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

In the Matter of the Accusation Against: **OMAC PHARMACY, INC.,** **dba OMAC PHARMACY,** **ROBERT ERIC VALUSEK,** CEO/TREASURER/CFO **AND** **PHARMACIST IN CHARGE;** APRIL VALUSEK, SECRETARY, 901 W. 7th Street Oxnard, CA 93030 Pharmacy Permit No. PHY 48314, **AND** **ROBERT ERIC VALUSEK** 195 Meadowlark Drive Alpine, Utah 84004 Pharmacist No. RPH 55766 Respondents.	Case No. 5371 **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 October 5, 2006, the Board of Pharmacy issued Pharmacy Permit Number PHY 48314 to Omac Pharmacy, Inc.; dba OMAC PHARMACY, Robert Eric Valusek, CEO/Treasurer/CFO, and April Valusek, Secretary (Respondent Pharmacy), with Robert Eric Valusek also designated as Pharmacist in Charge of Respondent Pharmacy. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on October 1, 2017, unless renewed.

3. On or about July 28, 2004, the Board of Pharmacy issued Pharmacist Number RPH 55766 to Robert Eric Valusek (Respondent Valusek). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on December 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 **118**, subdivision (b), of the Code provides that the suspension, expiration, surrender or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

6. Section **4300** of the Code states:

"(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.

"(c) The board may refuse a license to any applicant guilty of unprofessional conduct. The board may, in its sole discretion, issue a probationary license to any applicant for a license who is guilty of unprofessional conduct and who has met all other requirements for licensure. The board may issue the license subject to any terms or conditions not contrary to public policy, including, but not limited to, the following:

"(1) Medical or psychiatric evaluation.

"(2) Continuing medical or psychiatric treatment.

"(3) Restriction of type or circumstances of practice.

"(4) Continuing participation in a board-approved rehabilitation program.

"(5) Abstention from the use of alcohol or drugs.

"(6) Random fluid testing for alcohol or drugs.

"(7) Compliance with laws and regulations governing the practice of pharmacy.

"(d) The board may initiate disciplinary proceedings to revoke or suspend any probationary certificate of licensure for any violation of the terms and conditions of probation. Upon satisfactory completion of probation, the board shall convert the probationary certificate to a regular certificate, free of conditions.

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

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."

8. 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 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.

. . .

9. 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."

10. Section **4081** 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.

"(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.

"(c) The pharmacist-in-charge or representative-in-charge shall not be criminally responsible for acts of the owner, officer, partner, or employee that violate this section and of which the pharmacist-in-charge or representative-in-charge had no knowledge, or in which he or she did not knowingly participate."

11. Section **4105** of the 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."

12. Section **4306.5** of the 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."

13. Section **4307(a)** of the Code states that:

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 manger,

administrator, owner, member, officer, director, associate, or partner had knowledge 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 manger, 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.

14. Health and Safety Code section **11153** 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."

15. California Code of Regulations, title 16, section **1707.3** states:

"Prior to consultation as set forth in section 1707.2, a pharmacist shall review a patient's drug therapy and medication record before each prescription drug is delivered. The review shall include screening for severe potential drug therapy problems."

16. California Code of Regulations, title 16, section **1716** states, in part:

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

17. 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

18. Section **125.3** of the Code provides, in 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.

19. **DRUG CLASSIFICATIONS**

Brand Name(s)	Generic Name	Dangerous Drug [Bus.& Prof. Code § 4022]	Scheduled Drug [Health & Safety Code (HSC)]	Indications For Use
Ativan	Lorazepam 2mg	Yes	Schedule IV HSC § 11057(d)(16)	Anxiety
Dolophine	Methadone	Yes	Schedule II HSC § 11055(c)(14)	Pain, Narcotic Addiction
Dilaudid	Hydromorphone	Yes	Schedule II HSC § 11055(b)(1)(J)	Pain
Klonopin	Clonazepam 2mg	Yes	Schedule IV HSC § 11057(d)(7)	Anxiety
Norco[1], Vicodin ES, Lorcet	Hydrocodone/ acetaminophen (APAP)	Yes	Schedule III HSC § 11056(e)(4)	Pain

[1] Norco 10/325 mg contains 10 mg of hydrocodone and 325 mg of acetaminophen (brand name, Tylenol). The maximum recommended dosage for acetaminophen is four (4) grams or 4000 mg every 24 hours.

