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

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| In the Matter of the Accusation Against:<br><br>**IRVINE MEDICAL PHARMACY, INC.**<br>**DBA IRVINE MEDICAL PHARMACY**<br>**14130 Culver Drive, Suite D**<br>**Irvine, CA 92714**<br><br>**Pharmacy Permit No. PHY 42046**<br><br>**and**<br><br>**NASSER FATHI**<br>**25652 Nellie Gail Road**<br>**Laguna Hills, CA 92653**<br><br>**Pharmacist License No. RPH 48441**<br><br>Respondents. | Case No. 4969<br><br>**A C C U S A T I O N** |

Complainant alleges:

**PARTIES**

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

2. On or about January 20, 1997, the Board of Pharmacy issued Pharmacy Permit Number PHY 42046 to Irvine Medical Pharmacy, Inc., dba Irvine Medical Pharmacy (Respondent) with Nasser Fathi as President and Pharmacist-in-Charge (PIC). The Pharmacy

Permit was in full force and effect at all times relevant to the charges brought herein and will expire on January 1, 2015, unless renewed.

3. On or about December 6, 1995, the Board of Pharmacy issued Pharmacist License Number RPH 48441 to Nasser Fathi (Respondent). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2015, unless renewed.

**JURISDICTION**

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

5. Section 4011 of the Code provides that the Board shall administer and enforce both the Pharmacy Law [Bus. & Prof. Code, § 4000 et seq.] and the Uniform Controlled Substances Act [Health & Safety Code, § 11000 et seq.].

6. Section 4300(a) of the Code provides that every license issued by the Board may be suspended or revoked.

7. Section 4300.1 of the 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.

**STATUTORY PROVISIONS**

8. Section 4022 of the Code states:

> "Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:
>
> (a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Section 4113, subdivision (c) of the 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."

10. Section 4301 of the 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:
>
> . . . .
>
> (c) Gross negligence.
>
> (d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.
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> . . . .
>
> (j) The violation of any of the statutes of this state, of 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.
>
> . . . .

11. Health and Safety Code section 11153 states in pertinent part:

> (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.

12. Health and Safety Code section 11165 states:

(a) To assist law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, and the Osteopathic Medical Board of California Contingent Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

(b) The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds from the Department of Justice. The department may seek and use grant funds to pay the costs incurred from the reporting of controlled substance prescriptions to CURES. Funds shall not be appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, or the Osteopathic Medical Board of California Contingent Fund to pay the costs of reporting Schedule III and Schedule IV controlled substance prescriptions to CURES.

(c) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal persons or public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy or clinic shall provide the following information to the Department of Justice on a weekly basis and in a format specified by the Department of Justice:

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

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

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

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

(5) Quantity of the controlled substance dispensed.

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

(7) Number of refills ordered.

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

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) This section shall become operative on January 1, 2005.

**REGULATORY PROVISIONS**

13. Code of Federal Regulations, title 21, section 1306.04 states in pertinent part:

(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his 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. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

. . . .

14. California Code of Regulations, title 16, section 1707.5(d) states in pertinent part:

(a) Labels on drug containers dispensed to patients in California shall conform to the following format:

. . . .

(d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

. . . .

15. California Code of Regulations, title 16, section 1761 states:

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

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

**COST RECOVERY**

16. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

## DRUGS

17. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Carisoprodol, the generic name for Soma, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, and is a dangerous drug pursuant to Business and Professions Code section 4022.

19. Opana, a brand name for oxymorphome hydrochloride, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b), and is a dangerous drug pursuant to Business and Professions Code section 4022.

20. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Vicodin, a brand name for acetaminophen and hydrocodone bitartrate, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

## FACTUAL ALLEGATIONS

22. At all times mentioned herein and since January 20, 1997, Nasser Fathi (Respondent Fathi), has been the President and Pharmacist-in-Charge (PIC) of Irvine Medical Pharmacy, Inc., dba Irvine Medical Pharmacy (Respondent Irvine Medical Pharmacy).

23. In or around January 2013, the Board of Pharmacy initiated an investigation of Respondents. The Board inspector discovered that most Schedule II controlled substance prescriptions filled by Respondents came from the same five doctors, that patients traveled a distance to have their Schedule II prescriptions filled at the pharmacy, and that patients always paid in cash for controlled substances. The Board inspector also discovered that some patients came to Respondent Irvine Medical Pharmacy as a group in a van or SUV in order for them all to obtain controlled substances.

