into the spreadsheet below. There were several early fills, several scripts were not provided to her. RX #2209222 for

Oxycodone liquid was written for 220 ml, but was filled with 210 ml. There is no documentation why the quantity was changed."

Date	Rx	Drug	Strength	Amt	Day supply	MD	early?	problem?	script?
2/6/2009	2207254	methadone	10	60	30	glass			no
4/12/2011	2213184	oxycodone	30	360	20	glass			no
2/9/2009	2207252	oxycodone	20	480 ml	30	glass			
2/7/2009	2207253	morphine	20	120 ml	15	glass			
5/21/2009	2208032	morphine	20	60 ml	3	glass			
5/26/2009	2208060	methadone	10	90	30	glass			
5/26/2009	2208062	fentora	400	28	28	glass			
6/1/2009	2208101	hydromorphone	8	120	10	glass			
6/5/2009	2208138	methadone	10	360	30	glass			
6/30/2009	2208311	methadone	10	360	30	glass	5 days early		
7/23/2009	2208452	methadone	10	360	30	glass	7 days early		
8/12/2009	2208613	methadone	10	66	6	glass	10 days early		
8/18/2009	2208661	methadone	10	360	30	glass			
9/5/2009	2208789	methadone	10	144	12	glass	13 days early		
9/15/2009	2208860	methadone	10	360	30	glass			
9/15/2009	2208861	oxycodone	20	240 ml	30	glass			
10/28/2009	2209222	oxycodone	20	210 ml	14	glass		220ml ordered	
11/10/2009	2209312	methadone	10	420	27	glass			
12/4/2009	2209506	methadone	10	420	27	glass			
12/26/2009	2209674	methadone	10	420	27	glass			
1/19/2010	2209831	methadone	10	420	27	glass			
2/5/2010	2209982	oxycodone	30	120	7	glass			
2/9/2010	2209994	methadone	10	420	27	glass	5 days early		
3/1/2010	2210108	methadone	10	480	30	glass	8 days early		
2/23/2010	2210109	oxycodone	30	240	20	glass			
3/26/2010	2210305	methadone	10	480	30	glass	5 days early		
3/22/2010	2210306	oxycodone	30	240	20	glass			
4/24/2010	2210524	methadone	10	480	30	glass			

4/24/2010	2210525	oxycodone	30	240	20	glass			
5/21/2010	2210720	methadone	10	480	30	glass			
5/21/2010	2210721	oxycodone	30	240	20	glass			
6/28/2010	2210993	methadone	10	480	30	glass			
6/28/2010	2210994	oxycodone	30	240	20	glass			
8/2/2010	2211247	methadone	10	480	30	glass			
8/2/2010	2211248	oxycodone	30	240	20	glass			
8/30/2010	2211434	methadone	10	480	30	glass			
10/16/2010	2211812	methadone	10	420	26	glass			
10/16/2010	2211813	hydromorphone	8	360	20	glass			
11/11/2010	2211960	methadone	10	420	27	glass			
11/3/2010	2211961	oxycodone	30	360	20	glass			
12/13/2010	2212255	methadone	10	420	27	glass			
1/18/2011	2212533	methadone	10	420	27	glass			
1/18/2011	2212534	oxycodone	30	360	20	glass			
3/2/2011	2212851	methadone	10	140	9	glass			
3/2/2011	2212852	oxycodone	30	120	7	glass			
3/15/2011	2212976	methadone	10	420	27	glass			
3/15/2011	2212977	oxycodone	30	360	20	glass			
4/12/2011	2213183	methadone	10	420	27	glass			
5/16/2011	2213467	methadone	10	420	27	glass			
6/15/2011	2213750	methadone	10	420	27	glass			
7/19/2011	2213896	methadone	10	420	27	glass			
7/2/2011	2213897	oxycodone	20	540 ml	17	glass			
8/17/2011	2214245	methadone	10	420	27	glass			
8/17/2011	2214246	oxycodone	20	540ml	17	glass			
9/13/2011	2214468	methadone	10	420	27	glass			
10/5/2011	2214669	methadone	10	420	27	glass	5 days early		
10/25/2011	2214670	hydromorphone	8	90	5	glass			
11/3/2011	2214950	methadone	10	420	27	glass			
11/29/2011	2215171	methadone	10	480	30	glass			
12/24/2011	2215425	methadone	10	480	30	glass			
1/27/2012	2215731	methadone	10	480	30	glass			
2/24/2012	2215988	methadone	10	480	30	glass			
3/17/2012	2216092	methadone	10	480	30	glass	9 days early		
4/9/2012	2216266	methadone	10	360	30	frey	7 days early		
3/26/2012	2216267	morphine	1	120	30	frey			
3/26/2012	2216268	fentanyl	25	10	30	frey			
5/5/2012	2216649	methadone	10	270	30	frey			
5/5/2012	2216650	fentanyl	25	10	30	frey			

5/29/2012	2216821	methadone	10	270	30	frey	6 days early		
6/20/2012	2217008	methadone	10	270	30	frey			
7/17/2012	2217009	fentanyl	25	10	30	frey			
7/17/2012	2217230	methadone	10	270	30	frey			
8/13/2012	2217231	fentanyl	25	10	30	frey			
8/13/2012	2217467	methadone	10	270	30	frey			
9/6/2012	2217689	methadone	10	270	30	frey	6 days early		
9/6/2012	2217690	fentanyl	25	10	30	frey	6 days early		
10/1/2012	2217902	methadone	10	240	30	frey			
11/1/2012	2218175	methadone	10	210	30	frey			
11/30/2012	2218439	methadone	10	210	30	frey			
12/31/2012	2218699	methadone	10	210	30	frey			
1/28/2013	2218956	methadone	10	210	30	frey			
2/26/2013	2219233	methadone	10	210	30	frey			
8/6/2009	4417768	clonazepam	0.5	30	30	glass			
9/15/2009	4418273	dronabinol	10	120	30	glass			
11/10/2009	4419034	dronabinol	5	120	30	glass			
12/7/2009	4419418	dronabinol	5	120	30	glass			

PATIENT S.M.

59. In response to the following question "What can you tell me about this patient-What is the patient being treated for?" Respondent Cassar replied "We have not filled prescriptions for this patient since March 2012. Based on the type of medication she filled, I suspect she has chronic pain, anxiety, ADD/ADHD, hypertension, and some type of air constriction."

60. In response to the following question "Have they tried any non-medication therapies, or alternative therapies for their condition before trying pain medications?" Respondent Cassar replied "I am not aware if she had tried any non-medication therapies or alternative therapies."

61. In response to the following question "What type of consultation have they received from you regarding their prescriptions? What is your consultation like when it comes to pain medication?" Respondent Cassar replied "Patients received consultation as required by OBRA-90 and California law which includes a review of the patient's profile. I review with the patient which medication is short vs. long acting. If they receive other non-narcotic or non-pain

medications that causes sedation, I typically review that with them as well. In addition, I ask they be aware of the restrictions of alcohol and driving with this medication."

62. In response to the following question "Did the patient pick up their medications themselves, was it delivered, or was it picked up by someone else?" Respondent Cassar replied "As I recall, Ms. [S.M.] picked up her own medication, though I believe on an occasion or two she had her son pick-up her medication. In those cases, I believe she called us in advance."

63. In response to the following question "Did you talk to the prescriber about any of the prescriptions for this patient in order to clarify or make therapy adjustments?" Respondent Cassar replied "If something required clarification we would contact the doctor. As we pull prescriptions, examples of that communication may turn up."

64. In response to the following question "Did you feel any of these patient's therapies may have been excessive?" Respondent Cassar replied "Based on her total treatment history, there was nothing that in my professional judgment indicated her therapy was excessive. Mrs. M. only used combinations of short acting narcotic pain medication throughout the day. In the nearly four years she filled prescriptions from Dr. [L.G.] at Kanan Pharmacy, her daily dose did rise. At no time did I observe Mrs. [M.] present in the pharmacy as incoherent or exhibit signs of slurred speech or intoxication. She was always very lucid. In my professional judgment, I did not have cause for concern. In addition, Mrs. M. has insurance and if a prescription is early, or duplicative we will be notified when the claim is processed. In any such case, we typically try to determine from the patient why and, if appropriate, call the doctor to discuss the situation."

65. In response to the following question "How do you document any conversations you have with doctor or patient?" Respondent Cassar replied "I would typically document any conversations with doctors or patients on their prescriptions."

66. In response to the following question "Did you use CURES at the time this patient was at your pharmacy?" Respondent Cassar replied "No, not that I can recall. There was no clear reason to consult CURES for this patient."

67. The Board investigator entered the information for S.M. into the spreadsheet below: there were several early fills and she was not given a prescription. The early fills add up over a

period of time. For example, from 3/22/10-2/12/12 (2 year or 730 day period), S.M. received a 810 day supply of Alprazolam, 804 day supply of Methadone, and 780 day supply of Methylphenidate, all due to early fills. This means the patient is taking more than prescriber wrote for. S.M. received 80 days more of Alprazolam, 74 days more of Methadone, and 50 days more of Methylphenidate in those two years. This can lead to overdose, and the prescriber does not have an accurate knowledge of what the patient is taking. RX 4425972, 2213046, 2213044, and 2213043 all said to dispense on 3/29 but they were dispensed on 3/28. RX 2211845 was written for a quantity of 300 but it was filled with 240, and there was no explanation why.

Date	Rx	Drug	Strength	Amt	Day supply	MD	early?	problem?	Script ?
3/10/2012	4430725	alprazolam	2	60	30	glass			
2/12/2012	4430359	alprazolam	2	60	30	glass			
2/11/2012	4430355	hydrocodone/apap	10/325	40	7	matzner			
1/16/2012	4429962	alprazolam	2	60	30	glass			
12/20/2011	4429605	alprazolam	2	60	30	glass			
11/23/2011	4428942	alprazolam	2	60	30	glass			
10/26/2011	4428838	alprazolam	2	60	30	glass			
9/29/2011	4428479	alprazolam	2	60	30	glass			
9/2/2011	4428098	alprazolam	2	60	30	glass			
8/4/2011	4427694	alprazolam	2	60	30	glass	7 days early		
7/11/2011	4427327	alprazolam	2	60	30	glass	6 days early		
6/17/2011	4427076	alprazolam	2	60	30	glass			
5/21/2011	4426733	alprazolam	2	60	30	glass			
4/25/2011	4426352	alprazolam	2	60	30	glass			
3/28/2011	4425972	alprazolam	2	60	30	glass	5 days early	says dispense 3/29 but dispensed 3/28	
3/3/2011	4425669	alprazolam	2	60	30	glass			
2/4/2011	4425296	alprazolam	2	60	30	glass			
1/7/2011	4424943	alprazolam	2	60	30	glass			
12/7/2010	4424523	alprazolam	2	60	30	glass			
11/2/2010	4424026	alprazolam	2	60	30	glass			
10/6/2010	4423623	alprazolam	2	60	30	glass	5 days early		