OxyContin	Oxycodone	Yes	Schedule II HSC § 11055(b)(l)(M)	Pain
Opana ER	Oxycodone	Yes	Schedule II HSC § 11055(b)(1)(N)	Pain
Oxy IR	Oxycodone 30 mg	Yes	Schedule II HSC § 11055(b)(1)(M)	Pain
Subutex, Suboxone	Buprenorphine	Yes	Schedule V HSC § 11058(d)	Narcotic Addiction
Valium	Diazepam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(9)	Anxiety
Xanax	Alprazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(1)	Anxiety

FACTUAL SUMMARY

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

A. At all times relevant herein, Respondent Robert Eric Valusek was Pharmacist-in-Charge of the retail pharmacy owned and operated by OMAC Pharmacy Inc., dba OMAC Pharmacy (Respondent Pharmacy), located at 901 West 7th Street, in the city of Oxnard, CA.

Background

B. Beginning in approximately January 2013, the Board initiated an investigation of Respondent Pharmacy.

C. On or about January 5, 2012, the Board was notified that Dr. Julio Gabriel Diaz also known as Otero Julio Gabriel Diaz, MD (Dr. Diaz) was arrested on federal painkiller trafficking charges. He was linked to a string of drug overdose deaths. Dr. Julio Diaz, a General Practice physician with secondary practice areas in Geriatrics and Pathology, operated Family Medical Clinic, located at 510 Milpas Street, Santa Barbara, CA 93103. Respondent Pharmacy dispensed numerous prescriptions for controlled substances written by Dr. Diaz, despite the fact that Respondent Pharmacy was located in Oxnard – a considerable distance from Dr. Diaz's office.

D. On or about January 18, 2012, pursuant to a criminal complaint filed in United States District Court, Dr. Diaz was charged with illegal distribution of controlled substances. The affidavit in support of the criminal complaint stated that Dr. Diaz wrote prescriptions for powerful painkillers, such as OxyContin, for "patients" who were drug addicts with no legitimate need for the drugs. Some of Dr. Diaz's "patients" diverted the pills they received to the black market and/or suffered fatal overdoses from the narcotics. [2]

E. Effective November 2, 2012, the California Medical Board revoked Dr. Diaz's medical license 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 committing gross negligence and incompetence and for excessive prescribing narcotic medications to a patient.

Inspection - January 9, 2013

F. On or about January 9, 2013, two Board inspectors conducted an unannounced inspection of Respondent Pharmacy. Respondent Valusek was on duty at the time of the inspection.

G. To investigate controlled substance dispensing practices of Respondents, Board inspectors selected 21 random patients of Dr. Diaz who filled their prescriptions at Respondent Pharmacy to profile and asked Respondent Valusek to complete questionnaires regarding these patients. Questions asked included the patients' diagnoses, the methods of payment, and the nature of the prescriber's practice. Board inspectors further obtained from Respondent prescription records of the 21 randomly selected patients for later analysis.

Corresponding Responsibility Analysis

H. As part of their investigation, Board inspectors also obtained and analyzed CURES[3] data for Respondent Pharmacy for the 21 randomly selected patients.

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[2] On August 28, 2015, following a jury trial, Dr. Diaz was found guilty in a federal District Court of more than 25 counts of felony drug trafficking offenses, in *United States of America v. Julio Gabriel Diaz* (U.S.D.C.(CA Central), criminal case no. 8:11MJ00636

[3] CURES is an acronym for "California Utilization Review and Evaluation System." It contains over 100 million entries of controlled substance drugs that were dispensed in California. Pharmacists and prescribers can register with the Department of Justice to obtain access to the CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an

(continued...)

I. In analyzing the controlled substance drug treatment and therapy regimen for the sample group of 21 patients, Inspectors found that Respondents routinely filled prescriptions despite key objective factors indicating the prescriptions were not legitimate, or circumstances that should have caused Respondents to question and investigate the prescription's legitimacy:

J. The CURES data for Respondent Pharmacy revealed that Respondents dispensed a total of 24,949 controlled substance prescriptions from January 1, 2010 through December 5, 2012. During this period, Respondent Pharmacy dispensed 2,732 controlled substance prescriptions written by Dr. Diaz, which represented 10.95 % of the total controlled substance prescriptions dispensed by the pharmacy. Dr. Diaz was the pharmacy's largest controlled substance prescriber for a total of 442,539 dosage units dispensed.

