KAMALA D. HARRIS
Attorney General of California
LINDA L. SUN
Supervising Deputy Attorney General
ANTONIO LOPEZ, JR.
Deputy Attorney General
State Bar No. 206387
300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-2536
Facsimile: (213) 897-2804
Attorneys for Complainant

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

In the Matter of the Accusation Against: **THE MEDICINE SHOPPE; SANJIV BHALLA** **1435 State Street** **Santa Barbara, CA 93101** **Pharmacy Permit No. PHY 49809,** **and** **SANJIV BHALLA** **1250 La Venta Dr. #114** **Westlake Village, CA 91361** **Pharmacist License No. RPH 46064** Respondent.	Case No. 5251 **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 February 17, 2009, the Board of Pharmacy issued Pharmacy Permit Number PHY 49809 to The Medicine Shoppe with Sanjiv Bhalla as Pharmacist-In-Charge ("Respondent Pharmacy"). The Pharmacy Permit is cancelled, expired on February 1, 2014, and has not been renewed.

3. On or about March 15, 1993, the Board of Pharmacy issued Pharmacist License Number RPH 46064 to Sanjiv Bhalla ("Respondent Bhalla"). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, 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 4300 of the Code states, in pertinent part:

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

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

(1) Suspending judgment.

(2) Placing him or her upon probation.

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

(4) Revoking his or her license.

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

6. 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."

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STATUTES AND REGULATIONS

7. Section 4301 of the Code states, in pertinent part:

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

. . . .

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

. . . .

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

. . . .

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

8. Section 4081, subdivision (a) of the Code states:

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

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

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

. . . .

(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."

10. Health and Safety Code section 11153, subdivision (a), 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."

11. 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

12. 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.

CONTROLLED SUBSTANCES[1]

13. Alprazolam, the generic name for Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1). Alprazolam is a depressant used to treat anxiety and is a popular member of a class of drugs called "benzodiazepines," which is a general name for any group of psychotropic agents used as anti-anxiety agents, muscle relaxants, sedatives, and hypnotics.

14. Clonazepam, the generic name for Klonopin, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7). Clonazepam treats seizures, panic disorder, and anxiety and belongs to the class of drugs called "benzodiazepines."

15. Diazepam, a generic name for Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9). Diazepam treats anxiety, muscle spasms, seizures, and belongs to the class of drugs called "benzodiazepines."

16. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8). Fentanyl is a narcotic opioid used to treat moderate to severe chronic pain.

17. The combination of Hydrocodone/Acetaminophen ("HC/AP") is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4). Hydrocodone is an opioid pain reliever that is subject to abuse because of the euphoric feeling it induces.

18. Lorazepam, the generic name for Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16). Lorazepam is used to

[1] All of the controlled substances listed are also dangerous drugs pursuant to Code section 4022.

treat anxiety, anxiety with depression, and insomnia and belongs to the class of drugs called "benzodiazepines."

19. Hydromorphone, the generic name for Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J). Hydromorphone is a narcotic opioid that is used to treat moderate to severe pain.

20. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14). Methadone treats moderate to severe pain and when used together with medical supervision and counseling is used for the treatment of narcotic drug addiction.

21. Opana ER, a brand name for Oxymorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N). Oxymorphone is a narcotic opioid that is used to treat moderate to severe pain.

22. Oxycodone, a generic name for Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxycodone is a narcotic opioid that is used to treat moderate to severe pain.

23. Percocet, a brand name for the combination of Oxycodone and Acetaminophen ("Oxy/Ap"), is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxy/Ap is a narcotic opioid that is used to treat moderate to moderately severe pain.

BOARD INVESTIGATION

24. Beginning in January 2013, the Board conducted an investigation into Respondent Pharmacy. The Board was alerted that Julio Diaz, M.D., a general practitioner with secondary practices in geriatrics and pathology, who had a medical practice in Santa Barbara, was arrested for trafficking narcotics. Respondent Pharmacy dispensed many controlled substances that Dr. Diaz prescribed.

25. On January 15, 2013, two Board Inspectors conducted an inspection of Respondent Pharmacy. When questioned about Dr. Diaz's prescriptions, Respondent Bhalla initially

responded that he did not know if Dr. Diaz was a pain specialist but stated that he checked the prescriptions by calling the doctor's office and writing the diagnosis code on the prescriptions.

26. The Board Inspectors selected 21 patients to profile and asked Respondent Bhalla to complete questionnaires regarding the patients. Amongst the questions asked were the patients' diagnoses, the methods of payment, and the nature of prescriber's practice. All of the patients were Dr. Diaz's patients and Respondent Bhalla indicated that Dr. Diaz had a general practice.

