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

In the Matter of the Accusation Against: **MATS PHARMACY INC. DBA MATS PHARMACY AND MEDICAL SUPPLIES, BANJI ALADE ADERETI AND FUMNI MOJISOLA ADERETI, OWNERS** 3625 Martin Luther King Jr. Blvd., Ste. 1 Lynwood, CA 90262-3509 BANJI ALADE ADERETI, Pharmacist-in-Charge **Original Permit No. PHY 49180** **BANJI ALADE ADERETI** PO Box 1136 Placentia, CA 92670 **Original Pharmacist License No. RPH 45057** Respondents.	Case No. 5576 **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 17, 2008, the Board of Pharmacy issued Original Permit Number PHY 49180 to Mats Pharmacy Inc. doing business as Mats Pharmacy and Medical Supplies with Banji Alade Adereti as the Pharmacist-in-Charge, President and the owner of fifty percent of the

outstanding shares and Fumni Mojisola Adereti as the Secretary and the owner of fifty percent of the outstanding shares ("Respondent Pharmacy"). The Original Permit was in full force and effect at all times relevant to the charges brought herein and will expire on October 1, 2016, unless renewed.

3. On or about March 5, 1992, the Board of Pharmacy issued Original Pharmacist License Number RPH 45057 to Banji Alade Adereti ("Respondent Adereti"). The Original Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2017, unless renewed.

JURISDICTION

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

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

6. Section 4300.1 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

7. Section 4022 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.

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"(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."

8. Section 4036.5 states: "Pharmacist-in-charge" means a pharmacist proposed by a pharmacy and approved by the board as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

9. Section 4301 states:

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

....

"(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."

10. Section 4307 states, in pertinent part:

"(a) Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner, member, officer, director, associate, or partner of

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

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

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

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."

REGULATORY PROVISION

12. 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.

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"(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

13. Section 125.3 states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

14. Alprazolam, brand name Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

15. Carisoprodol, brand name Soma, is a Schedule IV controlled substance pursuant to Code of Federal Regulations, title 21, section 1308.14, subdivision (c)(6), and a dangerous drug pursuant to Business and Professions Code section 4022, as of January 11, 2012.

16. Diazepam, brand name Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9), and a dangerous drug pursuant to Business and Professions Code section 4022.

17. Norco, a combination product containing the controlled substance hydrocodone and non-narcotic acetaminophen, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Promethazine with codeine syrup is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, subdivision (c)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

19. Vicoden, a combination product containing the controlled substance hydrocodone and non-narcotic acetaminophen, is a Schedule III controlled substance pursuant to Health and Safety

Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Business and Professions Code section 4022.

FACTUAL BACKGROUND

20. On or about May 29, 2014, the Board initiated an investigation into Respondent Pharmacy and Respondent Adereti (collectively, "Respondents") following receipt of correspondence from Cardinal Health, a pharmaceutical distribution company, stating that the company had suspended Respondent Pharmacy from ordering controlled substances because the company determined that continued sales would create an unreasonable risk of potential diversion.

21. A Board Inspector reviewed CURES[1] data for all controlled substances that were dispensed at Respondent Pharmacy, as reported by Respondent Pharmacy, between October 19, 2011, and October 30, 2014. The Board Inspector reviewed hard copies of prescriptions filled at Respondent Pharmacy and Respondent Pharmacy's electronic computer records of dispensed prescriptions, amongst other documents. The Board Inspector also interviewed Pharmacist-in-Charge Respondent Adereti.

22. The Board Inspector's review identified factors of irregularity or red flags consistent with illegitimate doctor prescribing and indiscriminate pharmacy dispensing. These red flags included initial prescriptions written for strong dosages of opiates (in contrast to an initial prescription at a lower dose, which is slowly raised to a higher dose); some patient profiles showed the patient using prescription insurance for non-controlled substances yet paying with cash for controlled substances (a review of Patient Activity Reports identified doctor shopping patterns for these patients); and, Respondents also filled prescriptions in which groups of the same or similar prescriptions were processed together, a factor of irregularity because it is unusual to have several patients with the same diagnoses, all requiring the same drug therapy, to arrive in the pharmacy at

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

once. These red flags either gave, or should have given, Respondent Pharmacy and Respondent Adereti sufficient information to identify potential problems with the prescriptions, and put them on notice to conduct further inquiries into the legitimacy of the prescriptions.