K. **Prescribing Pattern of Dr. Diaz** - The CURES data for Respondent Pharmacy also showed Dr. Diaz's questionable prescribing pattern. Dr. Diaz normally prescribed large quantities of opiates in combination with one or more anti-anxiety agents (e.g. tranquilizers).The usual combination included hydromorphone, hydrocodone/acetaminophen, oxycodone, methadone, fentanyl, OxyContin, morphine sulfate with either alprazolam, clonazepam, lorazepam, and/or diazepam in large quantities. He typically prescribed on average 3 to 4 opiate medications with 1 to 2 anxiolytic medication prescriptions to his patients. The table below contains a list of selected drugs and the average quantities of those drugs prescribed by Dr. Diaz and dispensed by Respondent pharmacy for the one year period of January 1, 2011 to January 9, 2012.

Drug	Avg. qty prescribed by Dr. Diaz (1/1/2011 to 1/9/2012)
Hydrocodone/APAP 10/325mg	231
Oxycodone 30mg	190
Methadone 10mg	213
Alprazolam 2mg	100
Hydromorphone 8mg	135

(...continued)
individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to report to the California Department of Justice every schedule II, II and IV drug prescription under Health and Safety Code section 1165, subdivision (d).

Diazepam 10mg	110

L. Payment Method – In cases of drug diversion, medications are often purchased for cash (cash, debit card or credit card) from the pharmacy without the use of insurance in order to avoid tracking of activity. If the 'patients" are fictitious, there is no insurance to bill. In the instant case, Board Inspectors found that of the 24,949 controlled substance prescriptions dispensed, approximately 34.24% were for cash patients.[4]

M. **Distance Traveled**- The "common trading area" in this part of California is estimated by Board staff to be approximately 5 miles, due to the ready accessibility of pharmacies. Analysis of the 21 patients' records showed that the total distance these patients travelled to obtain controlled substances was objectively and clearly excessive. Using reported home addresses, Inspectors calculated that the distances travelled from patients' home to doctor's office and home to pharmacy ranged from 73.42 to 207.4 miles – with an average distance of 90.76 miles.

N. **Pattern of Early Refills** – Inspectors noted a consistent pattern of early refills with prescriptions for Dr. Diaz's patients.

O. **Continuing Omissions** – In review and analysis of CURES data and prescription records of the 21 sample patients, Board inspectors identified several continuing problems with Respondents' handling of medical legitimacy issues, including the following:

(1) **Diaz was General Practitioner** - Nearly all of the Diaz prescriptions reviewed for the sample patients were for pain or anxiety medications. In his patient questionnaires, Respondent Valusek incorrectly identified Dr. Diaz as a pain management prescriber, and indicated his belief that what Diaz prescribed was appropriate for his practice. In fact, Dr. Diaz was a general practice physician with a secondary practice in

[4] In cases of drug diversion, most of the medications purchased from a pharmacy are purchased without the use of insurance to avoid tracking of activity. If the patients are fictitious persons, there is no insurance to bill. The bypassing of insurance is commonly referred to as "paying cash." Frequently, the medications are purchased with actual money but "paying cash" could also mean using a debit or credit card. The use of electronic payment is rare for the same reason drug diverters avoid using insurance.

geriatrics and pathology.

(2) **Inability to use CURES reports** - At the time of the January 2013 inspection, Respondent Valusek advised Inspectors that he had not signed up for the California Prescription Drug Monitoring Program (PDMP) until March, 2012. Therefore, CURES Patient Activity Reports (PARs) (reflecting all controlled substances dispensed to an individual, pharmacies and physicians visited), a useful tool in meeting Respondents' responsibility to determine medical legitimacy prior to dispensing, was not available for use or review by Respondents prior to March, 2012.

(3) **No Drug Therapy Records** -The pharmacy did not maintain files or notes to monitor the drug therapy of its own patients.

Review and Analysis of Sample Patient Records

P. In review and analysis of CURES data and prescription records of the 21 sample patients by Board inspectors revealed that Respondents routinely ignored key objective factors which should have caused them to investigate or challenge the medical legitimacy of prescriptions. Examples are provided as follows:

(1) **Patient MB**

Patient MB saw 6 prescribers and went to 6 different pharmacies from 1/1/2009 to 4/5/2013. MB had no history of anxiety 22 months prior to 9/2010, so starting treatment with diazepam 10mg, the highest dose of diazepam tablet available, is questionable. Additionally, Respondent did not provide prescription hard copies for **RX#6239683, 6266004 and 6275829**

(2) **Patient CB**

Patient CB saw 8 prescribers and went to 15 pharmacies from 1/1/2009 to 4/5/2013. CB had no known history of pain or anxiety for 6 months prior to 6/3/2009, so starting with oxycodone 30mg, Oxycotin 40mg, methadone 10mg, HC/AP 10/325mg and alprazolam 2mg, for a "narcotic naïve" patient is questionable.