24. With respect to the verification of prescriptions, Respondents' ancillary staff verified medications by contacting the patient's doctor. Staff only verified the drug, strength, and quantity, and did not ask about indication or past medical history. Respondent Fathi did not verify prescriptions written by Dr. W.[1] or Dr. C.[2] Instead, Respondents' practice was to have ancillary staff call Dr. W.'s cell phone or speak with the receptionist at Dr. C.'s office, when verifying prescriptions.

25. Some patients presented with what appeared to pharmacy staff to be "fake" IDs when picking up the prescriptions from Respondents. Although this was brought to Respondent Fathi's attention, Respondents instructed staff to fill prescriptions for individuals even if the IDs appeared to be fake. Respondent Fathi also did not utilize the Prescription Drug Monitoring Program (PDMP) or CURES[3] to ensure that controlled substances were dispensed for a legitimate medical purpose.

26. On May 30, 2012, Respondents dispensed 180 tablets of oxycodone 30 mg to a person who posed as Patient MA pursuant to a prescription from Dr. C. MA's address was in Inglewood, California, approximately 47 miles from Respondent Irvine Medical Pharmacy. However, the Board inspector contacted the real MA and learned that MA's driver's license was stolen in 2012, that someone had stolen his identity, that he has never been to Irvine before, that he has never seen Dr. C. and that he has never taken oxycodone 30 mg.

27. Patient DG's address was approximately 45 miles from Respondent Irvine Medical Pharmacy. DG did not receive any controlled substance medications from January 1, 2012 through October 11, 2012. However, between October 11, 2012 and March 2013, Respondents

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[1] Dr. W.'s office was located in Anaheim Hills, approximately 18 miles from Respondent Irvine Medical Pharmacy. Dr. W. was convicted of Medicare fraud on April 14, 2013.

[2] Dr. C. has an office in Toluca Lake and Studio City, approximately 51 miles and 49 miles from Respondent Irvine Medical Pharmacy, respectively.

[3] Controlled Substance Utilization Review and Evaluation System (CURES) is a database in a program developed by the California Department of Justice, Bureau of Narcotic Enforcement, which allows access to the Prescription Drug Monitoring Program system. The Prescription Drug Monitoring Program 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.

dispensed 120 tablets of oxycodone 30 mg and 90 tablets of Norco 10mg/325 to DG pursuant to prescriptions written by Dr. W. Respondents did not question the prescriber about the high starting dose of oxycodone in addition to the Norco, for the treatment of an opioid naïve patient. On October 11, 2012, Respondents also dispensed alprazolam 2mg to DG pursuant to a prescription written by Dr. W. Respondents did not question the prescriber about why DG was started on the highest dose of alprazolam before trying a low strength dose or requiring a follow-up. DG was doctor and pharmacy shopping. DG also had insurance but did not use insurance to pay for all of the medications.

28. Patient DW's address was approximately 43 miles from Respondent Irvine Medical Pharmacy. From January 1, 2012 through February 21, 2012, DW did not receive any controlled substance medications. However, between February 12, 2012 and January 7, 2013, DW was doctor, pharmacy and medication shopping. In August 2012 and December 2012, Respondents dispensed oxycodone 30 mg to DW pursuant to prescriptions written by Dr. W.

29. Patient RS's address was approximately 45 miles from Respondent Irvine Medical Pharmacy. Between January 6, 2012 and August 2, 2013, RS was doctor, pharmacy, and medication shopping. On August 24, 2012, Respondents dispensed 120 tablets of Oxycodone 30 mg to RS pursuant to a prescription written by Dr. W., even though RS had received a 30 day supply of another pain medication from another pharmacy on August 23, 2012. On September 24, 2012, Respondents dispensed another 120 tablets of Oxycodone 30 mg to RS pursuant to a prescription written by Dr. W., even though RS had received a 30 day supply of another pain medication from another pharmacy on September 24, 2012.

30. Patient JW's address was approximately 32 miles from Respondent Irvine Medical Pharmacy. From January 8, 2008 through April 19, 2012, JW was doctor, pharmacy and medication shopping. On July 27, 2012, Respondents dispensed a 90 day supply of Oxycodone 30 mg and a 90 day supply of Vicodin to JW pursuant to prescriptions written by Dr. W., even though JW had been dispensed several other controlled substance medications from several other pharmacies and doctors shortly before this date.