27. The Board Inspectors requested CURES[2] data for Respondent Pharmacy from January 1, 2011 to December 5, 2012 and CURES Patient Activity Reports ("PARs") for the 21 selected patients from January 1, 2009 to January 28, 2013.

28. On October 4, 2012, the Medical Board of California revoked Dr. Diaz's license to practice medicine, in the case entitled *In the Matter of the Accusation Against Otero Julio Gabriel Diaz, M.D.*, case no. 06-2010-209660. Dr. Diaz's license was revoked for gross negligence, incompetence, and excessive prescribing of narcotic medications to a patient.

FIRST CAUSE FOR DISCIPLINE

(Corresponding Responsibility)

29. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivisions (d), Code section 4301, subdivision (j) for violating Health and Safety Code section 11153, subdivision (a), and Code section 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1761, in that between January 1, 2011 and December 5, 2012, Respondents failed to assume their corresponding responsibility by failing to validate the legitimacy of prescriptions dispensed and/or by failing to review patients' drug therapy and thus dispensing prescriptions to physician shoppers or habitual users. The circumstances, which include by reference Paragraphs 24 through 28, are as follows:

[2] All prescription drug history information is maintained in the California Controlled Substance Utilization Review and Evaluation System, or CURES, a database. This CURES database includes information about the drug dispensed, drug quantity and strength, patient name, address, prescriber name, and authorization number including DEA number or prescription number.

30. For the 21 patients that the Board Inspectors selected to profile, there were many irregularities found with the prescriptions and dispensing methods, including: (1) no diagnosis for many patients; (2) a general practitioner that was prescribing an excessive amount of narcotics; (3) many patients that came to Respondent Pharmacy outside of the normal trading area, which is considered to be 5 miles from the patient's residence or adjacent to the prescriber's office; (4) consistent early fills of controlled substance prescriptions; (5) patients paying cash for expensive narcotics; (6) no verification in CURES Patient Activity Reports (PARs) for suspicious prescriptions; (7) evidence of doctor/pharmacy shopping; and (8) evidence of a pattern of prescribing controlled substances in large and redundant quantities and in questionable combinations.

31. A detailed review of the 21 patients reveals the following results:

a) Patient T.B. Patient T.B. was diagnosed with cervical myositis pain and Chronic Pain Syndrome. Between January 1, 2009 and January 1, 2013, Patient T.B. saw 4 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. On several occasions (January 5, 2010, January 25, 2010, February 19, 2010, April 7, 2010, August 27, 2010, September 17, 2011, and December 16, 2011) Patient T.B. received 2 hard copy prescriptions from Dr. Diaz for Percocet with the same date. This should have been a red flag for the pharmacy. Respondent Pharmacy dispensed RX #1178784 for Fentanyl patches every 48 prescribed by Dr. Diaz. The recommended dosage is every 72 hours. Patient T.B. utilized insurance to pay for her medications but paid cash, including $1,298.90 for Opana and $732.90 for Fentanyl, when insurance did not cover her medications.

b) Patient D.B. Patient D.B. was diagnosed with degenerative chronic disease of the cervical spine. Between January 20, 2009 and January 3, 2013, Patient D.B. saw 5 different prescribers and went to 4 different pharmacies, including Respondent Pharmacy. Prior to seeing Dr. Diaz, Patient D.B. received HC/AP 10-325 monthly for approximately 1 year. Dr. Diaz prescribed hydromorphone 8 mg and morphine 60 mg. Dr. Diaz also prescribed buprenorphine 8 mg (which is commonly used to treat opiate addiction.) After Patient D.B. stopped seeing Dr. Diaz, Patient D.B. received morphine but the strength was much smaller. Patient D.B. utilized

insurance to pay for his medications but paid cash, including $202.90 for Alprazolam, when insurance did not cover his medications.

c) Patient K.B. Patient K.B. was diagnosed with lumbar reticulopathy and spondylosis. Between March 31, 2009 and December 4, 2012, Patient K.B. saw 5 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and March 31, 2009, Patient K.B. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: HC/AP 10-325, Methadone 10 mg, and Alprazolam 2 mg. Patient K.B. also received numerous HC/AP 10-325 prescriptions from Dr. Diaz and had them dispensed at multiple pharmacies on or around the same time:

- On April 30, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply from Respondent Pharmacy and on May 8, 2009 he received 240 tablets (40 day supply from LM Caldwell Pharmacist.
- On May 28, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply) from Respondent Pharmacy and 240 tablets (40 day supply) from Walgreens. On June 4, 2009, he received 240 tablets (40 day supply) from LM Caldwell Pharmacist.
- On July 23, 2009, Patient K.B. received RX #1128237, 240 tablets (30 day supply) the Respondent Pharmacy and on July 28, 2009, he received 240 tablets (30 day supply) from Walgreens.
- On August 21, 2009, Patient K.B. received RX #1129966, 240 tablets (30 day supply) from Respondent Pharmacy and on August 28, 2009, he received 240 tablets (30 day supply) from Walgreens.