Further, Omac Pharmacy dispensed RX#2002854, 2003195, 2003265, 2004108 for Oxycontin above the recommended dosing interval of twice daily. Review of CB's profile from

Omac Pharmacy revealed he received most of his pain medication from Dr. Diaz, though Diaz was not a pain specialist.

Additionally, Respondents did not provide prescription hardcopies **for Rx#2002918, 2002919, 2002920, 2002990 , 2002991, 2002992 and 6270192.**

(3) **Patient SG**

SG saw 9 different prescribers and went to 29 different pharmacies from 1/1/2009 to 4/5/2013. Review of CURES reports revealed that SG received multiple prescriptions for HC/AP 10/325mg on or about the same time all prescribed by Dr. Diaz, which he filled at numerous pharmacies as listed below:

Date	Drug	RX#	Pharmacy	Notes
06/06/2011	HC/AP 10/325 #300	6291463	**Omac Phy**	SG was prescribed 540-1200 tablets of HC/AP within 1 month/30 days. SG received 55-105 day's supply within 30 day time.
06/18/2011	HC/AP 10/325 #240	507941	Studio City Phy	LC received 6,500-14,950mg/day of acetaminophen
07/12/2011	HC/AP 10/325 #300	1432422	Rite Aid 5452	The maximum recommended dose of acetaminophen is 4,000mg/day
7/20/2011	HC/AP 10/325 #240	6296360	**Omac Phy**	
08/04/2011	HC/AP 10/325 #300	6296360	**Omac Phy**	
08/10/2011	HC/AP 10/325 #300	1432422	Rite Aid 5452	
9/1/2011	HC/AP 10/325 #300	6296360	**Omac Phy**	
9/4/2011	HC/AP 10/325 #300	1074034	Walgreens 6700	
9/7/2011	HC/AP 10/325 #300	566153	Rite Aid 5542	
9/13/2011	HC/AP 10/325 #00	1074034	Walgreens 6700	

Additionally, the following prescriptions dispensed to SG by Omac Pharmacy were questionable:

(a) **RX#6284830** for Diazepam 10mg with a direction of 2-3 tablets every 6 hours (Note: the high dose) Usual diazepam dosage as an anti-anxiety agent is 2mg-

10mg 2-4 times daily. SG received 20-30mg every 6 hours.

(b) **RX#2005972** for methadone had an unclear date on the prescription document and should have been questioned by the pharmacy before dispensing.

(4) **Patient SH**

SH had no significant pain history 2 years prior to 3/9/2011. For Dr. Diaz to start treatment with oxycodone 30mg, HC/AP 10/325mg, and methadone 10mg, for an "opioid naïve" patient is questionable. Similarly, SH also had no significant anxiety history 2.5 years prior to 7/1/2011. For Dr. Diaz to start treatment with alprazolam 2mg, at the highest available dose is questionable.

(5) **Patient DH**

DH saw 6 prescribers and went to 15 pharmacies from 1/1/2009 to 4/5/2013. Review of this patient's PAR report revealed that DH received multiple prescriptions for HC/AP 10/325mg and alprazolam 2mg on or around the same time all prescribed by Dr. Diaz. DH went to numerous pharmacies to have them dispensed.

Date	Drug	RX#	Pharmacy	Notes
11/8/2010	HC/AP 10/325 #240	6259009	**Omac Phy**	DH was prescribed 480-800 tablets of HC/AP within 1 month/30 days. DH received 60 day worth of supply within 30 day time frame.
11/19/2010	HC/AP 10/325 #240	149894	Farmacia Estrella	DH received 5,200-7,800mg/day of acetaminophen
3/3/2011	HC/AP 10/325 #240	6259009	**Omac Phy**	The maximum recommended dose of acetaminophen is 4,000mg/day
3/14/2011	HC/AP 10/325 #280	170012	Farmacia Estrella	
3/31/2011	HC/AP 10/325 #280	170012	Framacia Estrella	
11/18/2010	Alprazolam 2mg #150	6259010	**Omac Phy**	DH was prescribed 300-450 tablets of alprazolam 2mg within 22 days, ZG received 51-76 day's supply within 22 day time frame.
11/19/2010	Alprazolam 2mg #150	149892	Farmacia Estrella	
11/30/2010	Alprazolam 2mg #150	262238	Taft Phy	
3/3/2011	Alprazolam	6271544	**Omac Phy**	

	2mg #150			
3/14/2011	Alprazolam 2mg #150	170010	Farmacia Estrella	

The pharmacy did not provide prescription hardcopies for Rx # 6266924, and 6271544.

