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

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|---|---|
| In the Matter of the Accusation Against:<br><br>**SGP INC DBA LA'S PHARMACY & MEDICAL EQUIPMENT**<br>**7903 S. Atlantic Ave., Ste. E**<br>**Cudahy, CA 90201**<br><br>**Pharmacy Permit License No. PHY 49169**<br><br>**ROGER TRAN**<br>**31 Bell Pasture**<br>**Ladera Ranch, Orange CA 92694**<br><br>**Pharmacist License No. RPH 44467**<br><br>Respondents. | Case No. 5768<br><br>**FIRST AMENDED ACCUSATION** |

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 September 8, 2008, the Board of Pharmacy issued Pharmacy Permit License Number PHY 49169 to SGP Inc dba LA's Pharmacy & Medical Equipment (SGP). The Pharmacy Permit License was in full force and effect at all times relevant to the charges brought herein and will expire on September 1, 2017, unless renewed.

3. On or about August 9, 1991, the Board of Pharmacy issued Pharmacist License Number 44467 to Roger Tran (TRAN). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2017, unless renewed.

## JURISDICTION

4. This First Amended 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.

## STATUTORY AUTHORITIES

5. **Section 118, subdivision (b),** of the Code states:

" The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

6. **Section 4006** of the Code states:

"The board may adopt regulations consistent with this chapter and Section 111485 of the Health and Safety Code or regulations adopted thereunder, limiting or restricting the furnishing of a particular drug upon a finding that the otherwise unrestricted retail sale of the drug pursuant to Section 4057 is dangerous to the public health or safety."

7. **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:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self use, except veterinary drugs that are labeled as such, 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

. . . .

"(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. **Health and Safety Code section (HSC) 11153(a)** states:

"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 PROVISIONS

9. 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; and

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

## CONTROLLED SUBSTANCES AND/OR DANGEROUS DRUGS

10. **"Controlled substance"** means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

11. **Phenergan with Codeine Syrup** is a Schedule V controlled substance as designated by Health and Safety Code section 11058(c)(1) and a dangerous drug as designated by

Business and Professions Code section 4022. The generic name is promethazine with codeine syrup.

12. **Norco** is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), a dangerous drug as designated by Business and Professions Code section 4022, and Schedule II per 21 CFR 1308 as of October 6, 2014. The generic name is hydrocodone/acetaminophen.

13. **Roxicodone** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M) and a dangerous drug as designated by Business and Professions Code section 4022. The generic name is oxycodone.

14. **Xanax** is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(1) and a dangerous drug as designated by Business and Professions Code section 4022. The generic name is alprazolam.

15. **Kelfex** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is cephalexin.

16. **DOK** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is docusate.

17. **Motrin** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is Ibuprofen.

18. **Mobic** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is Meloxicam.

**COST RECOVERY**

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

**ARREST OF DR. M.G. FOR SELLING ILLEGAL PRESCRIPTIONS**

20. The Board of Pharmacy became aware of the arrest and federal indictment of Dr. M.G. as described by the United States Attorney's Office. The federal authorities arrested five

defendants, including Dr. M.G., linked to a narcotics trafficking ring, "that sold illegal prescriptions for cash and obtained drugs that were shipped to Texas for sale on the black market." The operation was based in the Southfork Medical Clinic and alleged the clinic was a "pill mill" where Dr. M.G. wrote prescriptions "without a legitimate medical purpose." Dr. M.G. issued more than 10,000 prescriptions over a 15 month period and nearly 80 percent of the prescriptions were for hydrocodone or alprazolam. The undercover operations conducted at Southfork Medical Clinic in which Dr. M.G. gave undercover cooperators prescriptions for oxycodone and promethazine/codeine syrup, "in exchange for the person returning to the clinic with the bottles of the prescribed cough syrup."

21. The Board reviewed the California Controlled Substance Utilization and Review and Evaluation System (CURES) database which contains information about controlled substance prescriptions filled in California, as reported by pharmacies. Review of CURES data indicated SGP filled a portion of Dr. M.G.'s controlled substances prescriptions. The Board initiated an investigation at SGP based on this information.

**REVIEW OF CURES DATA FOR SGP**

22. Board's Inspector N.R. reviewed CURES data for SGP showing controlled substance prescriptions dispensed at SGP from 01/01/2012 to 02/03/2015. In addition to Dr. M.G., Inspector N.R. noted the following prescribers with seemingly irregular controlled substance dispensing profiles:

| Prescriber | Number of Prescriptions Dispensed | Payment Method | Summary of Prescribing at LA's Pharmacy & Medical Equipment |
|---|---|---|---|
| Dr. S. W. | 550 | 99.45% Cash | 88.18% of controlled substance prescriptions reported to CURES during the query period were oxycodone 30 mg, hydrocodone/acetaminophen 10/325 mg, or alprazolam 2 mg. |
| Dr. C.A. | 457 | 99.78% Cash | 98.91% of controlled substance prescriptions reported to CURES were hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg. |
| Dr. M.P. | 222 | 100% Cash | 55.65% of the controlled substance prescriptions reported to CURES were for oxycodone 30 mg. |

| Dr. D.W. | 210 | 99.05% Cash | 66.67% of the controlled substance prescriptions reported to CURES were for oxycodone 30 mg. |
|---|---|---|---|
| Dr. S.O. | 78 | 100% Cash | 56.41% of the controlled substance prescriptions reported to CURES were for alprazolam 2 mg. |