FIRST CAUSE FOR DISCIPLINE

(Filling Erroneous Prescriptions and Failure to Assume Corresponding Responsibility in Legitimacy of Prescriptions)

23. Respondents are subject to disciplinary action under section 4301, subdivisions (d), (j), and (o), in conjunction with Health and Safety Code section 11153, subdivision (a), and California Code of Regulations, title 16, section 1761, in that Respondents failed to comply with their corresponding responsibility to only fill medically legitimate prescriptions, by failing to review patients' drug history and by dispensing erroneous/uncertain prescriptions. The circumstances include the presence of multiple red flags for irregular prescriptions coming from both the statistics of a prescribing doctor as well as and from patients who sought early refills.

A. Excessive Cash Payments

24. Respondent Pharmacy dispensed 100,312 medications between October 29, 2011, and October 30, 2014. Of these, 60,267, or 60.08%, were for non-controlled substances and 40,045, or 39.92%, were for controlled substances. While 91% of the non-controlled substances were billed to an insurance plan, only 45% of controlled substances were billed to insurance. The much higher rate at which patients paid cash for controlled substances is a red flag because patients want to receive financial assistance from insurance, but insurance companies will deny payment if a patient is attempting to purchase an excessive amount of medication, or has previously purchased the same medication at another pharmacy within a short period of time.

B. Irregular Prescriptions

25. Respondent Pharmacy dispensed 13,592 prescriptions written by Dr. E.R. between October 29, 2011, and October 30, 2014. 80.29% of those prescriptions were for controlled substances while 19.71% were for non-controlled substances. Furthermore, over 75% (or 10,275) of Dr. E.R's prescriptions filled at Respondent Pharmacy were for Carisoprodol 350 mg, alprazolam 2 mg, or hydrocodone combinations. None of the hydrocodone combinations

contained the lower strength, 5 mg, of hydrocodone and all of the alprazolam prescriptions were for 2 mg. Of the controlled substance prescriptions written by Dr. E.R., 93.9% showed cash as the payment, thus those patients received no financial assistance from insurance.

26. Many of the prescriptions written by Dr. E.R. and filled at Respondent Pharmacy showed instances in which groups of the same or similar prescriptions were processed together. This is a red flag because it is unusual to have several patients with the same diagnoses, requiring the same drug therapy, arriving at the pharmacy at the same time. Some examples are as follows:

a. On February 1, 2013, per pharmacy records, between 10:52 a.m. and 11:30 a.m., Respondent Pharmacy entered twelve new prescriptions, for seven patients, that were written by Dr. E.R. Pharmacy dispensing software assigns prescription numbers consecutively as prescriptions are processed. Thus, between the relevant time period, every new prescription entered by the pharmacy was written by Dr. E.R.[2] All twelve of the prescriptions were either for Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750. For the patients that had two prescriptions, they had a prescription for each of the referenced controlled substances. It is a red flag for a pharmacy to create twelve new sequential prescriptions for seven different patient from the same doctor, and to have all of those prescriptions be for the same two controlled substances, within such a short period of time.

b. On July 5, 2012, per pharmacy records, between 6:12 a.m. and 6:41 a.m., Respondent Pharmacy entered thirteen prescriptions, for thirteen different patients, written by Dr. E.R. Ten of the prescriptions were newly entered by Respondent Pharmacy with sequential prescription numbers. Thus, between the relevant time period, every new prescription entered by the pharmacy was written by Dr. E.R. All thirteen of the prescriptions were either for Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750. Additionally, two of the patients who had their prescriptions entered (as refills) within one minute of each other had sequential prescription numbers for the same prescription, Hydrocodone/APAP, indicating that they also had their original prescriptions

[2] As pharmacy dispensing software only creates a prescription number for a new prescription, Respondent Pharmacy may have entered or filled refills for old prescriptions during this time period.

first entered by Respondents sequentially. It is a red flag for a pharmacy to enter thirteen prescriptions from the same doctor for the same two controlled substances and for a pharmacy to sequentially enter ten new prescriptions for the same two controlled substances from the same doctor all within such a short time period.

c. On September 12, 2012, per pharmacy records, between 10:55 a.m. and 11:02 a.m., Respondent Pharmacy entered seven prescriptions, for seven different patients, written by Dr. E.R. Six of the prescriptions were newly entered by Respondent Pharmacy with sequential new prescription numbers. Thus, between the relevant time period, every new prescription entered by the pharmacy was written by Dr. E.R. All seven of the prescriptions were for Carisoprodol 350 mg. It is a red flag for a pharmacy to enter seven prescriptions from the same doctor for the same controlled substance and for a pharmacy to sequentially enter six new prescriptions for the same controlled substances from the same doctor all within such a short time period.