9/11/2010	4423195	alprazolam	2	60	30	glass			
8/14/2010	4422781	alprazolam	2	60	30	glass	8 days early		
7/22/2010	4422461	alprazolam	2	60	30	glass	15 days early		
7/6/2010	4422267	diazepam	10	10	5	glass			
7/7/2010	4422228	alprazolam	2	30	30	glass	7 days early		
6/14/2010	4421823	alprazolam	2	30	30	glass	6 days early		
5/21/2010	4421626	alprazolam	2	30	30	glass			
4/22/2010	4421219	alprazolam	2	30	30	glass			
3/22/2010	4420837	alprazolam	2	30	30	glass			
2/5/2010	4420262	alprazolam	2	30	30	glass			
1/8/2010	4419848	alprazolam	2	30	30	glass			
11/19/2009	4419161	alprazolam	2	30	30	glass			
10/22/2009	4418763	alprazolam	2	30	15	glass			
8/31/2009	4418053	alprazolam	2	30	15	glass			
8/7/2009	4417773	alprazolam	2	30	15	glass			
4/22/2009	4416391	alprazolam	2	30	30	glass			
3/20/2012	2216209	oxycodone	30	60	8	matzner			
3/10/2012	2216119	methylphenidater		90	30	glass			
3/10/2012	2216118	methadone	10	480	30	glass			
2/25/2012	2216001	oxycodone	30	300	17	glass			
2/17/2012	2215919	morphine	30	60	3	glass	8 days early		
2/12/2012	2215867	methylphenidater		90	30	glass			
2/12/2012	2215866	methadone	10	480	30	glass			
1/29/2012	2215712	oxycodone	30	300	17	glass			
1/26/2012	2215711	morphine	30	60	30	glass			
1/16/2012	2215604	methylphenidater		90	30	glass	12 days early		
1/16/2012	2215452	methadone	10	480	30	glass			
1/3/2012	2215451	oxycodone	30	300	17	glass			
12/29/2011	2215450	morphine	30	60	5	glass			
12/29/2011	2215362	methylphenidater		30	30	glass			
12/20/2011	2215361	methadone	10	480	30	glass	5 days early		
12/7/2011	2215257	oxycodone	30	360	20	glass			

11/25/2011	2215147	methylphenidater	20	90	30	glass			
11/21/2011	2215101	morphine	30	150	9	glass			
11/10/2011	2215011	oxycodone	30	360	20	glass			
11/25/2011	2214945	methadone	10	480	30	glass			
11/3/2011	2214944	morphine	30	360	20	glass			
10/26/2011	2214865	methylphenidater		90	30	glass			
10/26/2011	2214864	methadone	10	480	30	glass			
10/12/2011	2214729	oxycodone	30	360	20	glass			
9/29/2011	2214615	methylphenidater		90	30	glass			
9/29/2011	2214614	methadone	10	480	30	glass			
9/15/2011	2214482	oxycodone	30	360	30	glass			
9/2/2011	2214374	methylphenidater	20	90	30	glass	5 days early		
9/2/2011	2214373	methadone	10	480	30	glass	5 days early		
8/23/2011	2214291	oxycodone	30	300	17	glass			
8/8/2011	2214154	methylphenidater		90	30	glass			
8/4/2001	2214153	oxycodone	30	300	17	glass			
8/8/2011	2214152	methadone	10	480	30	glass			
7/7/2011	2213929	oxycodone	30	300	17	glass			
7/11/2011	2213928	methylphenidater	20	90	30	glass	6 days early		
7/11/2011	2213927	methadone	10	480	30	glass	6 days early		
6/17/2011	2213762	methylphenidater	20	30	30	glass			
6/17/2011	2213761	oxycodone	30	300	17	glass			
6/17/2011	2213760	methadone	10	480	30	glass			
5/21/2011	2213509	methylphenidater	20	90	30	glass			
5/21/2011	2213508	oxycodone	30	300	17	glass			
5/21/2011	2213507	methadone	10	480	30	glass			
4/25/2011	2213292	methylphenidater	20	90	30	glass			
4/25/2011	2213291	oxycodone	30	300	30	glass			
4/25/2011	2213290	methadone	10	480	30	glass			
3/28/2011	2213046	methylphenidater		90	30	glass	5 days early	disp 3/29 per md, but disp 3/28	

3/28/2011	2213044	oxycodone	30	300	17	glass		disp 3/29 per md, but disp 3/28	
3/28/2011	2213043	methadone	10	480	30	glass	6 days early	disp 3/29 per md, but disp 3/28	
3/3/2011	2212865	methylphenidate er	20	90	30	glass			
3/3/2011	2212864	oxycodone	30	300	17	glass			
3/4/2011	2212863	methadone	10	480	30	glass			
2/9/2011	2212696	oxycodone	30	300	17	glass			
2/9/2011	2212695	methadone	10	480	30	glass			
2/4/2011	2212647	methylphenidate er	20	90	30	glass			
1/14/2011	2212459	oxycodone	30	300	17	glass			
1/14/2011	2212458	methadone	10	480	30	glass			
1/7/2011	2212457	methylphenidate er	20	90	30	glass			
12/30/2010	2212404	morphine	30	60	10	glass			
12/19/2010	2212333	oxycodone	30	300	17	glass			
12/19/2010	2212332	methadone	10	480	30	glass			
11/30/2010	2212131	methylphenidate er	20	90	30	glass			
11/22/2010	2212095	methadone	10	480	30	glass	8 days early		
11/22/2010	2212094	oxycodone	30	300	17	glass			
11/2/2010	2211944	morphine	30	240	15	glass			
11/2/2010	2211943	methylphenidate er	20	90	30	glass			
10/30/2010	2211919	methadone	10	480	30	glass			
10/27/2010	2211895	oxycodone	30	300	17	glass			
10/20/2010	2211845	morphine	30	240	14	glass		written for 300, filled with 240	
10/4/2010	2211683	methylphenidate er	20	90	30	glass			
10/4/2010	2211682	methadone	10	480	30	glass			
9/30/2010	2211681	oxycodone	30	300	17	glass			
9/18/2010	2211589	endocet	5/325	30	3	polisky			
9/3/2010	2211491	oxycodone	30	300	17	glass			no
9/3/2010	2211469	methadone	10	480	30	glass	10 days early		
9/7/2010	2211468	methylphenidate er	20	90	30	glass	6 days early		

8/14/2010	2211302	methylphenidater	20	90	30	glass	8 days early		
8/14/2010	2211301	methadone	10	480	30	glass	8 days early		
8/10/2010	2211297	oxycodone	30	300	17	glass			
7/22/2010	2211151	methadone	10	480	30	glass			
7/22/2010	2211150	methylphenidater	20	90	30	glass	6 days early		
7/20/2010	2211149	oxycodone	30	240	20	glass			
6/25/2010	2210983	methadone	10	480	30	glass	7 days early		
6/25/2010	2210982	oxycodone	30	240	20	glass			
6/28/2010	2210981	methylphenidater	20	90	30	glass	6 days early		
6/4/2010	2210822	methylphenidater	20	90	30	glass			
6/4/2010	2210821	oxycodone	30	240	20	glass			
6/2/2010	2210804	methadone	10	480	30	glass			
4/16/2010	2210479	methadone	10	420	27	glass			
4/16/2010	2210478	oxycodone	30	240	20	glass			
4/16/2010	2210477	methylphenidater	20	90	30	glass	5 days early		
3/22/2010	2210303	methadone	10	420	27	glass			
3/22/2010	2210302	oxycodone	30	240	20	glass			
3/22/2010	2210301	methylphenidater	20	90	30	glass			
2/26/2010	2210129	methylphenidater	20	90	30	glass	8 days early		
2/26/2010	2210128	oxycodone	30	240	20	glass			
2/26/2010	2210127	methadone	10	420	27	glass	5 days early		
2/4/2010	2209958	methadone	10	420	27	glass			
2/4/2010	2209957	oxycodone	30	240	20	glass			
2/4/2010	2209956	methylphenidater	20	90	30	glass			
1/8/2010	2209751	methylphenidater	20	90	30	glass	5 days early		
1/8/2010	2209750	oxycodone	30	240	20	glass			
1/8/2010	2209749	methadone	10	420	27	glass			
12/14/2009	2209572	methylphenidater	20	90	30	glass	8 days early		
12/14/2009	2209571	oxycodone	30	240	20	glass			
12/14/2009	2209570	methadone	10	420	27	glass			

11/20/2009	2209389	methylphenidater	20	90	30	glass			
11/19/2009	2209383	oxycodone	30	240	20	glass			
11/19/2009	2209382	methadone	10	420	27	glass			
10/22/2009	2209174	methylphenidater	20	90	30	glass			
10/22/2009	2209173	oxycodone	30	240	20	glass			
10/22/2009	2209172	methadone	10	420	27	glass			
9/25/2009	2208937	methylphenidater	20	90	30	glass	5 days early		
9/25/2009	2208936	oxycodone	30	240	20	glass			
9/25/2009	2208935	methadone	10	420	27	glass			
8/31/2009	2208747	methylphenidater	20	90	30	glass	6 days early		
8/31/2009	2208746	oxycodone	30	240	20	glass			
8/31/2009	2208745	methadone	10	420	27	glass			
8/7/2009	2208584	methylphenidater	20	90	30	glass			
8/7/2009	2208583	oxycodone	30	240	20	glass			
8/7/2009	2208582	methadone	10	420	27	glass			
7/10/2009	2208368	methylphenidater		90	30	glass	5 days early		
7/10/2009	2208367	oxycodone	30	240	20	glass			
7/10/2009	2208366	methadone	10	420	27	glass			
6/15/2009	2208191	oxycodone	30	240	20	glass			
6/15/2009	2208190	methylphenidater	20	90	30	glass			
6/15/2009	2208189	methadone	10	420	27	glass			
5/18/2009	2207989	oxycodone	30	240	20	glass			
5/18/2009	2207988	methylphenidater	20	90	30	glass			
5/18/2009	2207987	methadone	10	420	27	glass			
4/21/2009	2207785	methylphenidater	20	90	30	glass			
4/21/2009	2207784	oxycodone	30	240	20	glass			
4/21/2009	2207783	methadone	10	420	27	glass			
3/24/2009	2207585	methylphenidater	20	60	30	glass			
3/24/2009	2207584	methadone	10	420	35	glass			
3/24/2009	2207583	oxycodone	30	240	20	glass			
3/9/2009	2207443	oxycodone	30	140	12	glass			
2/24/2009	2207377	methylphenidater	20	60	30	glass			

2/24/2009	2207376	methadone	10	420	18	glass			
1/28/2009	2207182	methylphenidate er		60	30	glass			
1/28/2009	2207181	methadone	10	420	18	glass			
1/7/2009	2207051	oxycodone	30	240	20	glass			
1/2/2009	2206972	methylphenidate er		60	30	glass			
1/2/2009	2206971	methadone	10	240	18	glass			

PATIENT M.S.

68. In response to the following question "What can you tell me about this patient- What is the patient being treated for?" Respondent Cassar replied "Disc disease of lumbar spine, facet syndrome lateral SI dysfunction, mild radiculopathy of lower extremities. In the notes probably from Dr. [L.G.]."

69. In response to the following question "Have they tried any non-medication therapies, or alternative therapies for their condition before trying pain medications? Respondent Cassar replied "I am not aware if he had tried any non-medication therapies or alternative therapies."

70. In response to the following question "What type of consultation have they received from you regarding their prescriptions? What is your consultation like when it comes to pain medication?" Respondent Cassar replied "Patients received consultation as required by OBRA-90 and California law which includes a review of the patient's profile. I review with the patient which medication is short vs. long acting. If they receive other non-narcotic or non-pain narcotic medications that causes sedation, I typically review that with them as well. In addition, I ask they be aware of the restrictions of alcohol and driving with this medication."

71. In response to the following question "Did the patient pick up their medications themselves, was it delivered, or was it picked up by someone else?" Respondent Cassar replied "Usually Mr. [M.S.] picked up his own medication and sometimes his wife, [S.S.] would pick-up his medications."

72. In response to the following question "Did you talk to the prescriber about any of the prescriptions for this patient in order to clarify or make therapy adjustments?" Respondent

Cassar replied "If something required clarification we would contact the doctor. As we pull prescriptions, examples of that communication may turn up."

73. In response to the following question "Did you feel any of these patient's therapies may have been excessive?" Respondent Cassar replied "Based on his total treatment history, there was nothing that in my professional judgment indicated his therapy was excessive. Mr. M.S. used a combination of higher than normal doses of long acting narcotic pain medication as well as short acting narcotic pain medication. He was on the same dose for a few years with no increase noted. At the end of 2009, he changed his long-acting narcotic pain therapy for fentanyl patches. Dosing of these patches seemed to be consistent for the amounts of Oxycontin he used daily. He filled his prescriptions regularly and , in my professional judgment, I had no cause to be concerned. Like other patients, Mr. M.S. was always lucid and did not present in the pharmacy as intoxicated or having taken excess narcotic pain medication. In addition, Mr. M.S. has had insurance during the majority of the time we have been filling for him. If a prescription is early or duplicative we will be notified when the claim is processed. In any such case, we typically try to determine from the patient why and, if appropriate, call the doctor to discuss the situation."