31. Patient MC's address was approximately 29 miles from Respondent Irvine Medical Pharmacy. On March 3, 2011, MC received 240 tablets of oxycodone 30 mg from Respondent Irvine Medical Pharmacy, paying $350 cash. On April 20, 2011, MC received another 240 tablets of oxycodone 30 mg from Respondent Irvine Medical Pharmacy, paying $350 cash. On March 14, 2012, MC received 180 tablets of oxycodone 30 mg pursuant to a prescription written by Dr. C. from Respondent Irvine Medical Pharmacy, paying $300 cash. On May 15, 2012, MC received 180 tablets of oxycodone 30 mg pursuant to a prescription written by Dr. C., from Respondent Irvine Medical Pharmacy, paying $300 cash. On June 15, 2012, MC received 180 tablets of oxycodone 30 mg pursuant to a prescription written by Dr. C. from Respondent Irvine Medical Pharmacy, paying $300 cash. On July 17, 2012, MC received 180 tablets of oxycodone 30 mg pursuant to a prescription written by Dr. C. from Respondent Irvine Medical Pharmacy, paying $300 cash. On October 1, 2012, MC received 120 tablets of oxycodone 30 mg pursuant to a prescription written by Dr. C. from Respondent Irvine Medical Pharmacy, paying $200 cash. Therefore, from March 3, 2011 to October 1, 2012, MC traveled from her home in Long Beach to Dr. C.'s office in Studio City and then to Respondent Irvine Medical Pharmacy in Irvine to have her oxycodone 30 mg prescriptions filled, paying a total of $2,100.00 in cash to Respondent Irvine Medical Pharmacy.

32. Patient PE's address was approximately 50 miles from Respondent Irvine Medical Pharmacy. From April 30, 2009 to May 14, 2013, PE was doctor, pharmacy and medication shopping. On January 31, 2012, Respondents dispensed a 30 day supply of oxycodone 30 mg to PE, even though PE had received a 30 day supply of oxycodone 30 mg on January 16, 2012 (15 days prior) from a different doctor and at a different pharmacy. On February 21, 2012, Respondents dispensed another 30 day supply (120 tablets) of oxycodone 30 mg to PE, even though PE had received a 30 day supply of oxycodone 30 mg on February 13, 2012 (8 days prior) from a different doctor and at a different pharmacy. On May 25, 2012, without verifying the prescription with the prescriber, Respondents dispensed a 30 day supply (180 tablets) of oxycodone 30 mg to PE, even though PE had received a 30 day supply of oxycodone 30 mg and a 25 day supply of Vicodin on May 11, 2012 (14 days prior).

33. Patient RD's address was approximately 29 miles from Respondent Irvine Medical Pharmacy. From January 1, 2012 through May 22, 2012, RD received no controlled medications in California. However, from May 22, 2012 to June 12, 2013, RD began doctor, pharmacy and medication shopping. On May 22, 2012, Respondents dispensed a 30 day supply (180 tablets) of oxycodone 30 mg to RD pursuant to a prescription written by Dr. C., paying Respondents $300 cash. On July 3, 2012, Respondents dispensed a 45 day supply (180 tablets) of oxycodone 30 mg pursuant to a written prescription written by Dr. C., paying $300 cash.

34. The average distance that Dr. W.'s patients traveled from their homes to Respondent Irvine Medical Pharmacy was 38.8 miles. From May 21, 2011 to January 28, 2013 (20 months), Respondent Irvine Medical Pharmacy dispensed the following total controlled substances for prescriptions written by Dr. W.:

| Product Name | Total Tablets Dispensed |
|---|---|
| Alprazolam 2mg | 400 |
| APAP/Hydrocodone 10/325mg | 1,280 |
| APAP/Hydrocodone 7.5/750mg | 360 |
| Carisoprodol 350mg | 270 |
| OPANA ER 40mg | 90 |
| Oxycodone 30mg | 7,510 |
| GRAND TOTAL: | 9,910 |

35. The average distance that Dr. C.'s patients traveled from their homes to Respondent Irvine Medical Pharmacy was 36.7 miles.[4] From May 21, 2011 to January 28, 2013 (20 months), Respondent Irvine Medical Pharmacy dispensed a total of 10,370 tablets of oxycodone 30 mg from prescriptions written by Dr. C.

[4] Two of Dr. C.'s patients have Louisiana addresses. Those addresses were not used in calculating the average distance that Dr. C.'s patient's traveled to have their prescriptions filled at Respondent Irvine Medical Pharmacy.

36. The Board inspector also obtained data from nearby pharmacies, including "big-box" retail pharmacies, and discovered that Respondent Irvine Medical Pharmacy was dispensing over three times the amount of oxycodone 30 mg when compared to neighboring pharmacies.