d. On July 6, 2012, per pharmacy records, between 6:45 a.m. and 6:52 a.m., Respondent Pharmacy entered ten prescriptions, for nine different patients, written by Dr. E.R. Seven of the prescriptions were newly entered by Respondent Pharmacy with sequential prescription numbers. Thus, between the relevant time period, every new prescription entered by the pharmacy was written by Dr. E.R. Nine of the prescriptions were for Carisoprodol 350 mg and the other prescription was for Hydrocodone/APAP 7.5/750. It is a red flag for a pharmacy to enter ten prescriptions from the same doctor for the same two controlled substances and for a pharmacy to sequentially enter seven new prescriptions for the same controlled substances from the same doctor all within such a short time period.

e. On October 31, 2011, per pharmacy records, at 8:45 a.m., Respondent Pharmacy entered four prescriptions, for four different patients, written by Dr. E.R. All four prescriptions were for Alprazolam 2 mg. It is a red flag for a pharmacy to enter four prescriptions from the same doctor for the same controlled substance, for four different patients within one minute of each other.

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f. On October 9, 2012, per pharmacy records, between 12:26 p.m. and 12:28 p.m., Respondent Pharmacy entered four prescriptions, for four different patients, written by Dr. E.R. All four of the prescriptions were newly entered by Respondent Pharmacy with sequential new prescription numbers. All four of the prescriptions were for Hydrocodone/APAP 10/325. It is a red flag for a pharmacy to create four new prescriptions from the same doctor, for the same controlled substance, for four different patients, within such a short time period.

g. On July 2, 2012, per pharmacy records, between 6:11 a.m. and 6:19 a.m., Respondent Pharmacy entered ten prescriptions, for five different patients, written by Dr. E.R. All ten of the prescriptions were newly entered by Respondent Pharmacy with sequential new prescription numbers. Thus, between the relevant time period, every new prescription entered by the pharmacy was written by Dr. E.R. Each of the five patients had one prescription for Carisoprodol 350 and one prescription for Hydrocodone/APAP 7.5/750. It is a red flag for a pharmacy to enter tem prescriptions from the same doctor for five patients that all have the same two prescriptions within such a short time period.

h. On October 17, 2012, per pharmacy records, between 11:52 a.m. and 12:12 p.m., Respondent Pharmacy entered eight prescriptions, for four different patients, written by Dr. E.R. All eight of the prescriptions were newly entered by Respondent Pharmacy with sequential new prescription numbers. Thus, between the relevant time period, every new prescription entered by the pharmacy was written by Dr. E.R. Each of the four patients had one prescription for Alprazolam 2 mg and one prescription for Hydrocodone/APAP 10/325. It is a red flag for a pharmacy to enter eight prescriptions from the same doctor, for four patients that all have the same two prescriptions, within such a short time period.

27. Many of the prescriptions written by Dr. E.R. showed instances in which patients living at the same address received identical or very similar drug therapy. This is a factor of irregularity because it is unusual for multiple patients in the same household to have the same diagnoses requiring the same drug therapy. Some examples are as follows:

a. Six patients living at 10011 San Miguel each received several prescriptions for alprazolam 2 mg and Hydrocodone/APAP 10/325. Five of the six patients also had nearly

identical names, and listed the address only slightly differently, such as San Miguel Avenue as opposed to San Miguel Lane.

b. Three patients living at 1036 W. 98th Street each received several prescriptions for Carisoprodol 350 mg and Hydrocodone/APAP 7.5/325.

c. Two patients living at 13131 S. Largo Avenue each received several prescriptions for alprazolam 2 mg and Hydrocodone/APAP 10/325.

d. Two patients living at 14415 Lemoli Avenue received several prescriptions for alprazolam 2 mg and Hydrocodone/APAP 10/325.

e. Two patients living at 1702 W. Arbor and 1702 W. Arbutus Str. Each received several prescriptions for Carisoprodol 350 mg.

f. Seven patients, many of which with very similar names, living at 211 W. Cypress Street each received many prescriptions for alprazolam 2 mg and Hydrocodone/APAP 10/325.

g. Two patients living at 724 W. Tichenor Street received several prescriptions for Carisoprodol 350 mg and Hydrocodone/APAP 7.5/750.

h. Two patients living at 817 Flights Avenue received several prescriptions for alprazolam 2 mg and Hydrocodone/APAP 10/325.

i. Three patients living at 4126 W. Century Boulevard received prescriptions for Carisoprodol 350 mg in addition to Hydrocodone/APAP 7.5/750 and/or Acetaminophen/Codeine 300/60.