(6) **Patient MH**

MH saw 26 prescribers and went to 19 pharmacies from 1/1/2009 to 4/5/2013. Review of the PAR for this patient revealed that MH received multiple prescriptions for methadone 10mg HC/AP 10/325mg and oxycodone 30mg around the same time, then went to numerous pharmacies to have them dispensed.

Date	Drug	RX#	Pharmacy	Notes
3/7/2011	Methadone 10mg #120	171648	Farmacia Estrella	MH was prescribed 240-540 tablets of methadone within 10 days. MH received 60 days supply within 10 day time frame.
3/15/2011	Methadone 10mg #120	2005206	**Omac Phy**	
6/21/2011	Methadone 10mg #300	2005868	**Omac Phy**	
7/1/2011	Methadone 10mg #240	183508	Farmacia Estrella	
5/2/2011	Oxycodone 30mg #300	176686	Farmacia Estrella	MH was prescribed 600-7250 tablets of oxycodone within 30 days. MH received 60 day's supply within 30 day time frame.
5/21/2011	Oxycodone 30mg #300	2005676	**Omac Phy**	
7/1/2011	Oxycodone 30mg #300	183506	Farmacia Estrella	
7/28/2011	Oxycodone 30mg #300	2006151	**Omac Phy**	
5/25/2011	HC/AP 10-325mg #300	6297170	**Omac Phy**	MH was prescribed 600 tablets of HC/AP within 10 days. MH received 50 day worth of supply within 10 day time frame.
5/27/2011	HC/AP 10-325mg #300	174316	Farmacia Estrella	MH received 7,800mg/day of acetaminophen
11/8/2011	HC/AP 10-325mg #300	192365	Farmacia Estrella	The maximum recommended dose of acetaminophen is 4,000mg/day
11/10/2011	HC/AP 10-325mg	6313819	**Omac Phy**	Note: MH had HC/AP dispensed at least 2 different pharmacies all of

	#300			2011
12/1/2011	HC/AP 10-325mg #300	192365	Farmacia Estrella	
12/01/2011	HC/AP 10-325mg #300	6324116	**Omac Phy**	

The pharmacy did not provide prescription hardcopies for **RX # 2007157.**

(7) **Patient DL**

DL saw only Dr. Diaz and went to two pharmacies from 1/1/2009 to 4/5/2013, Omac Pharmacy and Farmacia Estrella. Review of this patient's PAR revealed that he received multiple prescriptions for HC/AP 10/25mg and alprazolam 2mg on or around the same time, all prescribed by Dr. Diaz.

Date	Drug	Rx#	Pharmacy	Notes
5/23/2009	HC/AP 10/325mg #240	6169592	**Omac Phy**	DL received 480 tablets of HC/AP within 10 days. DL received 60 days supply within 10 day time frame.
5/28/2009	HC/AP 10/325mg #240	114793	Farmacia Estrella	DL received 5,200mg/day of acetaminophen
1/26/2010	HC/AP 10/325mg #240	134415	Farmacia Estella	The maximum recommended dose of acetaminophen is 4,000mg/day
1/26/2010	HC/AP	6215106	**Omac Phy**	
	10/325mg #240			
6/19/2010	HC/AP 10/325mg #240	6226814	**Omac Phy**	
6/25/2010	HC/AP 10/325mg #240	145891	Farmacia Estrella	
1/9/2011	HC/A 10/325mg #240	160310	Framacia Estrella	
1/13/2011	HC/A 10/325mg #240	6254272	**Omac Phy**	
7/28/2009	Alprazolam 2mg #100	114795	Farmacia Estrella	DL received 200-220 tablets of alprazolam 2mg within 7 days
7/31/2009	Alprazolam 2mg #100	6184953	**Omac Phy**	DL received 50-55 days supply within 7 day time frame.
11/13/2010	Alprazolam 2mg #100	6254273	**Omac Phy**	
11/19/2010	Alprazolam 2mg #120	160311	Farmacia Estrella	
1/6/2011	Alprazolam 2mg	160311	Farmacia	

	#120		Estrella	
1/13/2011	Alprazolam 2mg #100	6254273	**Omac Phy**	

(8) **Patient DP**

DP saw 24 prescribers and went to 8 pharmacies form 1/1/2009 to 4/5/2013.Omac Pharmacy dispensed the following prescriptions for Oxycontin and Opana ER above the recommended dosing internal of twice daily: RX # 2003405, 2003575, 2003783, 2004100, 2003078, 2006091, 2006314, 2006559, 2007057, 2006778, 2007280, 2005504, 2005693, 2005344, 2005062, 2004734, 2004581, 2005862.