Had Respondent Pharmacy utilized PARs, it would have discovered the excessive dispensing. Patient K.B. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

d) Patient A.B. Patient A.B.'s diagnosis was unknown. Between May 21, 2009 and January 24, 2012, Patient A.B. saw 3 prescribers and went to 7 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 21, 2009, Patient A.B. received no

controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Fentanyl patch and Alprazolam 2 mg. Respondent Pharmacy dispensed RX #1175222 on June 29, 2011, RX #1178791 on August 26, 2011, and RX #1180528 on September 27, 2009 all prescribed by Dr. Diaz for Opana ER three times a day when the recommended dose is two times a day. Patient A.B. utilized insurance to pay for his medications but paid cash, including $828.90 and $421.95 for Opana and over $250 for Oxycodone and Adderall XR, when insurance did not cover his medications.

e) Patient J.C. Patient J.C.'s diagnosis was unknown. Between May 15, 2009 and January 3, 2012, Patient J.C. saw 8 different prescribers and went to 9 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 15, 2009, Patient J.C. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg, Methadone 10 mg, and clonazepam 2 mg. Patient J.C. resided in Solvang and traveled approximately 36 miles to see Dr. Diaz. Patient J.C. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

f) Patient M.C. Patient M.C.'s diagnosis was unknown. Between April 7, 2009 and January 8, 2013, Patient J.C. saw 8 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and April 7, 2009, Patient A.B. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medication: Oxycodone 80 mg. Between January 1, 2009 and May 8, 2009, Patient A.B. received no anxiety medication. Then Dr. Diaz prescribed the following high dosage medication: Alprazolam 2 mg (and later Lorazepam 2 mg). Respondent Pharmacy dispensed RX #1184620 Oxycontin 60 mg (22 day supply) and RX #1184646 Oxycontin 80 mg (22 day supply) on November 25, 2011 prescribed by Dr. Diaz. The directions were to take the mediation 2-3 times daily when the recommended dosage is twice daily. Patient M.C. utilized insurance to pay for his medication but paid cash, including $312 for morphine, $415 for Oxycontin, and $259 for hydromorphone, when insurance did not cover his medications.

g) Patient C.D. Patient C.D.'s diagnosis was unknown. Between April 19, 2009 and January 14, 2013, Patient C.D. went to 8 different prescribers and 9 different pharmacies,

including Respondent Pharmacy. Patient C.D. utilized insurance to pay for her medications but paid cash when insurance did not cover her medications.

h) Patient J.H. Patient J.H. was diagnosed with migraine headaches. Between February 13, 2009 and December 28, 2011, Patient J.H. went to 4 different prescribers and 13 different pharmacies, including Respondent Pharmacy. He went to 5 other pharmacies while going to Respondent Pharmacy. On August 3, 2011, Patient J.H. received RX #4487887, 240 tablets of HC/AP 10-325 (30 day supply) from Walmart #1989 and on August 18, 2011, he received RX #1178320, 240 tablets of HC/AP 10-325 (30 day supply) at Respondent Pharmacy. Both prescriptions were prescribed by Dr. Diaz. A review of PARs would have caught this excessive prescribing. Patient J.H. resided in Santa Maria and traveled approximately 62 miles to see Dr. Diaz. Patient J.H. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

i) Patient A.J. Patient A.J. was diagnosed with arthritis. Between January 19, 2009 and December 14, 2012, Patient A.J. saw 2 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Patient A.J. resided in Santa Ynez and travelled approximately 34 miles to see Dr. Diaz. Patient A.J. received early fills for Methadone and Oxycodone all prescribed by Dr. Diaz:

- On March 31, 2010, Patient A.J. received Methadone 10 mg (30 day supply) from Goleta Valley Pharmacy, on April 21, 2010, she received Methadone 10 mg (30 day supply) from LM Caldwell Pharmacist, and on May 10, 2010, she received RX #1148455, Methadone 10 mg (30 day supply) from Respondent Pharmacy.
- On May 21, 2010, Patient A.J. received RX #1149465, 240 tablets of Oxycodone 30 mg (30 day supply) from Respondent Pharmacy and on June 7, 2010, she received 200 tablets of Oxycodone (25 day supply) from Goleta Valley Pharmacy.