C. Prescriptions for Promethazine with Codeine Syrup

28. Respondent Pharmacy dispensed 8,579 prescriptions, totaling 8.54% of all prescriptions filled, for promethazine with codeine syrup between October 29, 2011, and October 30, 2014. Given the variety of medical conditions treated by generally practitioners and the vast amount of different treatment options available, it was a factor of irregularity that over 8% of the prescriptions filled during this time period were for one medication. Additionally, Promethazine with codeine syrup should be used for the temporary relief of coughs and upper respiratory symptoms. The maximum suggested volume of medication per day of use is 30 milliliters, the dosage should not be increased if the cough fails to respond, and a cough that is unresponsive after

five (5) days should be re-evaluated. Here, many patients received several consecutive months of therapy with Promethazine with codeine syrup, a red flag since the medication is indicated for short term treatment.

a. Patient J.B.: Patient J.B. received 240 mL once or twice each month for 15 consecutive months in combination with other controlled substances.

b. Patient W.B.: Patient W.B. received 240 mL once monthly for twelve consecutive months and again for seven consecutive months in combination with other controlled substances.

c. Patient M.C.: Patient M.C. received 240 mL once or twice each month for 22 consecutive months in combination with other controlled substances.

d. Patient D.C.: Patient D.C. received 240 mL once monthly for two periods of nine consecutive months and then eight consecutive months in combination with other controlled substances.

e. Patient J.C.: Patient J.C. received 240 mL once or twice a month for twelve consecutive months and again for five consecutive months in combination with other controlled substances.

f. Patient A.E.: Patient A.E. received 240 mL twenty-eight times over thirty-two months between October 2011 and May 2014 in combination with other controlled substances.

g. Patient M.E.: Patient M.E. received 240 mL once monthly for seventeen consecutive months in combination with other controlled substances.

h. Patient G.M.: Patient G.M. received 240 mL once monthly for twenty-one months in combination with other controlled substances.

D. Initiation of Therapy with High Doses

29. Standard practice for prescribers is to initiate therapy with a low dose of medication and increase the dose if necessary. Dispensing data for Respondents showed many instances where the patients' initial prescriptions were for the highest available dose.

a. Alprazolam is available in 0.25 mg tablets, 0.5 mg tablets, 1 mg tablets, and 2 mg tablets. Between October 29, 2011, and October 30, 2014, Respondent Pharmacy dispensed 4479

prescriptions for alprazolam 2 mg tablets to a total of 953 patients. Respondent Pharmacy only dispensed 106 prescriptions to 38 patients for all other strengths of alprazolam combined.

b. Diazepam is available in 2 mg, 5 mg, and 10 mg tablets. Between October 29, 2011, and October 30, 2014, Respondent Pharmacy dispensed 1,894 prescriptions for diazepam 10 mg tablets to a total of 359 patients. Respondent Pharmacy dispensed only 48 prescriptions to 10 patients for all other strengths of diazepam combined.

E. Controlled Substance Prescriptions Filled Too Early

30. Respondents also failed to assume corresponding responsibility by filling a large number of controlled substance prescriptions early. Early refills are defined as controlled substance prescriptions that were filled more than five days before a previous prescription was scheduled to expire. A Board of Pharmacy Inspector reviewed Prescription Drug Monitoring Program Patient Activity Reports ("PAR" or "PARs") for 29 patients whose profiles showed a pattern of paying cash for controlled substances and billing insurance for non-controlled substances from Respondent Pharmacy between October 29, 2011, and October 30, 2014. 21 of the 29 PARs showed multiple instances of early refills, where patients visited multiple pharmacies and received a refill from a pharmacy before their prior filling of a prescription at a different pharmacy was expected to be finished. Had Respondents recognized the multiple red flags above and reviewed PARs, a freely available resource to all pharmacists, Respondents would have identified multiple instances of early refilling and doctor shopping, as follows:

a. Patient J.B.: The PAR showed that J.B. used approximately 15 different pharmacies, including Respondent Pharmacy, between December 2011 and July 2013. During this time period J.B. obtained 25 early refills that consisted of either Hydrocodone/APAP 7.5/750 mg or Carisoprodol 350 mg from Respondent Pharmacy.

b. Patient V.B.: The PAR showed that V.B. used 7 different pharmacies, including Respondent Pharmacy, between May 2012 and October 2013. During this time period V.B. obtained 26 early refills that consisted of either Carisoprodol 350 mg or Acetaminophen/Codeine 300/60 mg from Respondent Pharmacy.