Review of DP's profile revealed DP received mostly pain and anxiety medication from Dr. Diaz, despite Dr. Diaz not being a pain specialist. DP usually paid cash for medications – and on numerous occasions paid over $2500.00 cash to have her Oxycontin prescription filled.

The pharmacy did not provide prescriptions hardcopies of **Rx # 2006314, 2002965, 6266058, 6270130 and 6266057.**

(9) **Patient LR**

LR saw 3 prescribers and went to 9 pharmacies from 1/1/2009 to 4/5/2013, LR saw prescribers in Oxnard and Santa Barbara and went to pharmacies in Oxnard and Ventura.

Prior to going to Omac Pharmacy, LR went to multiple pharmacies and Dr. Diaz. While going to Omac Pharmacy, LR continued to go to multiple pharmacies and Dr. Diaz.

Review of LR CURES PAR report also revealed, LR received multiple prescriptions for HC/AP 10/325 and alprazolam 2mg on or around the same time all prescribed by Dr. Diaz. LR went to numerous pharmacies to have them dispensed.

Date	Drug	RX#	Pharmacy	Notes
5/07/2010	HC/AP 10/325mg #200	1213310	Leon's Phy	LR received 400-500 tablets of HC/AP within 30 days. LR received 55-75 day's supply within 30 day time frame.
5/13/2010	HC/AP 10/325mg #200	6224915	**Omac Phy**	LR received 4,550-6,175mg/day of acetaminophen.
11/15/2010	HC/AP 10/325mg	6253379	**Omac Phy**	The maximum

	#200			recommended dose of acetaminophen is 4,000mg/day
11/26/2010	HC/AP 10/325mg #100	150759	Farmacia Estrella	
11/29/2010	HC/AP 10/325mg #200	1224071	Leon's Phy	
1/14/2011	Alprazolam 2mg #100	165774	Farmacia Estrella	LR received 200 tablets of alprazolam within 30 days.
1/20/2011	Alprazolam 2mg #100	6274550	**Omac Phy**	LR received 50 day supply within 30 day time frame.
4/9/2011	Alprazolam 2mg #100	6274550	**Omac Phy**	
4/22/2011	Alprazolam 2mg #100	176223	Farmacia Estrella	Note: this practice of LR received HC/AP and alprazolam from Dr. Diaz and multiple pharmacies occurred on numerous months from 2009 thru 2011.

Omac Pharmacy dispensed the following prescriptions of Oxycontin above the recommended dosage interval: RX#2002780, 2003151, and 2003293

The pharmacy did not provide prescriptions hardcopies for **Rx #2002968, 2002969 and 2002970.**

(10) **Patient AS**

AS saw 10 prescribers and went to 14 pharmacies from 1/1/2009 to 4/5/2013. While going to Omac Pharmacy, AS went to numerous prescribers and pharmacies.

AS was prescribed Suboxone, used for treatment of narcotic addiction, prior to Dr. Diaz. AS was also prescribed Subutex, indicated for treatment of narcotic addiction, by Dr. Diaz.

Review of AS PAR also revealed, AS received multiple prescriptions of HC/AP 10/325mg on or around the same time all prescribed by Dr. Diaz.

Date	Drug	RX#	Pharmacy	Notes
7/1/2011	HC/AP 10/325mg #300	183488	Farmacia Estrella	AS received 500-1,040 tablets of HC/AP within 30 days. AS received 50-104 days'

				supply within 30 day time frame.
7/08/2011	HC/AP 10/325mg #300	6285428	**Omac Phy**	AS received 6,500-13,000mg/day of acetaminophen.
7/9/2011	HC/AP 10/325mg #140	6285428	**Omac Phy**	The maximum recommended dose of acetaminophen is 4,000mg/day.
7/28/2011	HC/AP 10/325mg #300	6306202	**Omac Phy**	
10/18/2011	HC/AP 10/325mg #200	6317458	**Omac Phy**	
10/26/2011	HC/AP 10/325mg #300	183488	Farmacia Estrella	

Omac Pharmacy dispensed the following prescriptions in which the date was not in prescriber's handwriting RX # 2006626, 2006625, 2006624.