74. In response to the following question "How do you document any conversations you have with doctor or patient?" Respondent Cassar replied "I would typically document any conversations with doctors or patients on their prescriptions."

75. In response to the following question "Did you use CURES at the time this patient was at your pharmacy?" Respondent Cassar replied "No, not that I can recall. There was no clear reason to consult CURES for this patient."

76. The Board investigator entered the information for this patient into the spreadsheet below: there were several early fills. She did not receive some prescriptions. The physician also ordered Fentanyl patches as 1-2 patches every 2 days. The patient should not be guessing if they need one or two patches, because the absorption of the patch takes a while, so the patient will not feel instant relief. There was no mention about clarifying the prescription or talking to the patient on how to use the patches.

Date	Rx	Drug	Strength	Amt	Day supply	MD	early ?	problem ?	scri pt?
1/16/2009	2207112	oxycontin	80	150	18	glass			
1/26/2009	4415303	diazepam	10	30	30	glass			
2/13/2009	2207314	oxycontin	80	150	18	glass			
3/10/2009	2207485	oxycontin	80	150	18	glass			
3/11/2009	4415849	diazepam	10	30	30	glass			
3/11/2009	2207502	oxycodone	15	150	18	glass			
4/6/2009	2207665	oxycontin	80	150	18	glass			
4/28/2009	2207843	hydromorphone	8	150	13	glass			
4/28/2009	2207842	morphine		150	25	glass			
5/1/2009	2207856	oxycodone	15	150	13	glass			
5/1/2009	2207855	oxycontin	80	150	19	glass			
5/8/2009	4416591	diazepam	10	30	30	glass			
5/26/2009	2208059	oxycontin	80	150	19	glass			
5/26/2009	2208055	oxycodone	15	150	13	glass			
6/18/2009	4416591	diazepam	10	30	30	glass			no
6/22/2009	2208251	oxycontin	80	150	19	glass			
6/22/2009	2208240	oxycodone	15	150	13	glass			
7/15/2009	2208384	morphine	30	100	25	glass			
7/15/2009	2208383	methadone	10	360	30	glass			
11/24/2009	2209431	morphine	30	180	30	glass			
11/24/2009	4419252	diazepam	10	30	30	glass			
11/24/2009	2209430	oxycodone	30	150	13	glass			
12/7/2009	2209524	hydromorphone	8	240	20	glass			
12/7/2009	2209523	fentanyl	50	15	30	glass			
12/7/2009	2209522	fentanyl	100	15	30	glass			
12/16/2009	2209592	oxycodone	30	150	13	glass			
12/30/2009	2209701	oxycodone	30	240	20	glass			
1/19/2010	2209820	oxycodone	30	24	20	glass			

				0					
1/19/2010	2209819	fentanyl	50	15	30	glass			
1/19/2010	2209818	fentanyl	100	15	30	glass			
2/17/2010	2210062	oxycodone	30	240	20	glass			
2/17/2010	2210061	fentanyl	50	15	30	glass			
2/17/2010	2210060	fentanyl	100	15	30	glass			
3/12/2010	2210238	oxycodone	30	240	20	glass			
3/17/2010	2210237	fentanyl	50	15	30	glass			
3/17/2010	2210236	fentanyl	100	15	30	glass			
3/23/2010	2210300	morphine	30	240	20	glass			
4/9/2010	2210428	fentanyl	50	30	30	glass	7 days early		
4/9/2010	2210427	oxycodone	30	240	20	glass			
4/15/2010	2210299	fentanyl	100	30	30	glass			
5/6/2010	2210620	oxycodone	30	240	20	glass			
5/6/2010	2210619	fentanyl	50	30	30	glass		1-2 patches q2d?	
5/18/2010	4421577	diazepam	10	30	30	glass			
5/18/2010	2210691	fentanyl	100	15	30	glass			
5/28/2010	2210775	oxycodone	30	240	20	glass			
6/23/2010	4422075	diazepam	10	30	30	glass			
6/23/2010	2210956	oxycodone	30	240	20	glass			
6/23/2010	2210955	fentanyl	100	15	30	glass			
7/10/2010	2211096	fentanyl	50	15	30	glass			
7/19/2010	2211097	fentanyl	100	15	30	glass			
7/26/2010	4422569	diazepam	10	30	30	glass			
7/26/2010	2211199	oxycodone	30	240	20	glass			
8/7/2010	2211285	fentanyl	50	30	30	glass			
8/16/2010	2211284	fentanyl	100	15	30	glass			
8/19/2010	2211286	oxycodone	30	240	20	glass			
9/14/2010	2211566	fentanyl	100	15	30	glass			
9/14/2010	2211565	fentanyl	50	15	30	glass			
9/17/2010	2211583	oxycodone	30	240	20	glass			
10/13/2010	2211794	oxycodone	30	240	20	glass			
10/13/2010	2211793	fentanyl	100	15	30	glass			

10/13/2010	2211792	fentanyl	50	15	30	glass			
10/13/2010	4423731	diazepam	10	30	30	glass			
11/8/2010	2212001	oxycodone	30	240	20	glass			
11/8/2010	2211996	fentanyl	50	15	30	glass	5 days early		
11/8/2010	2211995	fentanyl	100	15	30	glass	5 days early		
12/4/2010	2212184	fentanyl	100	15	30	glass			
12/4/2010	2212183	fentanyl	50	15	30	glass			
12/4/2010	2212182	oxycodone	30	240	20	glass			
12/31/2010	4424841	diazepam	10	30	30	glass			
12/31/2010	2212414	oxycodone	30	240	20	glass			
1/7/2011	2212461	fentanyl	50	45	30	glass			
1/28/2011	2212614	oxycodone	30	240	20	glass			
1/28/2011	2212412	fentanyl	100	15	30	glass			
1/31/2011	4425253	diazepam	10	30	30	glass			
2/1/2011	2212413	fentanyl	50	15	30	glass	5 days early		
2/25/2011	2212823	oxycodone	30	240	20	glass			
2/25/2011	2212821	fentanyl	100	15	30	glass			
2/27/2011	4425600	diazepam	10	30	30	glass			
2/28/2011	2212822	fentanyl	50	15	30	glass			
3/24/2011	2213037	fentanyl	100	15	30	glass			
3/24/2011	2213035	oxycodone	30	240	20	glass			
3/24/2011	4425967	diazepam	10	30	30	glass			
3/30/2011	2213036	fentanyl	50	15	30	glass			
4/22/2011	2213283	oxycodone	30	240	20	glass			
4/22/2011	2213281	fentanyl	100	15	30	glass			
4/29/2011	2213282	fentanyl	50	15	30	glass			
5/20/2011	4426728	diazepam	10	30	30	glass			
5/20/2011	2213495	oxycodone	30	240	20	glass			
5/20/2011	2213494	fentanyl	100	15	30	glass			
5/29/2011	2213533	fentanyl	50	15	30	glass			
6/17/2011	2213763	oxycodone	30	240	20	glass			
6/17/2011	4426843	diazepam	10	30	30	glass			
6/19/2011	2213759	fentanyl	100	15	30	glass			
6/28/2011	2213758	fentanyl	50	15	30	glass			

7/20/2011	4427080	diazepam	10	30	30	glass			
7/28/2011	2214104	fentanyl	50	15	30	glass			
8/12/2011	4427797	diazepam	10	30	30	glass	8 days early		
8/12/2011	2214214	oxycodone	30	240	20	glass			
8/12/2011	2214213	fentanyl	100	15	30	glass			
8/26/2011	2214326	fentanyl	50	15	30	glass			
8/26/2011	2214325	oxycodone	30	240	20	glass	6 days early		
9/12/2011	2214458	fentanyl	100	15	30	glass			
9/16/2011	4428290	diazepam	10	30	30	glass			
9/16/2011	2214498	oxycodone	30	240	20	glass			
9/28/2011	2214600	fentanyl	50	15	30	glass			
10/11/2011	2214461	fentanyl	100	15	30	glass			
10/13/2011	4428675	diazepam	10	30	30	glass			no
10/25/2011	2214739	oxycodone	30	240	20	glass			
10/28/2011	2214738	fentanyl	50	15	30	glass			
11/17/2011	2215075	fentanyl	100	15	30	glass			
11/25/2011	4429238	diazepam	10	30	30	glass			
11/25/2011	2215137	oxycodone	30	240	20	glass			
11/25/2011	2215136	fentanyl	50	15	30	glass			
12/17/2011	2215266	fentanyl	100	15	30	glass			
12/22/2011	2215410	oxycodone	30	240	20	glass			
12/22/2011	2215409	fentanyl	50	15	30	glass			
12/22/2011	4429644	diazepam	10	30	30	glass			
1/10/2012	2215550	fentanyl	100	15	30	glass	6 days early		
1/19/2012	2215648	oxycodone	30	240	20	glass			
1/19/2012	4430016	diazepam	10	30	30	glass			
1/19/2012	2215647	fentanyl	50	15	30	glass			
2/15/2012	2215894	fentanyl	100	15	30	glass			
2/15/2012	2215893	hydromorphone	8	10	2	glass			
2/20/2012	2215942	fentanyl	50	15	30	glass			
2/20/2012	4430456	diazepam	10	30	30	glass			
2/20/2012	2215941	oxycodone	30	240	20	glass			
3/21/2012	2216225	oxycodone	15	90	23	glaser			

3/21/2012	2216223	fentanyl	100	10	30	glaser			
4/1/2012	2216332	oxycodone	15	120	23	stark			
4/10/2012	2216331	fentanyl	100	15	30	stark			
4/30/2012	2216599	oxycodone	30	120	30	stark			
5/6/2012	2216598	fentanyl	100	15	30	stark			
5/25/2012	2216809	morphine	60	30	30	stark			
5/25/2012	2216808	oxycodone	30	180	30	stark			
6/20/2012	2217037	oxycodone	30	180	30	stark			
6/20/2012	2217036	morphine	60	30	30	stark			
7/18/2012	2217249	oxycodone	30	180	30	stark			
7/18/2012	2217248	morphine	60	30	30	stark			
8/15/2012	2217494	oxycodone	30	180	30	stark			
8/15/2012	2217493	morphine	60	30	30	stark			
9/17/2012	2217783	morphine	60	30	30	stark			
9/17/2012	2217782	oxycodone	30	180	30	stark			
10/15/2012	2218020	morphine	60	30	30	stark			
10/15/2012	2218019	oxycodone	30	180	30	stark			
11/13/2012	4434332	diazepam	10	30	30	stark			
11/13/2012	2218241	oxycodone	30	180	30	stark			
11/15/2012	2218240	morphine	60	30	30	stark			
12/10/2012	2218518	oxycodone	30	180	30	stark			
12/10/2012	2218517	morphine	60	30	30	stark	5 days early		
1/9/2013	4435166	diazepam	10	30	30	stark			
1/9/2013	2218771	oxycodone	30	240	30	stark			
2/9/2013	2219089	oxycodone	30	240	30	stark			
3/10/2013	4436047	diazepam	10	30	30	stark			
3/10/2013	2219335	oxycodone	30	240	30	stark			

PATIENT B.K.

77. On or about May 29, 2013, the Board investigator obtained a copy of the death certificate for Patient B.K. who passed away on January 12, 2010 at the age of 26. The cause of death was listed as Oxycodone intoxication.

78. In response to the following question "What can you tell me about this patient-What is the patient being treated for?" Respondent Cassar replied "This patient was last in my pharmacy in November 2009. I do not know what he was treated for specifically, but I have to assume that he had chronic pain with possibly associated muscle spasms. He may have also had ADD or ADHD as well as some anxiety."