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c. Patient J.B.2: The PAR showed that J.B.2 obtained an early refill of Hydrocodone/APAP 7.5/325 mg from Respondent Pharmacy only three days after J.B.2 had received a fifteen day supply in August 2014 from another pharmacy.

d. Patient C.B.: The PAR showed that C.B. used 15 different pharmacies, including Respondent Pharmacy, between November 2011 and August 2013. During this time period C.B. obtained 20 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

e. Patient M.C.: The PAR showed that M.C. used 6 different pharmacies, including Respondent Pharmacy, between October 2012 and December 2013. During this time period M.C. obtained 12 early refills that consisted of either Acetaminophen/Codeine 300/30 mg or Diazepam 10 mg from Respondent Pharmacy.

f. Patient S.F.: The PAR showed that S.F. used 3 different pharmacies, including Respondent Pharmacy, between April 2012 and May 2013. During this time period S.F. obtained 4 early refills of Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

g. Patient J.H.: The PAR showed that J.H. used 3 different pharmacies, including Respondent Pharmacy, in March of 2012. During this time period J.H. obtained 2 early refills of Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

h. Patient S.H.: The PAR showed that S.H. used 4 different pharmacies, including Respondent Pharmacy, between December 2012 and December 2013. During this time period S.H. obtained 10 early refills of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

i. Patient B.J.: The PAR showed that B.J. used 10 different pharmacies, including Respondent Pharmacy, between April 2012 and April 2014. During this time period B.J. obtained 19 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

j. Patient A.K.: The PAR showed that A.K. used 5 different pharmacies, including Respondent Pharmacy, between November 2011 and January 2014. During this time period A.K.

obtained 26 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

k. Patient E.K.: The PAR showed that E.K. used 9 different pharmacies, including Respondent Pharmacy, between October 2011 and October 2013. During this time period E.K. obtained 32 early refills that consisted of Carisoprodol 350 mg, Hydrocodone/APAP 7.5/750 mg, and Alprazolam 2 mg from Respondent Pharmacy.

l. Patient R.M.: The PAR showed that R.M. used 5 different pharmacies, including Respondent Pharmacy, between November 2011 and May 2013. During this time period R.M. obtained 15 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

m. Patient G.R.: The PAR showed that G.R. used 10 different pharmacies, including Respondent Pharmacy, between November 2011 and December 2013. During this time period G.R. obtained 59 early refills that consisted of Alprazolam 2 mg, Hydrocodone/APAP 7.5/750 mg, and Carisoprodol 350 mg from Respondent Pharmacy.

n. Patient S.S.: The PAR showed that S.S. used 12 different pharmacies, including Respondent Pharmacy, between December 2011 and November 2013. During this time period S.S. obtained 39 early refills that consisted of Alprazolam 2 mg, Hydrocodone/APAP 7.5/750 mg, and Carisoprodol 350 mg from Respondent Pharmacy.

o. Patient S.S.2: The PAR showed that S.S.2 used 5 different pharmacies, including Respondent Pharmacy, between November 2011 and August 2013. During this time period S.S.2 obtained 9 early refills that consisted of either Acetaminophen/Codeine 300/60 mg, or Diazepam 10 mg from Respondent Pharmacy.

p. Patient Y.S.: The PAR showed that Y.S. used 4 different pharmacies, including Respondent Pharmacy, between January 2012 and July 2013. During this time period Y.S. obtained 8 early refills of Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

q. Patient D.S.: The PAR showed that D.S. used 2 different pharmacies, including Respondent Pharmacy, between May 2012 and July 2014. During this time period D.S. obtained

30 early refills that consisted of either Clonazepam 2 mg, or Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

r. Patient Y.T.: The PAR showed that Y.T. obtained an early refill of Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy. Y.T. received a fifty-three (53) day supply of Hydrocodone / APAP in the previous eight (8) days.

s. Patient C.W.: The PAR showed that C.W. used 3 different pharmacies, including Respondent Pharmacy, between November 2011 and August 2013. During this time period C.W. obtained 21 early refills that consisted of either Carisoprodol 350 mg or Hydrocodone/APAP 7.5/750 mg from Respondent Pharmacy.