The pharmacy did not provide prescription hardcopies for **Rx # 6264331 and 6318508.**

(11) **Patient JT**

JT went to multiple pharmacies and prescribers while going to Omac Pharmacy.

Omac Pharmacy dispensed the following questionable prescriptions:

RX # 6300131—JT received 5200 mg of acetaminophen

RX # 2006722, 2006723—date not written by prescriber

RX # 2005253 and 2005333—JT received 2 prescriptions for oxycodone on the same day.

RX # 2004946 and 2004863—JT received 2 prescriptions for oxycodone on the same day.

The pharmacy did not provide prescription hardcopies **for RX # 2002997 and 2002998.**

(12) **Patient CV**

CV saw 2 prescribers and went to 7 pharmacies from 1/1/2009 to 4/5/2013.

Review of this patient's PAR revealed that CV received multiple prescriptions for HC/AP 10/325mg on or around the same time all prescribed by Dr. Diaz, and went to multiple pharmacies to have them dispensed.

Date	Drug	RX#	Pharmacy	Notes

12/11/2009	HC/AP 10/325mg #240	128127	Farmacia Estrella	CV received 360-480 tablets of HC/AP within 10-15 days. CV received 60 day's supply within 10-15 day time frame.
12/24/2009	HC/AP 10/325mg #240	6210279	**Omac Phy**	CV received 5,200mg of acetaminophen per day.
9/18/2010	HC/AP 10/325mg #240	6254220	**Omac Phy**	
9/28/2010	HC/AP 10/325mg #120	C5005164	The Medicine Shoppe	Note: CV received HC/AP from Dr. Diaz and dispensed at multiple pharmacies occurred most months in 2010
11/16/2010	HC/AP 10/325mg #240	1223569	Leon's Phy	
11/26/2010	HC/AP 10/325mg #240	6254220	**Omac Phy**	
1/5/2011	HC/AP 10/325mg #240	72656	Walgreens 11707	
1/20/2011	HC/AP 10/325mg #240	6254220	**Omac Phy**	

Omac Pharmacy dispensed the following questionable prescriptions:

RX # 2004938 and 2004921 - 2 prescriptions for Oxydocone written on the same day.

RX # 2003051 written on 7/9/2009 and dispensed on 2/25/2010.

CV also was dispensed Suboxone and Subutex, indicated for opiate addiction, prescribed by Dr. Diaz in addition to the above medications.

(13) **Patient SV**

SV only saw Dr. Diaz in Santa Barbara and went to 2 pharmacies from 1/1/2009 to 4/5/2013. She went to pharmacies in Oxnard and Ventura.

While going to Omac Pharmacy, SV also went to Farmacia Estrella to have prescriptions by Dr. Diaz dispensed.

Review of PAR also revealed, SV received multiple prescriptions for HC/AP 10/325mg and alprazolam 2mg on or around the same time all prescribed by Dr. Diaz. SV went to two pharmacies to have them dispensed.

Date	Drug	RX#	Pharmacy	Notes
3/1/2011	HC/AP 10/325mg #300	6282935	**Omac Phy**	SV received 540-840 tablets of HC/AP within 30 days. SV received 60-90 days supply within 30 day time frame.
3/8/2014	HC/AP 10/325mg #240	160605	Farmacia Estrella	SV received 5,850-6,500mg of acetaminophen per day.
8/2/2011	HC/AP 10/325mg #300	6294631	**Omac Phy**	
8/10/2011	HC/AP 10/325mg #240	186733	Farmacia Estrella	
8/30/2011	HC/AP 10/325mg #300	6310459	**Omac Phy**	
3/8/2011	Alprazolam 2mg #90	160602	Farmacia Estrella	SV received 190 tablets of alprazolam within 10 days.
3/15/2011	Alprazolam 2mg #100	6273691	**Omac Phy**	SV received 55 day supply within 10 day time frame
5/9/2011	Alprazolam 2mg #90	177783	Farmacia Estrella	
5/10/2011	Alprazolam 2mg #100	6294628	**Omac Phy**	
7/1/2011	Alprazolam 2mg #100	6294628	Omac Phy	Notes: SV received HC/AP and alprazolam from Dr. Diaz and dispensed at multiple pharmacies occurred most months in 2011 as summarized in Exhibit 33 pages 5-6
7/6/2011	Alprazolam 2mg #90	177783	Farmacia Estrella	

SV was also known as Sylvia R. (different last name and had a different date of birth 1/10/1976. SV pharmacy patient profile had a date of birth of 5/18/1976. In addition, SV/SR had two medical record numbers at the prescriber's office.