79. In response to the following question "Have they tried any non-medication therapies, or alternative therapies for their condition before trying pain medications?" Respondent Cassar replied "I am not aware if he had tried any non-medication therapies or alternative therapies."

80. In response to the following question "What type of consultation have they received from you regarding their prescriptions? What is your consultation like when it comes to pain medication?" Respondent Cassar replied "Patients received consultation as required by OBRA-90 and California law which includes a review of the patient's profile. I review with the patient which medication is short vs. long acting. If they receive other non-narcotic or non-pain narcotic medication that causes sedation, I typically review that with them as well. In addition, I ask they be aware of the restrictions of alcohol and driving with this medication."

81. In response to the following question "Did the patient pick up their medications themselves, was it delivered, or was it picked up by someone else?" Respondent Cassar replied "As I recall, Mr. K. picked up his own medication."

82. In response to the following question "Did you talk to the prescriber about any of the prescriptions for this patient in order to clarify or make therapy adjustments?" Respondent Cassar replied "Because this patient was last seen in November 2009, I cannot recall whether or not I spoke with the prescriber to clarify or make therapy adjustments. However, as we pull prescriptions, if I did document it, it would be found on the prescription."

83. In response to the following question "Did you feel any of these patient's therapies may have been excessive?" Respondent Cassar replied "Based on his total treatment history, there was nothing that in my professional judgment indicated his therapy was excessive. I did not feel his Oxycontin doses were excessive because they were prescribed every 12 hours. In

addition, the patient has insurance and if the claim denied for early refill, we would have to contact the physician and/or discuss the situation with the patient."

84. In response to the following question "How do you document any conversations you have with doctor or patient?" Respondent Cassar replied "I would typically document any conversations with doctors or patients on their prescriptions."

85. In response to the following question "Did you use CURES at the time this patient was at your pharmacy?" Respondent Cassar replied "No. The on-line CURES program was not available at that time." However, even assuming that the on-line CURES program was not available at the time, Respondents could have obtained the CURES report via facsimile from the Department of Justice.

86. The Board investigator entered the prescription information from Respondent Pharmacy into a spreadsheet for this patient: there were early fills, and she was not provided some prescriptions.

Date	Rx	Drug	Strength	Amt	Day supply	MD	early?	problems?	script?
3/26/2009	6673850	carisprodol	350	60	30	glass			
3/26/2009	2207601	oxycontin	80	60	30	glass			
4/3/2009	2207650	dext/amp	30	25	13	mac			
4/6/2009	2207667	dext/amp	30	20	10	mac	10 days early		
4/17/2009	4416332	alprazolam	2	10	10	glass			
5/18/2009	2207990	dext/amp	30	60	30	mac			
6/8/2009	2208139	dext/amp	30	60	30	mac	9 days early		
6/22/2009	2208245	oxycontin	80	60	15	glass			
7/10/2009	4417446	alprazolam	2	10	5	glass			
7/10/2009	4417445	hydrocodone/ apap	10/325	210	18	glass			
7/10/2009	6673850	carisprodol	350	60	30	glass			no
7/21/2009	2208439	dext/amp	20	15	10	glass			no
7/27/2009	2208472	dext/amp	30	60	30	mac			
9/1/2009	2208754	dext/amp	30	60	30	mac			
9/3/2009	4418111	alprazolam	2	10	4	glass			
9/3/2009	4418110	hydrocodone/ apap	10/325	210	18	glass			

9/3/2009	6679975	carisprodol	350	60	30	glass			
9/10/2009	6683086	carisprodol	350	60	30	glass	23 days early		
9/21/2009	2208890	dext/amp	30	60	30	mac	10 days early		
10/2/2009	2209008	dext/amp	20	60	30	glass	19 days early		
10/2/2009	6685004	carisprodol	350	60	30	glass	8 days early		
10/2/2009	4418498	hydrocodone/ apap	10/325	180	15	glass			
10/2/2009	4418497	alprazolam	2	10	4	glass			
10/21/2009	2209160	dext/amp	30	60	30	mac	11 days early		
10/29/2009	4418861	hydrocodone/ apap	10/325	210	18	glass			
11/4/2009	2209239	dext/amp	20	60	30	glass	17 days early		
11/4/2009	2209236	oxycontin	80	60	30	glass			
11/12/2009	4419067	hydrocodone/ apap	10/325	156	13	glass	5 days early		
11/12/2009	2209326	oxycontin	80	32	16	glass	22 days early		
11/25/2009	2209327	dext/amp	20	45	23	glass	9 days early		
11/27/2009	2209445	oxycontin	80	35	18	glass			
1/7/2009	2207040	dext/amp	30	10	5	mac			
1/12/2009	6669713	carisprodol	350	60	30	glass			
1/12/2009	4415153	hydrocodone/ apap	10/325	210	18	glass			
1/12/2009	2207076	oxycontin	40	120	30	glass			
1/27/2009	2207169	dext/amp	30	60	30	mac			
2/10/2009	6671371	carisprodol	350	60	30	glass			
2/10/2009	4415500	hydrocodone/ apap	10/325	210	18	glass			
2/10/2009	2207281	oxycontin	40	60	30	glass			
2/17/2009	2207329	amphetamine		60	30	mac			
2/23/2009	2207365	oxycontin	80	30	15	glass			
3/9/2009	6672891	carisprodol	350	60	30	glass			

3/9/2009	4415815	hydrocodone/ apap	10/325	210	18	glass			
3/9/2009	2207480	oxycontin	40	120	30	glass			
3/16/2009	2207528	dext/amp	30	60	30	kumar			
3/26/2009	4416051	hydrocodone/ apap	10/325	210	18	glass			

87. The Board of Pharmacy ran a CURES report on B.K. from June 1, 2008 through October 11, 2011 which revealed that in 2009, B.K. used Respondent Pharmacy, West Val Pharmacy, Longs Drugs, Costco, CVS and Rite Aid. B.K saw Drs. L.G, Dr. K., Dr. M. and Dr. S. in 2009. This patient was a doctor shopper and used multiple pharmacies. Said CURES data is detailed below.

Date	Drug	Strength	Amt	Day supply	Pharmacy	PHY	MD
6/11/2008	suboxone	8 2	3	2	CVS 9715	47994	Nathan
6/18/2008	suboxone	8 2	4	2	CVS 9715	47994	Nathan
6/19/2008	suboxone	8 2	3	1	CVS 9715	47994	Nathan
6/20/2008	suboxone	8 2	5	3	CVS 9715	47994	Nathan
6/23/2008	suboxone	8 2	3	3	CVS 9715	47994	Nathan
6/24/2008	suboxone	8 2	3	2	CVS 9715	47994	Nathan
6/29/2008	suboxone	8 2	3	30	CVS 9715	47994	Nathan
7/28/2008	morphine	60	90	0	Longs 326	39157	Glass
7/28/2008	morphine	30	60	0	Longs 326	39157	Glass
8/7/2008	oxycontin	80	60	30	Kanan	46707	Glass
8/22/2008	amphetamine salt	20	60	30	Costco 117	41682	Mac
8/26/2008	vyvanse	30	5	5	Costco 117	41682	Mac
9/2/2008	hydrocodone/apap	10/325	150	25	Costco 117	41682	Glass
9/3/2008	oxycontin	80	60	30	Kanan	46707	Glass
9/4/2008	amphetamine salt	30	60	30	Costco 117	41682	Mac
9/16/2008	amphetamine salt	30	60	30	Costco 117	41682	Mac
9/24/2008	amphetamine salt	30	60	0	Longs 326	39157	Mac
9/26/2008	hydrocodone/apap	10/325	150	0	Longs 326	39157	Glass
9/26/2008	oxycontin	80	60	0	Longs 326	39157	Glass
10/10/2008	amphetamine salt	20	60	30	Costco 117	41682	Mac

10/15/2008	amphetamine salt	30	60	30	Costco 117	41682	Mac
10/22/2008	dexmethylphenidate	10	60	30	rite aid 5560	42493	Mac
10/27/2008	amphetamine salt	30	60	30	Costco 117	41682	Mac
11/4/2008	amphetamine salt	30	60	30	Costco 117	41682	Mac
11/20/2008	amphetamine salt	30	60	0	Longs 326	39157	Mac
12/15/2008	amphetamine salt	30	60	30	Costco 117	41682	Mac
12/23/2008	oxycodone/apap	5/325	60	0	longs 9326	49387	Mcgovern
12/29/2008	soma	350	90	30	ralphs	46794	Glass
12/29/2008	hydrocodone/apap	10/325	210	17	ralphs	46794	Glass
12/29/2008	oxycodone	80	60	30	ralphs	46794	Glass
3/9/2009	hydrocodone/apap	10/325	210	18	Kanan	46707	Glass
3/9/2009	oxycodone	40	120	30	Kanan	46707	Glass
3/16/2009	dextroamphetamine	30	60	30	Kanan	46707	Kumar
3/26/2009	hydrocodone/apap	10/325	210	18	Kanan	46707	Glass
3/26/2009	oxycontin	80	60	30	Kanan	46707	Glass
4/3/2009	dextroamphetamine	30	25	13	Kanan	46707	Mac
4/6/2009	dextroamphetamine	30	20	10	Kanan	46707	Mac
4/17/2009	alprazolam	2	10	10	Kanan	46707	Glass
4/17/2009	amphetamine salt	20	10	10	west val	46707	Glass
5/11/2009	hydrocodone/apap	10/325	210	18	west val	11433	Glass
5/6/2009	oxycontin	80	60	15	west val	11433	Glass
5/15/2009	hydrocodone/apap	10/325	28	5	west val	11433	Glass
5/18/2009	dextroamphetamine	30	60	30	Kanan	46707	Mac
5/26/2009	oxycodone	80	60	15	west val	11433	Glass
6/8/2009	dextroamphetamine	30	60	30	Kanan	46707	Mac
6/16/2009	hydrocodone/apap	10/325	210	17	west val	11433	Glass

6/22/2009	oxycontin	80	60	15	Kanan	46707	Glass
6/23/2009	oxycodone/apap	5/325	16	2	longs	49387	stoops
6/29/2009	oxycodone/apap	5/325	8	2	costco	41682	stoops
6/30/2009	oxycodone	30	60	10	west val	11433	Glass
7/7/2009	amphetamine salt	30	60	30	cvs	47835	Mac
7/10/2009	hydrocodone/apap	10/325	210	18	Kanan	46707	Glass
7/10/2009	alprazolam	2	10	5	Kanan	46707	Glass
7/21/2009	dextroamphetamine	20	15	10	Kanan	46707	Glass
7/27/2009	dextroamphetamine	30	60	30	Kanan	46707	Mac
7/30/2009	oxycodone	30	30	7	west val	11433	Glass
8/7/2009	alprazolam	2	10	5	rite aid 5560	42493	Glass
8/7/2009	hydrocodone/apap	10/325	210	18	west val	11433	Glass
8/18/2009	oxycodone	30	60	20	west val	11433	Glass
9/1/2009	dextroamphetamine	30	60	30	Kanan	46707	mac
9/3/2009	hydrocodone/apap	10/325	210	18	Kanan	46707	Glass
9/3/2009	alprazolam	2	10	4	Kanan	46707	Glass
9/15/2009	oxycontin	80	60	30	cvs 9751	47835	Glass
9/15/2009	alprazolam	2	10	5	cvs 9751	47835	Glass
9/15/2009	amphetamine salt	20	60	30	cvs 9751	47835	Glass
10/12/2009	alprazolam	2	10	5	west val	11433	Glass
10/12/2009	amphetamine salt	20	60	30	west val	11433	Glass
10/12/2009	hydrocodone/apap	10/325	210	30	west val	11433	Glass
10/12/2009	oxycontin	80	60	30	west val	11433	Glass
10/21/2009	dextroamphetamine	30	60	30	Kanan	46707	Mac
10/23/2009	alprazolam	2	10	5	west val	11433	Glass
10/29/2009	hydrocodone/apap	10/325	210	18	Kanan	46707	Glass
10/29/2009	alprazolam	2	10	5	west val	11433	Glass
11/4/2009	oxycontin	80	60	30	Kanan	46707	Glass
11/4/2009	dextroamphetamine	20	60	30	Kanan	46707	Glass
11/9/2009	amphetamine salt	30	60	30	cvs 9715	47994	Mac
11/12/2009	alprazolam	2	6	3	west val	11433	Glass
11/12/2009	hydrocodone/apap	10/325	156	22	west val	11433	Glass
11/12/2009	hydrocodone/apap	10/325	156	13	Kanan	46707	Glass
11/12/2009	oxycontin	80	32	16	Kanan	46707	Glass
11/12/2009	oxycontin	80	45	22	west val	11433	Glass
11/12/2009	amphetamine salt	20	45	22	west val	11433	Glass
11/24/2009	alprazolam	2	10	5	west val	11433	Glass
11/24/2009	oxycontin	80	25	30	west val	11433	Glass
11/24/2009	hydrocodone/apap	10/325	210	18	west val	11433	Glass