Had Respondent Pharmacy checked PARs it would have caught this excessive prescribing. Patient A.J. utilized insurance to pay for her medications but paid cash, including up to $660 for Oxycontin, when insurance did not cover her medications.

j) Patient G.L. Patient G.J. was diagnosed with chronic pain, multiple disc degeneration, and a pinched nerve. Between February 4, 2009 and January 10, 2013, Patient G.L. saw 14 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. Patient G.L. engaged in both doctor and pharmacy shopping while he had his prescriptions filled at Respondent Pharmacy. In 2009 and 2010, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed, HC/AP 10-325 and HC/AP 10-500 around the same time. This excessive prescribing and dispensing caused Patient G.J. to receive an excessive amount of Acetaminophen. Also, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed Opana ER and Oxycodone at the same time. Both medications are long lasting and the normal practice is to dispense one or the other, but not both. Patient G.J. utilized insurance to pay for his medications but paid cash, including $2,305 for Fentanyl OT and $202 for Alprazolam (the cost to Respondent Pharmacy was $10.82), when insurance did not cover his medications.

k) Patient A.M. Patient A.M. was diagnosed with a cervical lumbar sprain, right foot pain, and pain post trauma. Between January 12, 2009 and November 15, 2011, Patient A.M. saw 4 different prescribers and went to 8 different pharmacies, including Respondent Pharmacy. Patient A.M. engaged in pharmacy shopping while he had his prescriptions filled at Respondent Pharmacy. A check of PARs would have reveals that Patient A.M. was going to multiple pharmacies to obtain and excessive amount of controlled substances prescribed by Dr. Diaz. Patient A.M. resided in Lompoc and traveled approximately 56 miles to see Dr. Diaz. Patient A.M. paid for his medications with cash. Patient A.M. passed away from a drug overdose in November 2011.

l) Patient S.M. Patient S.M.'s diagnosis was unknown. Between April 1, 2009 and November 30, 2012, Patient S.M. saw 8 different prescribers and went to 10 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and April 1, 2009, Patient S.M. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 40 mg and oxy/apap. Between January 1, 2009 and May 26, 2009, Patient S.M.. received no anxiety medication. Then Dr. Diaz prescribed Alprazolam 2 mg. Patient S.M. paid for his medications with cash.

m) Patient W.M. Patient W.M. was an amputee with Chronic Pain Syndrome and Phantom Pain Syndrome. Between February 20, 2009 and January 4, 2013, Patient W.M. saw 11 different prescribers and when to 5 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs it would have noticed that Patient W.M. was a doctor shopper. Patient W.M. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

n) Patient B.P. Patient B.P. was diagnosed with a slipped disc, pinched sciatic nerve, muscle spasm, and anxiety. Between January 1, 2009 and April 16, 2009, Patient B.P. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg and Alprazolam 2 mg. Patient B.P. also received numerous prescriptions for Alprazolam 2 mg prescribed by Dr. Diaz around the same time, which Respondent Pharmacy dispensed:

- On September 4, 2009, Patient B.P. received RX #1129218, 120 tablets (30 supply) and on September 8, 2009, he received RX #1130929, 100 tablets (25 day supply);
- On September 30, 2009, Patient B.P. received RX #1130929, 120 tablets (30 day supply) and on October 5, 2009, he received RX #1132519, 120 tablets (30 day supply);
- On November 23, 2009, Patient B.P. received RX #1130929, 100 tablets (25 day supply), on November 24, 2009 he received RX #1129218, 120 tablets (30 day supply), and on December 1, 2009, he received RX #1136288, 180 tablets (30 day supply);
- On February 24, 2010, Patient B.P. received RX #1136288, 180 tablets (30 day supply) and RX #1142355, 180 tablets (30 day supply); and
- On September 17, 2011, Patient B.P. received RX #1173125, 180 tablets (30 day supply) and RX #1178161, 180 tablets (30 day supply), and on September 23, 2011, Patient B.P. received RX #1178161, 180 tablets (30 day supply).