FIRST CAUSE FOR DISCIPLINE

(Failure to Assume Corresponding Responsibility)

21. Respondent OMAC Pharmacy and Respondent Valesek are subject to discipline

pursuant to Code section 4300 for unprofessional conduct as defined in section 4301, subdivision (d), (j) and (o), in conjunction with sections 4302, and 4113, in that on dates approximately between January 9, 2010 and April 1, 2013, Respondents failed to assume their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose, in violation of Code section 4306.5, Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, subdivision (b). Based on evidence reviewed by Board Inspectors, including but not limited to records of patients, MB, CB, SG. SH, DH, MH, DL, DP, LR, AS, JT, CV and SV, Respondents routinely ignored numerous warning signs or red flags that should put a reasonable and prudent dispensing pharmacist on notice that a prescription may not have been legitimate, including but not limited to the prescribing pattern of Dr. Diaz, cash payments, distance traveled and pattern of early refills. Respondents additionally failed use or access readily available tools such as CURES reports and its own pharmacy records, to meet their corresponding responsibility.

SECOND CAUSE FOR DISCIPLINE

(Failure of Respondent Pharmacist to Exercise Best Professional Judgment)

22. Respondent Valesek is subject to disciplinary action under Business and Professions Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with section 4306.5 subdivisions (b), in that on dates approximately between January 9, 2010 and April 1, 2013, as an owner and/or pharmacist in charge and/or dispensing pharmacist, Respondent failed to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, in connection with Dr. Diaz's controlled substance prescriptions. Allegations of paragraphs 19 and 20 above are realleged as though fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Required Records)

24. Respondent OMAC Pharmacy and Respondent Valesek are subject to disciplinary action under Business and Professions Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4081, subdivisions (a) and

(b) and 4105, subdivision (a), by failing to maintain the required records of sale, acquisition and disposition of dangerous drugs. Specifically, Respondents failed to account for prescription hard copies for RX# 6239683, 6266004, 6275829, 2002918, 2002919, 2002920, 2002991, 2002990, 2002992, 6270192, 6268131, 6266924, 6274544, 2007157, 2002965, 6266058, 6270130, 6266057, 2002968, 2002969, 20022970, 6264331, 6318058, 2002997 and 2002998, which Respondents dispensed approximately between January 9, 2010 and January 1, 2013.

OTHER MATTERS

25. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number Permit Number PHY 48314 issued to Omac Pharmacy, Inc.; dba Omac Pharmacy, Omac Pharmacy, Inc. 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 48314 is placed on probation or until PharmacyPermit Number PHY 48314 is reinstated if it is revoked.

26. Pursuant to Code section 4307, if discipline is imposed on Permit Number PHY 48314 issued to Omac Pharmacy, Inc. while Robert Eric Valusek has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Robert Eric Valusek 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 48314 is placed on probation or until Pharmacy Permit Number PHY 48314 is reinstated if it is revoked.

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 48314, issued to Omac Pharmacy, Inc.; dba Omac Pharmacy, Robert Eric Valusek, CEO/Treasurer/CFO, and April Valusek, Secretary;

2. Revoking or suspending Pharmacist Number RPH 55766, issued to Robert Eric

Valusek;

3. Prohibiting Omac Pharmacy, Inc. from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 48314 is placed on probation or until Pharmacy Permit Number PHY 48314 is reinstated if Pharmacy Permit Number PHY 48314 issued to Omac Pharmacy, Inc. is revoked;

4. Prohibiting Robert Eric Valusek from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 48314 is placed on probation or until Pharmacy Permit Number PHY 48314 is reinstated if Pharmacy Permit Number PHY 48314 issued to Omac Pharmacy, Inc. is revoked;

5. Ordering Omac Pharmacy, Inc. dba Omac Pharmacy, Robert Eric Valusek, CEO/Treasurer/CFO, and April Valusek, Secretary 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;

6. Ordering Robert Eric Valusek 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;

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

DATED: 2/4/17

Virginia Herold

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

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