11/25/2009	dextroamphetamine	20	45	23	Kanan	46707	Glass
11/27/2009	oxycontin	80	35	18	Kanan	46707	Glass
11/30/2009	amphetamine salt	20	60	30	west val	11433	Glass
12/7/2009	amphetamine salt	30	60	30	cvs 9751	47835	Mac
12/21/2009	oxycontin	80	60	30	west val	11433	Glass
12/21/2009	hydrocodone/apap	10/325	210	30	west val	11433	Mac
12/23/2009	amphetamine salt	20	60	30	west val	11433	Glass
1/6/2010	amphetamine salt	30	60	30	costco 117	41682	Mac
1/6/2010	alprazolam	2	10	5	costco 117	41682	Glass

88. Had Respondent Pharmacy used CURES information for B.K., it would have shown that he was getting the same prescriptions filled for the same drug on the same day at two different pharmacies. For example, Oxycontin 80mg #32 and Norco 10/325 # 156 was filled at Respondent Pharmacy on 11/12/09, and Oxycontin 80mg #45 and Norco 10/325 #156 was filled at West Val on the same day. On 10/12/09 West Val Pharmacy filled Norco 10/325 #210 and Respondent Pharmacy filled Norco 10/325 #210 on 10/29/09.

89. The following pharmacies filled B.K.'s controlled substance prescriptions from June 11, 2008 through January 6, 2010:

Kanan Pharmacy - 29 prescriptions
West Val Pharmacy- 26 prescriptions
Costco Pharmacy- 13 prescriptions
CVS- Pharmacy 8 prescriptions
Longs- Pharmacy 6 prescriptions
CVS- 5 prescriptions
Ralphs- 3 prescriptions
Rite Aid- 2 prescriptions
Longs- 2 prescriptions

90. The following chart shows the oxycodone containing prescriptions for B.K. Respondent Pharmacy filled 487 tablets of Oxycodone containing tablets (filled over 15 months, from 8/7/08-11/27/09).

Date	Drug	Strength	Amt	Day supply	Pharmacy	PHY	MD
8/7/2008	oxycontin	80	60	30	Kanan	46707	Glass
9/3/2008	oxycontin	80	60	30	Kanan	46707	Glass

9/26/2008	oxycontin	80	60	0	Longs 326	39157	Glass
12/23/2008	oxycodone/apap	5/325	60	0	longs 9326	49387	Mcgovern
12/29/2008	oxycodone	80	60	30	ralphs	46794	Glass
3/9/2009	oxycodone	40	120	30	Kanan	46707	Glass
3/26/2009	oxycontin	80	60	30	Kanan	46707	Glass
5/6/2009	oxycontin	80	60	15	west val	11433	Glass
5/26/2009	oxycodone	80	60	15	west val	11433	Glass
6/22/2009	oxycontin	80	60	15	Kanan	46707	Glass
6/23/2009	oxycodone/apap	5/325	16	2	longs	49387	stoops
6/29/2009	oxycodone/apap	5/325	8	2	costco	41682	stoops
6/30/2009	oxycodone	30	60	10	west val	11433	Glass
7/30/2009	oxycodone	30	30	7	west val	11433	Glass
8/18/2009	oxycodone	30	60	20	west val	11433	Glass
9/15/2009	oxycontin	80	60	30	cvs 9751	47835	Glass
10/12/2009	oxycontin	80	60	30	west val	11433	Glass
11/4/2009	oxycontin	80	60	30	Kanan	46707	Glass
11/12/2009	oxycontin	80	32	16	Kanan	46707	Glass
11/12/2009	oxycontin	80	45	22	west val	11433	Glass
11/24/2009	oxycontin	80	25	30	west val	11433	Glass
11/27/2009	oxycontin	80	35	18	Kanan	46707	Glass
12/21/2009	oxycontin	80	60	30	west val	11433	Glass

91. The Board investigation on Respondent Pharmacy revealed various violations of pharmacy law including incorrect filling, variation from a prescription, lack of documentation of why prescriptions are filled at high doses and against normal dosing recommendations, prescriptions could not be found, and CURES is not used to deter doctor shoppers and pharmacy shoppers. Respondent Pharmacy was one of the last pharmacies that filled oxycodone prescriptions before Brady K. passed away. On May 31, 2013, The Board investigator sent notices of non-compliance to Respondent Pharmacy and Respondent Cassar.

FIRST CAUSE FOR DISCIPLINE

(Alteration of Records, Deceit, Fraud, Dishonesty, Subverting the Board's Investigation, Making Documents that Falsely Represent the Existence or Non Existence of the Facts)

92. Respondents are subject to disciplinary action under Code §4301, subdivisions (f), (g), (q), on the grounds of unprofessional conduct in that Respondents presented an "altered"

prescription to the Board inspector, subverted the Board's investigation, committed deceit, dishonesty and fraud by fabricating an altered document that falsely represented the original unaltered prescription. The circumstances underlying the alteration of record is as follows: On or about March 15, 2013, the Board inspector gave Respondent Cassar a list of the three patients (KC, SM and MS) the Board inspector got off the CURES report and asked for patient profiles, as well as one for BK.

- On or about April 22, 2013, pursuant to a request for prescriptions, the Board inspector received prescription Rx# 2213183 and RX# 2213184 for patient K.C, for Methadone and Oxycodone, signed on **4/11/11**. On or about September 3, 2013 (five months later), Respondent Kassar provided the Board inspector with an "**altered"** version of prescription Rx# 2213183 and RX# 2213184 for patient K.C. the Board inspector compared the **altered** and unaltered prescriptions and noticed the two were different. The "**altered**" version was signed by prescriber, Dr. L.G., on 4/11/11, with an "**altered" notation in the prescriber's alleged writing: "OK to dispense 4/11/12 per MD" with initials next to the notation.**
- On or about April 22, 2013, pursuant to a request for prescriptions, the Board inspector received prescription Rx#4416591 for patient M.S. for Diazepam 10 mg tablet. The Board inspector believed she did not receive this prescription, and issued a notice for not providing Rx#4416591. On or about September 3, 2013, the Board inspector was provided with Rx#4416591. the Board inspector compared the prescriptions and noticed the two were different. The unaltered prescription provided to her on or about April 22, 2013, had a date of **5/ /09**. The altered version provided to her on or about September 3, 2013 (approximately five months later) had a date of **5/08/09** and had the following handwritten note, "**Date Rx 5/8/09 per MD" with initials next to the notation**.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Corresponding Duty: Early Fills of Prescriptions)

93. Respondent Kanan Pharmacy and Respondent Cassar (collectively referred as Respondents) are subject to disciplinary action under Bus. Prof. C. §§4113, 4156, 4301, 4301(d), 4301 (j), 4301(o), 4302, 4035 and 4306.5, in conjunction with Health & Safety C. §11153,

subdivision (a), and pursuant to *Vermont & 110th Medical Arts v. Board of Pharmacy* (1981) 125 Cal.App.3d 19 (hereinafter referred as *Vermont*), pursuant to *Sternberg v. Board of Pharmacy* (2015) 239 Cal. App. 4th 1159 (hereinafter referred as *Sternberg*), and pursuant to the Board of Pharmacy's Precedential Decision[3] No. 2013-01 (*Board of Pharmacy v. Pacifica Pharmacy Corporation, et al.*, (2012) Case No. 3802, OAH No. 2011010644) (hereinafter referred as *Pacifica*) on the grounds of unprofessional conduct because Respondents failed to exercise or implement their best professional judgment or their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose when they filled 65 prescriptions early for patients K.C., S.M., M.S., and B.K. between approximately April 6, 2009 and December 10, 2012. The early fills for the prescriptions led to these patients receiving more medications than they were prescribed. The following prescriptions were filled early:

Date	Rx	Drug	Strength	Amt	Day supply	MD	early?
4/6/2009	2207667	dext/amp	30	20	10	mac	10 days early
9/21/2009	2208890	dext/amp	30	60	30	mac	10 days early
8/12/2009	2208613	methadone	10	66	6	glass	10 days early
10/5/2011	2214669	methadone	10	420	27	glass	5 days early
9/3/2010	2211469	methadone	10	480	30	glass	6 days early
10/21/2009	2209160	dext/amp	30	60	30	mac	11 days early
1/16/2012	2215604	methylphenidate er		90	30	glass	12 days early
9/5/2009	2208789	methadone	10	144	12	glass	13 days early
7/22/2010	4422461	alprazolam	2	60	30	glass	15 days early
11/4/2009	2209239	dext/amp	20	60	30	glass	17 days early
10/2/2009	2209008	dext/amp	20	60	30	glass	19 days early
11/12/2009	2209326	oxycontin	80	32	16	glass	22 days early
9/10/2009	6683086	carisprodol	350	60	30	glass	23 days early
11/12/2009	4419067	hydrocodone/apap	10/325	156	13	glass	5 days early
11/8/2010	2211996	fentanyl	50	15	30	glass	5 days early
11/8/2010	2211995	fentanyl	100	15	30	glass	5 days early
2/1/2011	2212413	fentanyl	50	15	30	glass	5 days early
12/10/2012	2218517	morphine	60	30	30	stark	5 days early
6/30/2009	2208311	methadone	10	360	30	glass	5 days early

[3] Under the Administrative Procedure Act (APA) a decision that contains a significant legal or policy determination of general application that is likely to recur may be designated as precedential (see Government Code section 11425.60). Once a decision is designated as precedential, the California State Board of Pharmacy may rely on it, and parties may cite to such decision in their argument to the Board and courts.