Patient B.P. paid for his medications with cash.

o) Patient J.P. Patient J.P's diagnosis was unknown. Patient J.P. utilized insurance to pay for his medications but paid cash, including $620 for morphine when insurance did not cover his medications.

p) Patient J.R. Patient J.R.'s diagnosis was unknown. Between March 1, 2009 and December 27, 2012, Patient J.R. saw 12 different prescribers and went to 16 different pharmacies, including Respondent Pharmacy. Patient J.R. engaged in pharmacy shopping while getting his prescriptions filled at Respondent Pharmacy. Had Respondent Pharmacy checked PARs, it would have noticed this practice. Dr. Diaz prescribed Opana ER to Patient J.R. to take the mediation every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1177927 on August 15, 2011 and RX #1179557 on September 9, 2011. Patient J.R. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

q) Patient J.S. (DOB 9/2/86) Patient J.S was diagnosed with knee and back pain, retinacular capsular trauma, fibromyalgia, and spondylosis. Between October 21, 2009 and July 28, 2012, Patient J.S. saw 5 different prescribers and three different pharmacies. Between January 1, 2009 and October 23, 2009, Patient J.S. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: oxycodone 30 mg, Hydromorphone, and Alprazolam 2 mg. J.S. resided in Solvang and travelled approximately 34.5 miles to see Dr. Diaz. Patient J.S. utilized insurance to pay for his medications but paid cash, including $391 for oxycodone when insurance did not cover his medications.

r) Patient J.S. (DOB 7/16/77) Patient J.S.'s diagnosis was unknown. Patient J.S. resided in Lompoc and traveled approximately 58 miles to see Dr. Diaz. Dr. Diaz began Patient J.S.'s treatment with oxycodone 30 mg, Opana ER 20 mg, Diazepam 10 mg, and Lorazepam 2 mg. The latter two drugs, Diazepam and Lorazepam, are both in the same class and are not to be prescribed together. This should have raised a red flag for Respondent Pharmacy. Dr. Diaz prescribed Opana ER to Patient J.S. and instructed her to take the medication every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1182433 on October 24, 2011 and RX #1186298 on December 19, 2011. Patient J.S. paid for her medications with insurance.

s) Patient R.S. Patient R.S. was diagnosed with multiple injuries and trauma. Between January 3, 2009 and June 22, 2012, Patient R.S. saw 12 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have noticed that Patient R.S. was a doctor and pharmacy shopper. Dr. Diaz prescribed Oxycontin 80 mg to Patient R.S. and instructed him to take the medication every 6 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1157030 on September 21, 2010 and RX #1158402 on October 14, 2010. Dr. Diaz also prescribed Opana ER 80 mg to Patient R.S. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Opana ER and Oxycontin are both long acting narcotic pain killers and are not commonly prescribed together. This should have been a red flag for Respondent Pharmacy. Respondent Pharmacy dispensed this prescription as RX #1158399 on October 14, 2010. R.S. resided in Lompoc at the same location as Patient J.S. (DOB 7/16/77) and travelled approximately 58 miles to see Dr. Diaz. Patient R.S. paid for his medications with insurance.

t) Patient E.T. Patient E.T. was a right leg amputee diagnosed with phantom pain, left leg radicular pain, and a left foot fracture. Between June 20, 2011 and December 11, 2012, Patient E.T. saw 10 different prescribers and went to 4 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have discovered that Patient E.T. was a doctor shopper. Between January 1, 2009 and June 20, 2011, Patient E.T. received no controlled substance pain killers or anxiety medication. Then, on July 6, 2011, Dr. Diaz prescribed the following high dosage medications at the same time: methadone 10 mg, oxycodone 30 mg, Hydromorphone 8 mg, Opana ER 40 mg, morphine 100 mg, and Diazepam 10 mg. Dr. Diaz prescribed Opana ER 80 mg to Patient E.T. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1175540 on July 6, 2011, RX #1177255 on August 3, 2011, and RX #1180758 on September 28, 2011. Patient E.T. utilized insurance to pay for his medications but paid cash, including $179 for HC/AP (the cost to Respondent Pharmacy was $39.22), when insurance did not cover his medications.

u) Patient C.W. Patient C.W was diagnosed with pain, anxiety, and Attention Deficit Disorder. Patient C.W. received numerous prescriptions for HC/AP from Dr. Diaz around the same time and had them dispensed at multiple pharmacies:

- Patient C.W. filled RX #1125098, 10-325 mg, 100 tablets (25 day supply) on May 30, 2009, she filled RX #1123636, 10-500 mg, 180 tablets (22 day supply) on June 2, 2009, and she filled RX #1125367, 7.5-750 mg, 120 tablets (30 supply) on June 3, 2009 all at Respondent Pharmacy.
- Patient C.W. filled a prescription for 7.5-750 mg, 180 tablets (30 day supply) at CVS on December 16, 2009 and then filled RX #1130383, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on December 29, 2009.
- Patient C.W. filled a prescription for 7.5-750 mg, 120 tablets (30 supply) at CVS on March 17, 2010 and then filled RX #1144415, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on March 23, 2010.
- Patient C.W. filled a prescription for 7.5-750 mg, 150 tablets (30 supply) at CVS on April 11, 2010, then filled RX #1145891, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on April 13, 2010.
- Patient C.W. filled RX #1176959, 120 tablets, 10-325 mg (30 day supply) and RX #1176962, 120 tablets, 7.5-750 mg (30 day supply) on August 13, 2011 at Respondent Pharmacy.