37. Respondents also acquired oxycodone 30 mg at an average price of $30.12 per 100 tablet bottle, or $.30 per tablet. Respondents charged their cash patients $1.64 per tablet, for a total mark-up of 546 percent.

38. During the first inspection on July 8, 2013, the Board inspector discussed with Respondent Fathi the requirement to report to CURES on a weekly basis. The Board inspector showed Respondent Fathi the report reflecting that Respondents were not reporting regularly to CURES. The Board inspector also discovered that Respondents did not report to CURES from January 2010 through June 2010. Respondents also did not report CURES data from July 2010 to December 2010, until July 10, 2013 (after the Board inspection on July 8, 2013).

## FIRST CAUSE FOR DISCIPLINE

**(Unprofessional Conduct - Failure to Implement Corresponding Responsibility)**

39. Respondent Irvine Medical Pharmacy and Respondent Fathi are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (j), for violation of Health and Safety Code section 11153, subdivision (a), in that Respondents failed to comply with their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose. The circumstances are that Respondents failed to evaluate the totality of the circumstances (information from the patient, physician, CURES and other sources) to determine the prescriptions' were issued for a legitimate medical purpose in light of information showing that several patients demonstrated drug seeking behaviors such as doctor, pharmacy and drug shopping, numerous patients had addresses outside Respondents' normal trade area, patients paid only cash for their controlled substances, pharmacy staff questioned the validity of patients' identification, certain prescribers (Dr. C. and Dr. W.) wrote a disproportionate number of prescriptions for oxycodone, having no personal knowledge about prescribers' practice or patients' treatment histories, among other things, as set forth in paragraphs 22 through 38, which are incorporated herein by reference.

## SECOND CAUSE FOR DISCIPLINE

**(Unprofessional Conduct - Excessive Furnishing of Controlled Substances)**

40. Respondent Irvine Medical Pharmacy and Respondent Fathi are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (d), for unprofessional conduct in that Respondents clearly excessively furnished controlled substances, when from February 20, 2012 through July 17, 2012, Respondents dispensed 50 prescriptions of oxycodone 30mg prescribed by Dr. C. for a total 10,370 tablets and from May 21, 2011 to January 28, 2013, Respondents dispensed 93 controlled substance prescriptions prescribed by Dr. W. for a total of 9,910 tablets, as set forth in paragraphs 22 through 38, which are incorporated herein by reference.

## THIRD CAUSE FOR DISCIPLINE

**(Unprofessional Conduct – Gross Negligence)**

41. Respondent Fathi is subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (c), in that Respondent was grossly negligent in dispensing controlled substances. The circumstances are that Respondent knew or should have known that the controlled substances prescribed by Dr. C. and Dr. W. were likely to be used for other than a legitimate medical purpose and Respondent failed to take appropriate steps when presented with numerous prescriptions for controlled substances, including oxycodone 30mg, from a small group of prescribers. Respondent failed to personally contact the prescriber about the indication or past medical history and perform additional investigation to determine whether the prescriptions were issued for a legitimate medical purpose, as set forth in paragraphs 22 through 38, which are incorporated herein by reference.

## FOURTH CAUSE FOR DISCIPLINE

**(Unprofessional Conduct – Negligence)**

42. Respondent Fathi is subject to disciplinary action for unprofessional conduct under Code section 4301, in that Respondent was negligent in dispensing controlled substances when Respondent knew or should have known that the controlled substances prescribed by Dr. C. and Dr. W. were likely to be used for other than a legitimate medical purpose and Respondent failed

to take appropriate steps upon which being presented with numerous prescriptions controlled substances, including oxycodone 30mg, from a small group of prescribers, including but not limited to, personally contacting the prescriber about the indication or past medical history and performing additional investigation to determine whether the prescriptions were issued for a legitimate medical purpose, as set forth in paragraphs 22 through 38, which are incorporated herein by reference.

**FIFTH CAUSE FOR DISCIPLINE**

**(Unprofessional Conduct - Failure to Report to CURES)**

43. Respondent Irvine Medical Pharmacy and Respondent Fathi are subject to disciplinary action for unprofessional conduct under Code section 4301(j) and (o), for violating Health and Safety Code section 11165, subdivision (d), for failing to submit data to CURES on a weekly basis, as set forth in paragraph 38, which is incorporated herein by reference.

**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 42046, issued to Irvine Medical Pharmacy, Inc. dba Irvine Medical Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 48441 to Nasser Fathi;

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

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

DATED: 3/12/14

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

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