2/9/2010	2209994	methadone	10	420	27	glass	5 days early
3/26/2010	2210305	methadone	10	480	30	glass	5 days early
3/28/2011	4425972	alprazolam	2	60	30	glass	5 days early
10/6/2010	4423623	alprazolam	2	60	30	glass	5 days early
12/20/2011	2215361	methadone	10	480	30	glass	5 days early
9/2/2011	2214374	methylphenidate er	20	90	30	glass	5 days early
9/2/2011	2214373	methadone	10	480	30	glass	5 days early
3/28/2011	2213046	methylphenidate er		90	30	glass	5 days early
4/16/2010	2210477	methylphenidate er	20	90	30	glass	5 days early
2/26/2010	2210127	methadone	10	420	27	glass	5 days early
1/8/2010	2209751	methylphenidate er	20	90	30	glass	5 days early
9/25/2009	2208937	methylphenidate er	20	90	30	glass	5 days early
7/10/2009	2208368	methylphenidate er		90	30	glass	5 days early
8/26/2011	2214325	oxycodone	30	240	20	glass	6 days early
1/10/2012	2215550	fentanyl	100	15	30	glass	6 days early
5/29/2012	2216821	methadone	10	270	30	frey	6 days early
9/6/2012	2217689	methadone	10	270	30	frey	6 days early
9/6/2012	2217690	fentanyl	25	10	30	frey	6 days early
7/11/2011	4427327	alprazolam	2	60	30	glass	6 days early
6/14/2010	4421823	alprazolam	2	30	30	glass	6 days early
7/11/2011	2213928	methylphenidate er	20	90	30	glass	6 days early
7/11/2011	2213927	methadone	10	480	30	glass	6 days early
3/28/2011	2213043	methadone	10	480	30	glass	6 days early
9/7/2010	2211468	methylphenidate er	20	90	30	glass	6 days early
7/22/2010	2211150	methylphenidate er	20	90	30	glass	6 days early
6/28/2010	2210981	methylphenidate er	20	90	30	glass	6 days early
8/31/2009	2208747	methylphenidate er	20	90	30	glass	6 days early
4/9/2010	2210428	fentanyl	50	30	30	glass	7 days early
7/23/2009	2208452	methadone	10	360	30	glass	7 days early
4/9/2012	2216266	methadone	10	360	30	frey	7 days early
8/4/2011	4427694	alprazolam	2	60	30	glass	7 days early
7/7/2010	4422228	alprazolam	2	30	30	glass	7 days early
6/25/2010	2210983	methadone	10	480	30	glass	7 days early
10/2/2009	6685004	carisprodol	350	60	30	glass	8 days early
8/12/2011	4427797	diazepam	10	30	30	glass	8 days early
3/1/2010	2210108	methadone	10	480	30	glass	8 days early
8/14/2010	4422781	alprazolam	2	60	30	glass	8 days early
2/17/2012	2215919	morphine	30	60	3	glass	8 days early
11/22/2010	2212095	methadone	10	480	30	glass	8 days early
8/14/2010	2211302	methylphenidate er	20	90	30	glass	8 days early
8/14/2010	2211301	methadone	10	480	30	glass	8 days early
2/26/2010	2210129	methylphenidate er	20	90	30	glass	8 days early
12/14/2009	2209572	methylphenidate er	20	90	30	glass	8 days early

6/8/2009	2208139	dext/amp	30	60	30	mac	9 days early
11/25/2009	2209327	dext/amp	20	45	23	glass	9 days early
3/17/2012	2216092	methadone	10	480	30	glass	9 days early
4/3/2009	2207650	Dext/amp	30	25	13	Mac	12 days early

94. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 39 through 91, as though set forth fully herein.

THIRD CAUSE FOR DISCIPLINE

(Misuse of Education)

95. Respondents are subject to disciplinary action under Respondents are subject to disciplinary action under Business and Professions Code §§4035, 4301(d), 4302, 4306.5, 4113, 4156, 4301, 4301(o), in conjunction with Health and Safety C. §11153, CCR §1761 and pursuant to *Sternberg, Vermont & Pacifica* in that Respondents committed acts or omissions that involve, in whole or in part the inappropriate exercise of their education. Specifically, Respondent Cassar, the PIC (Pharmacist-In- Charge) of Respondent Pharmacy did not document or question the following: (1) why RX 2210619 for Fentanyl patch 50mcg was dosed as 1-2 patches every 2 days without questioning why the dose is not consistent: (2) why CURES data wasn't used for patients including B.K. who was doctor shopping and who received medications from various doctors and various pharmacies.

96. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 39 through 91, as though set forth fully herein.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Violating Rules Regulating Keeping Prescriptions of Controlled Substances)

97. Respondents are subject to disciplinary action under Business and Professions Code §§4035, 4059, 4081, 4105, 4169(a)(5), 4301(j) and (o), 4302, 4306.5, 4113, 4156, and Health & Safety C. §11179, and pursuant to *Sternberg* in that Respondents failed to retain prescriptions filled by the pharmacy for the following controlled substances for three (3) years from the date of filling. Specifically, Respondents failed to retain the following prescriptions:

///

Date	Rx	Drug	Strength	Amt	Day supply	MD	Script?
7/21/2009	2208439	dext/amp	20	15	10	glass	no

98. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 39 through 91, as though set forth fully herein.

FIFTH CAUSE FOR DISCIPLINE

(Three Years of Records Not Available in Pharmacy)

99. Respondents are subject to disciplinary action under Business and Professions Code §§4059, 4081, 4105 (a)(b)(c) and (e)(1), and §§4113, 4156, 4169(a)(5), 4301, 4301 (j), 4301(o), 4302, 4035,4306.5, and pursuant to *Sternberg*, in that Respondents failed to maintain in the pharmacy three years of acquisition and disposition records in a readily retrievable form. Specifically, Respondents failed to retain the following prescriptions:

Date	Rx	Drug	Strength	Amt	Day supply	MD	Script?
7/21/2009	2208439	dext/amp	20	15	10	glass	no

100. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 39 through 91, as though set forth fully herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Variation from Prescriptions)

101. Respondents are subject to disciplinary action under Code §§4035, 4113, 4156, 4301, subdivision (j), 4302, 4306.5, 4301(o), in conjunction with California Code of Regulations (CCR), title 16, section 1716, on the grounds of unprofessional conduct in that 16 CCR §1716 provides that 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 in that Respondents improperly deviated from certain prescriptions for patients K.C. and S.M. without the consent of the prescriber. Specifically, the prescriptions below were filled with a different amount of drug or the prescription was filled before the doctor stated it could be filled:

///

///

Date	Rx	Drug	Strength	Amt	Day supply	MD	problems?
10/28/2009	2209222	oxycodone	20	210 ml	14	glass	220ml ordered
3/28/2011	2213046	methylphenidate er		90	30	glass	disp 3/29 per md, but disp 3/28
3/28/2011	2213043	methadone	10	480	30	glass	disp 3/29 per md, but disp 3/28
3/28/2011	2213044	oxycodone	30	300	17	glass	disp 3/29 per md, but disp 3/28
3/28/2011	4425972	alprazolam	2	60	30	glass	says dispense 3/29 but dispensed 3/28
10/20/2010	2211845	morphine	30	240	14	glass	written for 300, filled with 240

102. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 39 through 91, as though set forth fully herein.

SEVENTH CAUSE FOR DISCIPLINE

(Erroneous or uncertain prescriptions)

103. Respondents are subject to disciplinary action under California Code of Regulations section 1761, subdivision (a), in that Respondent Cassar, while pharmacist in charge and owner of the Respondent Pharmacy, filled the following prescriptions below, and there was no documentation showing any calls had been made or any patients were talked to about filling their prescriptions early.

Date	Rx	Drug	Strength	Amt	Day supply	MD	early?
4/6/2009	2207667	dext/amp	30	20	10	mac	10 days early
9/21/2009	2208890	dext/amp	30	60	30	mac	10 days early
8/12/2009	2208613	methadone	10	66	6	glass	10 days early
10/5/2011	2214669	methadone	10	420	27	glass	5 days early
9/3/2010	2211469	methadone	10	480	30	glass	10 days early
10/21/2009	2209160	dext/amp	30	60	30	mac	11 days early
1/16/2012	2215604	methylphenidate er		90	30	glass	12 days early
9/5/2009	2208789	methadone	10	144	12	glass	13 days early
7/22/2010	4422461	alprazolam	2	60	30	glass	15 days early

11/4/2009	2209239	dext/amp	20	60	30	glass	17 days early
10/2/2009	2209008	dext/amp	20	60	30	glass	19 days early
11/12/2009	2209326	oxycontin	80	32	16	glass	22 days early
9/10/2009	6683086	carisprodol	350	60	30	glass	23 days early
11/12/2009	4419067	hydrocodone/apap	10/325	156	13	glass	5 days early
11/8/2010	2211996	fentanyl	50	15	30	glass	5 days early
11/8/2010	2211995	fentanyl	100	15	30	glass	5 days early
2/1/2011	2212413	fentanyl	50	15	30	glass	5 days early
12/10/2012	2218517	morphine	60	30	30	stark	5 days early
6/30/2009	2208311	methadone	10	360	30	glass	5 days early
2/9/2010	2209994	methadone	10	420	27	glass	5 days early
3/26/2010	2210305	methadone	10	480	30	glass	5 days early
3/28/2011	4425972	alprazolam	2	60	30	glass	5 days early
10/6/2010	4423623	alprazolam	2	60	30	glass	5 days early
12/20/2011	2215361	methadone	10	480	30	glass	5 days early
9/2/2011	2214374	methylphenidate er	20	90	30	glass	5 days early
9/2/2011	2214373	methadone	10	480	30	glass	5 days early
3/28/2011	2213046	methylphenidate er		90	30	glass	5 days early
4/16/2010	2210477	methylphenidate er	20	90	30	glass	5 days early
2/26/2010	2210127	methadone	10	420	27	glass	5 days early
1/8/2010	2209751	methylphenidate er	20	90	30	glass	5 days early
9/25/2009	2208937	methylphenidate er	20	90	30	glass	5 days early
7/10/2009	2208368	methylphenidate er		90	30	glass	5 days early
8/26/2011	2214325	oxycodone	30	240	20	glass	6 days early
1/10/2012	2215550	fentanyl	100	15	30	glass	6 days early
5/29/2012	2216821	methadone	10	270	30	frey	6 days early
9/6/2012	2217689	methadone	10	270	30	frey	6 days early
9/6/2012	2217690	fentanyl	25	10	30	frey	6 days early
7/11/2011	4427327	alprazolam	2	60	30	glass	6 days early
6/14/2010	4421823	alprazolam	2	30	30	glass	6 days early
7/11/2011	2213928	methylphenidate er	20	90	30	glass	6 days early
7/11/2011	2213927	methadone	10	480	30	glass	6 days early
3/28/2011	2213043	methadone	10	480	30	glass	6 days early
9/7/2010	2211468	methylphenidate er	20	90	30	glass	6 days early
7/22/2010	2211150	methylphenidate er	20	90	30	glass	6 days early
6/28/2010	2210981	methylphenidate er	20	90	30	glass	6 days early
8/31/2009	2208747	methylphenidate er	20	90	30	glass	6 days early
4/9/2010	2210428	fentanyl	50	30	30	glass	7 days early
7/23/2009	2208452	methadone	10	360	30	glass	7 days early
4/9/2012	2216266	methadone	10	360	30	frey	7 days early
8/4/2011	4427694	alprazolam	2	60	30	glass	7 days early
7/7/2010	4422228	alprazolam	2	30	30	glass	7 days early
6/25/2010	2210983	methadone	10	480	30	glass	7 days early

10/2/2009	6685004	carisprodol	350	60	30	glass	8 days early
8/12/2011	4427797	diazepam	10	30	30	glass	8 days early
3/1/2010	2210108	methadone	10	480	30	glass	8 days early
8/14/2010	4422781	alprazolam	2	60	30	glass	8 days early
2/17/2012	2215919	morphine	30	60	3	glass	8 days early
11/22/2010	2212095	methadone	10	480	30	glass	8 days early
8/14/2010	2211302	methylphenidate er	20	90	30	glass	8 days early
8/14/2010	2211301	methadone	10	480	30	glass	8 days early
2/26/2010	2210129	methylphenidate er	20	90	30	glass	8 days early
12/14/2009	2209572	methylphenidate er	20	90	30	glass	8 days early
6/8/2009	2208139	dext/amp	30	60	30	mac	9 days early
11/25/2009	2209327	dext/amp	20	45	23	glass	9 days early
3/17/2012	2216092	methadone	10	480	30	glass	9 days early

104. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 39 through 91, as though set forth fully herein.

COMPLAINT FILED BY Dr. K.T.

105. On or about September 22, 2015, The Board received an email from Dr. K.T. who explained that a patient stole her prescription pad, forged her signature, and used the stolen prescription forms to fill prescriptions for herself and another patient at various pharmacies . Dr. K.T. identified the patients involved as CB and JC. Dr. K.T. explained CB and JC used the stolen forms to obtain prescriptions for Adderall (amphetamine immediate release tablets) and stated she had not prescribed Adderall for the patients in question since January 2015.