On February 11, 2010, Respondent Pharmacy dispensed both Clonazepam (RX #1141456) and Lorazepam (RX #1141458) – prescribed by Dr. Diaz – to Patient C.W. These medications are in the same classification and would not normally be prescribed together. On July 28, 2011, Dr. Diaz prescribed both HC/AP 10-325 and HC/AP 7.5-750 on the same prescription. Respondent Pharmacy dispensed both medications (RX #1176962 and RX #1176965) on August 13, 2011. Patient C.W. utilized insurance to pay for her medications but paid cash, including $54.90 HC/AP (the cost to Respondent Pharmacy was $4.40), when insurance did not cover her medications.

32. Patient M.M.[3] Between January 2, 2009 and January 23, 2013, Patient M.M. saw 18 different prescribers and went to 20 different pharmacies, including Respondent Pharmacy. Patient M.M. engaged in both doctor and pharmacy shopping while she had her prescriptions filled at Respondent Pharmacy. Prior to getting prescriptions filled at Respondent Pharmacy, Patient M.M. received numerous prescriptions for Oxycontin from Dr. Diaz and went to different pharmacies to get them dispensed. Had Respondent Pharmacy checked PARs, it would have noticed this obvious pharmacy shopping. Patient M.M. resided in Lompoc and travelled approximately 56 miles to see Dr. Diaz. Patient M.M. utilized insurance to pay for her medications but paid cash, including up to $1,806 and $2,703 for Oxycontin, when insurance did not cover her medications.

33. A detailed review of the 21 patients of Respondent selected for the profile revealed a pattern of early refills of prescriptions as to 11 patients for Dr. Diaz (Patients T.B., K.B., M.C., C.D., J.H., G.L., B.P., J.R., R.S., E.T. and C.W.), as described in the following table:

Pt.	Date Dispensed	Rx. No.	Qty	Day Supply	MD	Date Dispensed	Rx. No.	Qty	Day Supply	MD	Days Early
TB	01/07/10	1138630	120	30	Diaz	01/27/10	1140103	120	30	Diaz	6
TB	01/07/10	1138631	180	30	Diaz	01/30/10	1140471	180	30	Diaz	6
TB	01/30/10	1140471	180	30	Diaz	02/22/10	1142175	180	30	Diaz	7
TB	02/22/10	1142175	180	30	Diaz	03/18/10	1143889	180	30	Diaz	6
TB	04/15/10	1145415	180	30	Diaz	05/07/10	1147810	180	30	Diaz	8
TB	08/30/10	1155489	180	30	Diaz	09/22/10	1156903	180	30	Diaz	7
TB	06/28/11	1174094	10	30	Diaz	07/21/11	1175838	10	30	Diaz	7
TB	06/28/11	1174108	60	30	Diaz	07/21/11	1176076	60	30	Diaz	7
TB	07/21/11	1176076	60	30	Diaz	08/15/11	1177205	60	30	Diaz	5
TB	08/09/11	1177643	180	30	Diaz	09/02/11	1179184	180	30	Diaz	6
KB	04/29/10	1147574	240	30	Diaz	05/20/10	1149406	240	30	Diaz	9
KB	04/29/10	1145017	240	30	Diaz	05/24/10	1145017	240	30	Diaz	5

[3] No patient questionnaire was sent to Patient M.M. but the Board Inspector did gather CURES data, mileage data, prescription hard copies, and other relevant data regarding this patient.