t. Patient M.W.: The PAR showed that M.W. used approximately 25 different pharmacies, including Respondent Pharmacy, between January 2012 and September 2013. During this time period M.W. obtained 45 early refills that consisted of Diazepam 10 mg, Hydrocodone/APAP 7.5/750 mg, and Carisoprodol 350 mg from Respondent Pharmacy.

u. Patient E.W.: The PAR showed that E.W. obtained an early refill of Diazepam 10 mg from Respondent Pharmacy only six days after E.W. had received a thirty day supply in June of 2014. The PAR also showed that E.W. obtained a second early refill of Diazepam 10 mg from Respondent Pharmacy only eleven days after E.W. had received a thirty day supply in July of 2014

v. Patient F.W.: The PAR showed that F.W. used 8 different pharmacies, including Respondent Pharmacy, between October 2011 and February 2014. During this time period F.W. obtained 44 early refills that consisted of either Hydrocodone/APAP 7.5/750 mg, or Carisoprodol 350 mg from Respondent Pharmacy.

SECOND CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

31. Respondents are subject to disciplinary action under section 4301, subdivisions (d), (j), and (o), in conjunction with Health and Safety Code section 11153, subdivision (a), in that Respondents engaged in the clearly excessive furnishing of controlled substances, suggesting a level of specificity from patients when choosing what pharmacy to use when filling specific controlled substances. Respondent Pharmacy dispensed a significantly higher number of four

commonly abused controlled substances when compared to other pharmacies in close proximity as follows:

a. Respondent Pharmacy dispensed 265,885 tablets of Alprazolam 2 mg between October 29, 2011, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed 20,426 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed 2,885 tablets and Century Wood Pharmacy 0.2 miles away dispensed 760 tablets during this time period.

b. Respondent Pharmacy dispensed 506,440 tablets of Carisoprodol 350 mg between January 11, 2012, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed approximately 62,054 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed approximately 49,769 tablets and Century Wood Pharmacy 0.2 miles away dispensed approximately 11,458 tablets during this time period.

c. Respondent Pharmacy dispensed 351,583 tablets of Hydrocodone / APAP 10/325 mg between October 29, 2011, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed 106,466 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed 25,691 tablets and Century Wood Pharmacy 0.2 miles away dispensed 7,611 tablets during this time period.

d. Respondent Pharmacy dispensed 493,202 tablets of Hydrocodone / APAP 7.5/750 mg between October 29, 2011, and October 30, 2014, whereas a CVS Pharmacy 0.3 miles away dispensed 70,207 tablets of the controlled substance at that strength, IntraRx Drugs 0.2 miles away dispensed 93,923 tablets and Century Wood Pharmacy 0.2 miles away dispensed 27,331 tablets during this time period.

OTHER MATTERS

32. Pursuant to section 4307, if discipline is imposed on Original Permit Number PHY 49180 issued to Mats Pharmacy Inc., Mats 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 Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if the license is revoked.

33. Pursuant to section 4307, if discipline is imposed on Original Permit Number PHY 49180 issued to Mats Pharmacy Inc., while Banji Alade Adereti and/or Fumni Mojisola Adereti have been officers and owners and had knowledge of, or knowingly participated in, any conduct for which Mats Pharmacy Inc. was disciplined, Banji Alade Adereti and/or Fumni Mojisola Adereti shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if the license 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 Original Permit Number PHY 49180, issued to Mats Pharmacy Inc. doing business as Mats Pharmacy and Medical Supplies with Banji Alade Adereti as the Pharmacist-in-Charge;

2. Revoking or suspending Original Pharmacist License Number RPH 45057 issued to Banji Alade Adereti;

3. Prohibiting Mats Pharmacy Inc. from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if Original Permit Number PHY 49180 issued to Mats Pharmacy Inc. is revoked;

4. Prohibiting Banji Alade Adereti from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if Original Permit Number PHY 49180 issued to Mats Pharmacy Inc. is revoked;

5. Prohibiting Fumni Mojisola Adereti from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Original Permit Number PHY 49180 is placed on probation or until Original Permit Number PHY 49180 is reinstated if Original Permit Number PHY 49180 issued to Mats Pharmacy Inc. is revoked;

6. Ordering Mats Pharmacy and Medical Supplies and Banji Alade Adereti 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; and,

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

DATED: 4/8/16

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

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