106. The Board reviewed CURES Patient Activity Reports, which showed controlled substance dispensing histories for CB and JC as reported to CURES by pharmacies. These Patient Activity Reports indicated CB and/or JC received prescriptions for amphetamine tablets under the prescribing authority of Dr. K.T. from several pharmacies including:

- CVS Pharmacy #9751 (PHY 47835)
- Pavillions Pharmacy #2215 (PHY 52185)
- Kanan Pharmacy and Medical Supplies (PHY 46707)
- Medallion Prescription Pharmacy (PHY 48673)
- Super Care Drugs Malibu (PHY 46214)

107. The Board initiated an investigation at respondent pharmacy to evaluate the filling of these fraudulent prescriptions. Dr. K.T. later clarified her prescribing of amphetamine as follows,

"I previously prescribed amphetamine only to [CB] for 1-2 prescriptions that were a 10 day course only as she told me her psychiatrist was out of town and could not be reached. I never prescribed for [JC]. These prescriptions were forged . When asked how she discovered the prescription forms had been stolen, Dr. K.T. stated, "…a pharmacy contacted me with concern that I was prescribing too many prescriptions for amphetamines to [CB]. I was surprised of this fact and asked them to send me a fax of the prescription. The copy showed a forged signature on the prescription."

108. The Board's inspector reviewed Patient Activity Reports for CB and JC and identified the following prescriptions filled at Respondent Pharmacy:

Date Filled	**Rx Number**	Drug	**Strength**	Qty	Prescriber
CB					
08/13/2014	**2223784**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
09/13/2014	**2224046**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
10/07/2014	**2224264**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
11/03/2014	**2224558**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
11/29/2014	**2224887**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
12/29/2014	**2225226**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
03/29/2015	**2226311**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
05/10/2015	**2226855**	AMPHETAMINE SALT COMBO	**10 MG**	30	K.T.
06/20/2015	**2227394**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
08/20/2015	**2228145**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
JC					
08/14/2015	**2228102**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.
09/03/2015	**2228356**	AMPHETAMINE SALT COMBO	**10 MG**	60	K.T.

109. The prescriptions identified included prescriptions filled after January 2015 and earlier prescriptions for a 30-day supply of amphetamine tablets.

110. On April 13, 2016, the Board's inspector conducted an inspection at Respondent Pharmacy. Respondent Cassar was present and assisted in the inspection. Details of the inspection included but were not limited to the following:

- Respondent Pharmacy was an independent pharmacy in a retail plaza and Respondent Cassar estimated the pharmacy filled approximately 200 to 250 prescriptions per week day.
- The Board's inspector asked Respondent Cassar if he remembered CB and JC.
- Respondent Cassar recalled CB was a regular patient at Respondent Pharmacy. Respondent Cassar remembered CB picked up prescriptions for JC and stated JC was her sister. Respondent Cassar and the pharmacy staff could not recall if JC ever came to the pharmacy.
- Respondent Cassar stated he recalled an incident involving these patients. He stated he believed a staff pharmacist at Respondent Pharmacy ran a patient activity report for one of the patients and discovered she received frequent prescriptions for amphetamine tablets from multiple pharmacies. Respondent Cassar stated he recalled the pharmacy staff alerted the prescribers and other pharmacies involved.
- Respondent Cassar provided a, "Doctor Prescribed/Dispensed Detail Report" for Dr. K.T.. The report indicated Respondent Pharmacy filled eight prescriptions written by Dr. K.T. for amphetamine 10 mg tablets for CB and two prescriptions for JC either after 01/2015 or for 30 day supplies.
- The Board's inspector requested patient dispensing histories for CB and JC.
- The patient profile for JC contained the following patient memo: "[CB] picking up for this pt. Claiming to be her sister. [CB] & this pt poly rx & poly MD. Run PDMP."
- The profile indicated JC received six prescriptions at Kanan Pharmacy and Medical Supplies. All the prescriptions were for amphetamine 10 mg tablets and two of the prescriptions were filled under the prescribing authority of Dr. K.T..
- The patient profile for CB contained the following patient memo: "Patient is poly rx & poly MD. Uses many excuses to fill early."

- The profile indicated JC received 41 prescriptions from Respondent Pharmacy. Twenty six of these prescriptions were written for amphetamine 10 mg tablets.
- Between January 29, 2015 and August 20, 2015, CB received 13 prescriptions for immediate release and extended release amphetamine salt tablets and capsules. These medications were prescribed by four different prescribers; Dr. K.T., Dr. R.H., Dr. S.U., and Dr. N. A..
- Respondent Cassar also provided a DocuStorRx scanned prescription image for a prescription for CB for Adderall 10 mg tablets from Dr. K.T. with a handwritten note which read, "Fill 9/24 run PDMP (Exhibit 9)." The prescription was dated 09/19/2015 and the prescription image was associated with a Patient Activity Report for CB which indicated CB recently received four prescriptions for amphetamine 10 mg tablets and 1 prescription for Amphetamine 20 mg tablets. There was a handwritten note on the top of the Patient Activity Report indicating someone at Kanan Pharmacy and Medical Supplies spoke with Susie at Dr. K.T.'s office regarding the report.
- Respondent Cassar provided a sample prescription document for CB and JC's prescriptions filled under Dr. K.T.'s prescribing authority. The Board's inspector noted the following:
- The heading at the top of both prescriptions was, "T. Cosmetic & Reproductive Surgery."
- Both prescriptions were written for, "Adderall 10 mg, 1 PO BID x30 days."
- Both patients had the same phone number of record at Respondent Pharmacy.
- The Board's inspector asked Respondent Cassar about the pharmacy's polices for evaluating and filling controlled substance prescriptions in general. Respondent Cassar provided a copy of a document titled, "Kanan Pharmacy Diversion Initiative Program." Respondent Cassar stated the pharmacy frequently accessed Patient Activity Reports for patients receiving high dose or high pill count prescriptions for narcotics. Respondent Cassar stated the pharmacy checks the CURES database less frequently for prescriptions for medications to treat attention-deficit disorder as he believed these drugs were less frequently abused.

- At the end of the inspection, the Board's inspector reviewed the inspection report with Respondent Cassar and requested a statement from the pharmacist who contacted Dr. K.T.'s office and determined the prescriptions in question were fraudulent.
- The Board's inspector issued Official Receipt 612035 in exchange for the documents she collected.

111. On April 20, 2016, the Board's inspector received signed statements from Respondent Cassar and staff pharmacist R.H.. Respondent Cassar stated the following:

- "My part-time pharmacist, R.H., had left a prescription patient [CB] for me to investigate because a CURES report showed the patient was filling the same or similar prescriptions at multiple pharmacies and was too early to fill given our own fill history. I contacted Dr. K.T.'s staff and a staff member indicated the doctor had been seen and had written a prescription of Adderall this medication for patient C.B., however, it had been some time ago.
- Respondent Cassar wrote, "…the staff member told me not to fill it and not to return it to the patient because the prescription was fraudulent. I left a voicemail for the patient that I would neither be able to fill it nor would I be able to return it to her per the doctor's request. I proceeded to contact all pharmacies on the CURES report who had filled for her to let them know of the fraud and contacted all doctors I could find that filled for her. Furthermore, I instructed my staff to block her account from being filled and added a note describing the wrongdoing. The CURES report was documented and scanned under the patient's profile for future reference."
- Respondent Cassar added, "One of my staff reminded me that patient also picked up prescriptions for her sister, J.C., for the same medication. We immediately blocked J.C.'s account and added a note describing the situation."

112. Following the inspection, the Board's inspector requested and received images of the remaining prescription documents for CB and JC's prescriptions filled under Dr. K.T.'s prescribing authority and not collected during the inspection. Each prescription was written for Amphetamine 10 mg tablets with directions to take twice daily. Each of the prescription documents bore the header, "[K.T.] Cosmetic & Reproductive Surgery." The Board's inspector

requested the names and license numbers of the pharmacists who filled the prescriptions in question. Respondent Cassar provided the following information:

Prescription Number	Verifying Pharmacist
2223784	Respondent Cassar
2224046	RPH H.
2224264	Respondent Cassar
2224558	Respondent Cassar
2224887	RPH H.
2226311	RPH H.
2226855	Respondent Cassar*
2227394	Pharmacist H.
2228102	RPH H.
2228145	RPH H.
2228356	RPH H.

*Respondent Cassar initially stated RPH H. verified prescription 2226855, however, he corrected this statement on 10/30/2016.

Analysis of Prescriptions filled at Kanan Pharmacy & Medical Supplies:

113. The Board's inspector reviewed the prescriptions listed above and noted the following irregularities:

- All of the prescriptions were written for Amphetamine 10 mg, indicated to treat attention-deficit disorder, and the preprinted prescriber information on the prescription document indicated the prescriber was a cosmetic and reconstructive surgeon. It would not be typical for a surgeon to prescribe amphetamine 10 mg as it is not typically used during surgery or recovery.

- The majority, nine of eleven, of the prescriptions in question, were purchased in cash, meaning without the aid of prescription insurance. Prescriptions 2227394 and 2228145 were billed to prescription insurance. Patients typically prefer to pay for prescriptions with the aid of prescription insurance if possible. One reason a patient may elect not to use prescription insurance is to prevent the pharmacist from realizing the medication was recently filled and billed to insurance at another pharmacy. If the pharmacist billed the patient's insurance, the insurance company would alert the pharmacist the prescription was recently filled elsewhere. Therefore, this payment method was a red flag for potential diversion.

114. The Board's inspector reviewed CURES Patient Activity Reports for CB and JC and noted the following:

- Prior to receiving prescription 2223784 from Kanan Pharmacy & Medical Supplies on **08/13/2014**, CB received the following prescriptions:
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Sav-On Pharmacy #6388 on 08/07/2014
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Rite Aid 5539 on 08/01/2014
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from CVS Pharmacy #9627 on 07/25/2014
- Prior to receiving prescription 2224046 from Kanan Pharmacy & Medical Supplies on **09/13/2014**, CB received the following prescriptions:
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Sav-On Pharmacy #6388 on 09/06/2014
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Rite Aid 5539 on 08/27/2014
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Pavilions Pharmacy #2215 on 08/25/2014
- Prior to receiving prescription 2224264 from Kanan Pharmacy & Medical Supplies on **10/07/2014**, CB received the following prescriptions:
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Pavilions Pharmacy #2215 on 10/01/2014
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Rite Aid 5561 on 09/25/2014
  - Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from CVS Pharmacy #9627 on 09/19/2014
- Prior to receiving prescription 2224558 from Kanan Pharmacy & Medical Supplies on **11/03/2014**, CB received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Pavilions Pharmacy #2215 on 10/29/2014
- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Rite Aid 5558 on 11/22/2014

• Prior to receiving prescription 2224887 from Kanan Pharmacy & Medical Supplies on **11/29/2014**, CB received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from CVS Pharmacy #9751 on 11/26/2014
- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Rite Aid 5558 on 11/22/2014
- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Sav-On Pharmacy #6388 on 11/17/2014

• Prior to receiving prescription 2226311 from Kanan Pharmacy & Medical Supplies on **03/29/2015**, CB received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from CVS Pharmacy #9751 on 03/22/2015
- Amphetamine 10 mg tablets, quantity 30 for a 30 day supply, from Pavilions Pharmacy #2215 on 03/12/2015

• Prior to receiving prescription 2226855 from Kanan Pharmacy & Medical Supplies on **05/10/2015**, CB received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 30 for a 30 day supply, from Haggen Pharmacy #2132 on 05/03/2015
- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from CVS Pharmacy #9751 on 04/21/2015

• Prior to receiving prescription 2227394 from Kanan Pharmacy & Medical Supplies on **06/20/2015**, CB received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Haggen Pharmacy #2132 on 06/02/2014

- Amphetamine 10 mg tablets, quantity 30 for a 30 day supply, from Medallion Prescription Pharmacy on 05/18/2014

• Prior to receiving prescription 2228145 from Kanan Pharmacy & Medical Supplies on **08/20/2015**, CB received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 30 for a 15 day supply, from CVS Pharmacy #9627 on 08/11/2015
- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Super Care Drugs Malibu on 08/08/2015

• Prior to receiving prescription 2228102 from Kanan Pharmacy & Medical Supplies on **08/14/2015**, JC received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Pavilions Pharmacy #2215 on 08/04/2015
- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from CVS Pharmacy #9751 on 07/23/2015

• Prior to receiving prescription 2228356 from Kanan Pharmacy & Medical Supplies on **09/03/2015**, JC received the following prescriptions:

- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from Dr. Pharmacy on 08/28/2015
- Amphetamine 10 mg tablets, quantity 60 for a 30 day supply, from CVS Pharmacy #9751 on 08/19/2015

115. Despite the significant irregularity of a plastic surgeon prescribing a medication to treat attention-deficit disorder, Respondent Cassar's statements indicated pharmacists at Kanan Pharmacy & Medical Supplies did not confer with Dr. K.T. prior to filling the prescriptions in question. Had the pharmacists at Kanan Pharmacy & Medical Supplies contacted Dr. T. to discuss these prescriptions, it is reasonable to expect Dr. T. would have identified the prescriptions as fraudulent, as she did when Respondent Cassar contacted her office after 09/19/2015.