Pt.	Date Dispensed	Rx. No.	Qty	Day Supply	MD	Date Dispensed	Rx. No.	Qty	Day Supply	MD	Days Early
KB	08/30/10	1152434	240	30	Diaz	09/24/10	1152434	240	30	Diaz	5
MC	06/21/11	1174708	160	40	Diaz	07/08/11	1175758	90	30	Diaz	23
MC	06/21/11	1174707	180	30	Diaz	07/08/11	1175757	120	30	Diaz	13
MC	06/30/11	1174710	120	30	Diaz	07/21/11	1176496	120	30	Diaz	9
CD	06/23/11	1174893	120	30	Diaz	07/18/11	1174893	120	30	Diaz	5
JH	08/18/11	1178318	90	30	Diaz	09/02/11	1178318	90	30	Diaz	15
GL	02/15/10	1141621	240	30	Diaz	03/10/10	1143429	240	30	Diaz	7
GL	02/15/10	1141624	240	30	Diaz	03/10/10	1143422	240	30	Diaz	7
GL	02/15/10	1141623	360	30	Diaz	03/10/10	1143428	360	30	Diaz	7
GL	02/15/10	1141616	60	30	Diaz	03/10/10	1143425	60	30	Diaz	7
GL	04/06/10	1145332	120	30	Diaz	04/29/10	1143423	120	30	Diaz	7
GL	04/06/10	1145336	240	30	Diaz	04/29/10	1145336	240	30	Diaz	7
GL	04/16/10	1146454	240	30	Diaz	05/10/10	1148175	240	30	Diaz	6
GL	04/29/10	1143423	120	30	Diaz	05/24/10	1148172	120	30	Diaz	5
GL	04/29/10	1145336	240	30	Diaz	05/24/10	1145336	240	30	Diaz	5
GL	06/22/11	1174785	120	30	Diaz	07/15/11	1172951	120	30	Diaz	7
GL	11/28/11	1183585	300	25	Diaz	12/17/11	1185523	300	25	Diaz	6
GL	12/07/11	1185524	180	30	Diaz	12/30/11	1186912	180	30	Diaz	6
MM	07/22/11	1176580	240	30	Diaz	08/16/11	1178046	240	30	Diaz	5
MM	07/22/11	1176579	120	30	Diaz	08/16/11	1178047	120	30	Diaz	5
MM	08/18/11	1176387	240	30	Diaz	09/12/11	1176387	240	30	Diaz	5
MM	12/03/11	1185275	15	30	Diaz	12/28/11	1186952	15	30	Diaz	5
MM	12/03/11	1185274	120	30	Diaz	12/28/11	1186953	120	30	Diaz	5
BP	02/24/10	1136288	180	30	Diaz	02/24/10	1142325	180	30	Diaz	30
BP	02/24/10	1142325	180	30	Diaz	03/20/10	1136288	180	30	Diaz	6
BP	03/24/10	1144472	240	30	Diaz	04/02/10	1145097	140	17	Diaz	21
BP	03/20/10	1136288	180	30	Diaz	04/12/10	1142325	180	30	Diaz	7
BP	04/12/10	1142325	180	30	Diaz	04/29/10	1147582	180	30	Diaz	13
BP	04/29/10	1147582	180	30	Diaz	05/11/10	1142325	180	30	Diaz	18

Pt.	Date Dispensed	Rx. No.	Qty	Day Supply	MD	Date Dispensed	Rx. No.	Qty	Day Supply	MD	Days Early
BP	09/13/10	1154202	180	30	Diaz	10/08/10	1154202	180	30	Diaz	5
BP	09/17/11	1173125	180	30	Diaz	09/23/11	1178161	180	30	Diaz	24
BP	09/14/11	1179896	300	25	Diaz	09/23/11	1180520	270	30	Diaz	16
BP	09/14/11	1179895	360	30	Diaz	09/23/11	1180519	360	30	Diaz	21
JR	06/27/11	1175073	30	30	Diaz	07/18/11	1176291	30	30	Diaz	9
JR	08/15/11	1177927	90	30	Diaz	09/09/11	1179557	90	30	Diaz	5
JS	09/04/10	1156516	90	30	Diaz	10/07/10	1156516	90	30	Diaz	7
JR	07/19/11	1174816	90	30	Diaz	08/13/11	1174816	90	30	Diaz	5
JR	08/13/11	1174816	90	30	Diaz	09/07/11	1174816	90	30	Diaz	5
RS	06/28/11	1175121	300	30	Diaz	07/22/11	1176613	240	30	Diaz	6
RS	06/28/11	1175116	600	30	Diaz	07/22/11	1176610	600	30	Diaz	6
RS	06/28/11	1175113	120	30	Diaz	07/22/11	1176615	120	30	Diaz	6
ET	06/20/11	1173573	240	30	Diaz	07/13/11	1169455	240	30	Diaz	7
ET	12/27/11	1175542	240	30	Diaz	12/27/11	1175542	240	30	Diaz	6
CW	12/29/09	1130383	120	30	Diaz	01/20/10	1130383	120	30	Diaz	8
CW	01/19/10	1126967	60	30	Diaz	02/11/10	1141458	60	30	Diaz	7
CW	03/23/10	1144415	120	30	Diaz	04/13/10	1145891	120	30	Diaz	9
CW	04/13/10	1144415	120	30	Diaz	05/06/10	1144415	120	30	Diaz	7
CW	09/08/10	1154679	120	30	Diaz	10/01/10	1154679	120	30	Diaz	7

34. The table above compares the original prescription number on the left with the refilled prescription number on the right. The final column on the right shows the number of days early that the prescription was refilled, based on the number of days supply for the original prescription. This shows a consistent pattern of early refills of prescriptions for Dr. Diaz patients.