116. Furthermore, despite CB and JC paying cash for nine of eleven prescriptions in question, Kanan Pharmacy & Medical Supplies did not produce any documentation to indicate pharmacists reviewed the information in the CURES database prior to filling these prescriptions. While pharmacists are not required to access the CURES database prior to filling controlled substance prescriptions, it is a helpful tool for evaluating the legitimacy and appropriateness of a prescription. Had pharmacists at Kanan Pharmacy & Medical Supplies accessed and reviewed the patients' records in the CURES database, the pharmacists would have found evidence of poly-pharmacy and early filling of prescriptions for amphetamine salts for nine of the ten prescriptions. Further, RPH H. and Respondent Cassar ultimately identified the diversion and alerted Dr. T. after reviewing a Patient Activity Report on the CURES database on 09/19/2015.

117. The table below summarizes the analysis of the prescriptions in question:

Rx Number	Date Filled	Verifying Pharmacist	Rx Document Indicated Prescriber Was a Reconstructive Surgeon?	Rx Was Purchased in Cash?	Relevant Recent Fills on Patient Activity Report?
2223784	08/13/2014	Respondent Cassar	Yes	Yes	Yes
2224046	09/13/2014	RPH H.	Yes	Yes	Yes
2224264	10/07/2014	Respondent Cassar	Yes	Yes	Yes
2224558	11/03/2014	Respondent Cassar	Yes	Yes	Yes
2224887	11/29/2014	RPH H.	Yes	Yes	Yes
2226311	03/29/2015	RPH H.	Yes	Yes	Yes
2226855	05/10/2015	Respondent Cassar	Yes	Yes	Yes
2227394	06/20/2015	RPH H.	Yes	No	Yes
2228102	08/14/2015	RPH H.	Yes	Yes	Yes
2228145	08/20/2015	RPH H.	Yes	No	Yes
2228356	09/03/2015	RPH H.	Yes	Yes	Yes

118. On October 18, 2016, the board's inspector sent cover letters and written notices to Kanan Pharmacy & Medical Supplies, Respondent Cassar, RPH H., and RPH H.. On November 8, 2016, the board's inspector received a letter from P.G., an attorney acting on behalf of Respondent Cassar and Kanan Pharmacy who wrote:

> While the law requires a pharmacist to engage in a review of the prescriptions, it only requires that the pharmacist contact the physician where the prescription contains a 'significant error, omission, irregularity, uncertainty, ambiguity, or alteration.' You have been provided with each of the

prescriptions referenced in the notice of violation. Based on these prescriptions, you have concluded 'irregularity' based on the prescribing physician being a cosmetic and reconstructive surgeon and that 10 of the 12 prescriptions were paid in cash. However, what is overlooked in reaching this conclusion are several important facts:

1. Dr. Tansavatdi was a legitimate prescriber, who was authorized to write such prescriptions;
2. The quantity of the medication was not unusual or irregular. All prescriptions were for a 30 day period.
3. Each prescription was for 'no refill' and a new prescription was presented;
4. The patient residence and physician office locations were within a close geographical range to the pharmacy. The patient residence was 2.9 miles and the physician's office was 5.5 miles from the pharmacy.
5. Once the patient continued to return and the patient attempted an early fill, that was the first instance when it became questionable there was an irregularity. That is when the pharmacy ran a CURES report and contacted Dr. Tansavatdi to advise of this apparent irregularity. Dr. Tansavadti informed my client that the initial prescription was legitimately written to her patient as a 'courtesy' which suggests that there was an established physician-patient relationship, but that it appeared the patient may have stolen a prescription pad. My client advised all other physicians and corresponding pharmacies on the CURES report of the potential problem.

We believe your conclusions should be tempered by the above facts, as it was my client who acted properly and exercised reasonable professional judgment, until the 'irregularity' was noticeable.

119. In reviewing said letter, the board's inspector considered the following:

- Mr. P.G. highlighted the fact that some aspects of the prescriptions in question were not irregular. California Code of Regulations Section 1761 requires a pharmacist to contact the prescriber prior to filling a prescription with any significant irregularity. All aspects of the prescription are not required to be irregular for the pharmacist to be obligated to gain information to validate the prescription.

- As previously discussed, Dr. T. was identified as a reconstructive surgeon on each prescription document in question. Therefore, Mr. P.G.'s assertion that the irregularities were not noticeable until the patient attempted to fill a prescription early was not correct.

120. On November 8, 2016, the board's inspector received a letter via email from RPH H. who wrote:

> I would like to note that the 'Diversion Prevention Protocol' that was implemented at Kanan Pharmacy and Medical Supplies in June of 2013 was started due to my request for creating a process to evaluate the legitimacy of

each and every narcotic prescription presented to the pharmacy by our patients. This process consisted of verifying the appropriate need for the use of these narcotics by contacting the prescribing doctor listed on the prescription and requesting supporting material regarding each diagnosis which was kept in a binder for record keeping. After establishing a legitimate diagnosis, all pharmacists including myself, would generate and carefully review a CURES report each time a controlled substance prescription was filled at Kanan Pharmacy. In addition to these measures, our staff would refuse to fill prescriptions for patients and physicians who resided our practiced outside of adjacent cities from Agoura Hills.

As a responsible pharmacist and citizen, I have always taken my responsibility of dispensing narcotic medications to the public very seriously and have used my utmost care and professional judgment to ensure safe dispensing of these medications to our patients. Furthermore, I consider it my duty and moral obligation to safeguard the dispensing process in order to avoid the inappropriate access and use of these drugs by patients who misuse them. I consider myself a very moral individual and always strive to follow rules and regulations.

With regards to prescription numbers 2227394 and 2228102, I can assure you that this was an oversite and was the exception to the rules followed by me personally and Kanan Pharmacy for proper evaluation of controlled substance prescriptions. I would like to assure you that I will use this experience to be even more vigilant about dispensing controlled substances in the future.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct- Erroneous or Uncertain Prescriptions)

121. Respondents are subject to disciplinary action under Code §§4035, 4113, 4156, 4301, subdivision (j), 4302, 4306.5, 4301(o), in conjunction with California Code of Regulations (CCR), title 16, section 1761, in that Respondents dispensed eleven (11) prescriptions (over one year) approximately month after month, which contained significant error, omission, irregularity, uncertainty, ambiguity, or alteration. Respondents failed to contact the prescriber to obtain the information needed to validate the prescription. Specifically, between August 13, 2014 and September 3, 2015 (over one year), Respondents filled 11 prescriptions, prescription numbers 2223784, 2224046, 2224264, 2224558, 2224887, 2226311, 2226855, 2227394, 2228102, 2228145, 2228356, in the presence of the following factors of irregularity:

- All of the prescriptions were written for amphetamine 10 mg, indicated to treat attention-deficit disorder, and the preprinted prescriber information on the prescription document indicated the prescriber was a cosmetic and reconstructive surgeon. It would not be typical for a surgeon to prescribe amphetamine 10 mg as it is not typically used during surgery or recovery.

- The majority, nine of eleven, of the prescriptions in question, were purchased in cash, meaning without the aid of prescription insurance. Prescriptions 2227394 and 2228145 were billed to prescription insurance. This payment method was a red flag for potential diversion.

Despite the significant irregularity of a cosmetic surgeon prescribing a medication to treat attention-deficit disorder, Kanan Pharmacy & Medical Supplies did not produce any documentation to indicate pharmacists there contacted the prescriber to gain information needed to validate the prescriptions listed above prior to dispensing. This was a violation of pharmacy law.

122. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 105 through 120, as though set forth fully herein.

OWNERSHIP PROHIBITION

123. Business and Professions Code section 4307(a) provides, in pertinent part that any person whose license has been revoked or is under suspension shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate or partner of a licensee.

124. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 46707 to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies ("Respondent Pharmacy") and Anthony John Cassar (Respondent Kassar) while acting as the manager, administrator, owner, member, officer, director, associate, or partner of Respondent Pharmacy, had knowledge of or knowingly participated in any conduct for which Pharmacy Permit Number PHY 46707 issued to Respondent Pharmacy was revoked, suspended or placed on probation, Respondent Kassar shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 46707 issued to Respondent Pharmacy is placed on probation or until Pharmacy Permit Number PHY 46707, issued to Respondent Pharmacy is reinstated if it is revoked.

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DISCIPLINE CONSIDERATIONS

125. To determine the degree of discipline, if any, to be imposed on Respondent Cassar, Complainant alleges that he has received a prior warning, including a prior citation, fine, and correction notice.

126. On February 27, the Board of Pharmacy issued Citation Number CI 2002 25346 in the amount of $1,850 to Respondent Cassar for the following violations which occurred on or about May 1, 2003 and May 6, 2003:

- Business and Professions Code section 4116, subdivision (a) [*failure to secure area where controlled substances are stored*];
- California Code of Regulations, title 16, section 1751.5, section 1751.7, subdivisions (a), (d), and (e), section 1751.8, subdivision (f) [*quality assurance/training of staff, patient and caregiver/policies and procedures for parenteral products*];
- California Code of Regulations, title 16, section 1716.2, subdivision (a)(1), (2), (3), (4), (6) and (8) [*records requirement – compounding for future furnishing*];
- Business and Professions Code section 4116 subdivision (b) and California Code of Regulations, title 16, section 1714.1, subdivision (f) [*pharmacy operations during the temporary absence of a pharmacist*];
- California Code of Regulations, title 16, sections 1714, subdivision (d) [*improper pharmacy security*];
- California Code of Regulations, title 16, section 1715, subdivisions (a) and (b)(1) [*self-assessment of a pharmacy by the pharmacist-in-charge*]; a
- California Code of Regulations, title 16, section 1793.7, subdivision (b) [*requirements for pharmacies employing pharmacy technicians*].

127. That Citation 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 46707, issued to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies with Anthony John Cassar as the Pharmacist-in-Charge;

2. Revoking or suspending Pharmacist License Number RPH 49326, issued to Anthony John Cassar;

3. Ordering Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies and Anthony John Cassar to pay the Board of Pharmacy the reasonable costs of this case's investigation and enforcement under Business and Professions Code section 125.3; and

4. Prohibiting Anthony John Cassar from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 46707 to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies is placed on probation or until Pharmacy Permit Number PHY 46707 to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies is reinstated if Pharmacy Permit Number PHY 46707 to Pharmacy Care Network, Inc., dba Kanan Pharmacy & Medical Supplies is revoked;

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

DATED: May 21, 2018

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

LA2013510072