35. A review of the CURES data for Respondent Pharmacy shows that between January 1, 2011 and December 5, 2012, Respondent Pharmacy dispensed a total of 10,436 controlled substance prescriptions. Of these prescriptions, 12.99% of them, or 1,356, were controlled substance prescriptions from Dr. Diaz, despite not being one of the pharmacies adjacent to Dr. Diaz's medical office. When compared to three other pharmacies in the area (Federal Drugs PHY

37078 – 1.92 miles from Respondent Pharmacy, Rite Aid 5789 – 0.65 miles from Respondent Pharmacy, and CVS PHY 49473 – 0.41 miles from Respondent Pharmacy), Respondent Pharmacy dispensed an exponentially disproportionate number of Dr. Diaz's controlled substance prescriptions. In fact, of the neighboring pharmacies sampled, neither Federal Drugs nor Rite Aid dispensed any of Dr. Diaz's controlled substance prescriptions and CVS only dispensed 44 of his controlled substance prescriptions.

36. A review of CURES data for Respondent Pharmacy showed that between January 1, 2011 and December 5, 2012, Dr. Diaz had a clear pattern of prescribing controlled substances. His pattern was to prescribe Hydromorphone, HC/AP, Oxycontin, Oxycodone, Morphine, Opana ER, Fentanyl, Alprazolam, Methadone, Diazepam, Clonazepam, Lorazepam, and/or Oxy/Ap in large and redundant quantities and in questionable combinations. Nevertheless, Respondent Pharmacy filled prescriptions from Dr. Diaz's patients.

SECOND CAUSE FOR DISCIPLINE

(Records of Acquisition and Disposition)

37. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with Code section 4081 and Code section 4105, subdivision (a), on the grounds of unprofessional conduct in that Respondents were unable to account for the records of sale, acquisition, and/or disposition of dangerous drugs for at least three years from the date of making. Respondent Pharmacy could not account for prescription hard copies for the following prescriptions: RX #1152434, RX #1187257, RX #1184958, RX #1136283, RX #1183085, RX #1185522, RX #1185523, and RX #1171890.

THIRD CAUSE FOR DISCIPLINE

(Erroneous or Uncertain Prescriptions)

38. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct in that between January 1, 2010 and January 15, 2013, Respondent dispensed prescriptions which contained significant errors,

omissions, irregularities, uncertainties, ambiguities, or alterations. The facts and circumstances are as follows:

39. The following hard copy prescriptions had suspicious or no dates: (1) RX #1182583 was dated 10/7/68. The date was nonsensical. (2) RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have dates.

40. The following prescriptions were dispensed prior to the dates written on the prescriptions:

a) The hard copy of the prescription for RX #1176498 was dated July 22, 2011, but the prescription itself was dispensed on July 21, 2011.

b) The hardcopy of the prescription for RX #1156765 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

c) The hardcopy of the prescription for RX #1156766 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

d) The hardcopy of the prescription for RX #1156769 was dated September 18, 2011 but the prescription itself was dispensed on September 17, 2010.

e) The hardcopy of the prescription for RX #1175775 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

f) The hardcopy of the prescription for RX #1175776 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

g) The hardcopy of the prescription for RX #1175777 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

h) The hardcopy of the prescription for RX #1179567 was dated September 14, 2011 but the prescription itself was dispensed on September 9, 2011.

i) The hardcopy of the prescription for RX #1179202 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

j) The hardcopy of the prescription for RX #1179203 was dated October 1, 2011, but the prescription itself was dispensed on September 2, 2011.

k) The hardcopy of the prescription for RX # 1179204 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

41. The following prescriptions were dispensed without a signature from the prescriber: RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have Dr. Diaz's signature.

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 49809, issued to The Medicine Shoppe with Sanjiv Bhalla as the Pharmacist-In-Charge;

2. Revoking or suspending Pharmacist License Number RPH 46064, issued to Sanjiv Bhalla; and

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

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

DATED: 12/21/15

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

LA2014512773