## BOARD'S INSPECTION

23. On May 5, 2015, Inspectors A.N. and N.R. conducted an inspection at SGP. Pharmacist-in-charge (PIC) Roger Tran was not present, however, staff pharmacist R.N. was present and assisted in the inspection. RPH Nguyen explained that SGP filled about 100-150 prescriptions per day. The inspectors requested to review prescription documents for filled prescriptions which are usually filed sequentially in "books" by prescription number. Pharmacy Technician K.S. provided several "books" of completed prescription documents. The books contained prescription documents for schedule II controlled substances, schedules III-V controlled substances, and non-controlled substances, comingled.

24. The board inspectors reviewed the completed prescription documents, however, they were unable to find any prescription documents from the prescribers identified in the above chart. RPH Nguyen spoke with Pharmacy Technician K.S. who informed the inspectors that a portion of the pharmacy's prescription documents were filed separately in the back of the pharmacy. Technician Sanchez produced one rubber-banded stack of prescription for Drs. S.W., M.P., D.W. and S.O., and M.G.

25. Inspector A.N. inquired about the procedure for filing and retaining prescription documents at SGP.. It is common practice for pharmacies to assign prescription numbers to the prescription documents and file them numerically by prescription number. However, the inspectors had not seen a pharmacy organize prescription documents by prescriber. Further, it seemed unusual that prescriptions written by the prescribers the inspectors identified as having potentially irregular dispensing profiles were separated from the majority of the pharmacy's prescription documents. Technician Sanchez and RPH Nguyen were not able to explain why the pharmacy filed prescription documents from these prescribers separately.

26. The board inspectors reviewed and collected a sample of prescription documents. The majority of the prescription documents were stapled to a sheet of paper containing one or more of the following elements: a photocopy of the prescription itself, a photocopy of the patient's identification card, and/or a printout of a Patient Activity Report from the California Prescription Drug Monitoring Program which showed a patient's recent controlled substance dispensing history from pharmacies in California. The inspectors collected prescription documents and associated verifications from Drs. S.W., M.P., D.W., S.O., and M.G..

27. Inspector N.R. asked RPH Nguyen if he was familiar with the prescribers listed above. RPH Nguyen stated he believed Dr. S.W. had restrictions placed on his license by the Board of Medicine or the Drug Enforcement Administration (DEA) and he explained that SGP had stopped filling Dr. S.W.'s prescriptions. The inspectors reviewed and collected a sample of invoices for sales of medications from Cardinal Health to SGP. At the conclusion of the inspection, Inspector N.R. (1) left a questionnaire regarding corresponding responsibility and requested PIC Tran complete the questionnaire and provide it to her; and (2) asked SGP to provide their complete dispensing data for controlled and non-controlled substances in an excel file. She issued a correction for non-compliance with the Code of Federal Regulations Section 1304.04(f)(1) which states in part, Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all of the records of the registrant. She explained to RPH Tran that the prescription documents for Schedule II controlled substances should be filed separately from prescription documents for Schedules III-V and non-controlled substances.

**COMMUNICATIONS WITH PIC TRAN**

28. On May 15, 2015, Inspector N.R. received a fax from PIC TRAN which included PIC Tran's responses to the questions she left during the inspection on May 5, 2015. Inspector N.R.'s questions and PIC TRAN's responses were as follows:

1. Is your computer software the primary method of record keeping and maintenance in the pharmacy? If not, what is? "Yes".

2. Is the following statement true or false: The electronic computer record of dispensed prescriptions stored in the pharmacy software system is a true and accurate representation of the hard copy (paper) prescription record? "Yes".

3. Describe the sequential steps this pharmacy takes to satisfy its corresponding responsibility to dispense only medically legitimate controlled substance prescriptions. In other words, what criteria/criterion must a controlled substance prescription satisfy before this pharmacy decides to fill and dispense the medication? "Controlled prescriptions must be written on secure prescription form, Copy patient id and check patient address, DOB, Phone number, Verify MD with Physician Board, Patient is checked on PDMP/CURES to verify if the prescription was filled recently usually within 30 days, Profile on PDMP/CURES is checked for last 3 months. If the profile looks okay the doctor's office is called to verify that the prescription is okay, then the prescription is filled and dispensed."

4. Does this pharmacy have to capability to access information provided by the Prescription Drug Monitoring Program (PDMP) (sometimes referred to as CURES data) which is provided freely to pharmacists? If yes, provide a sample. "Yes. See sample."

5. If yes, explain the instances in which this pharmacy checks the PDMP. "Every controlled substance medications"

6. When the pharmacy does check the PDMP, how does the review of information affect the outcome of dispensing the controlled substance prescription? "Last fill date; how often controlled medications are filled, doctors that prescribe the medication; If there are discrepancies for any of the above mention; the prescription will be return to patient."

7. What is your and/or your pharmacy's policy on filling a controlled substance prescription early? In your opinion. How many days are too soon to fill a controlled substance prescription early? "Controlled substances are rarely filled early unless otherwise requested by the doctor with valid reason. Controlled substances are filled on or after the day supply of the last time the medication was received by the patient."

8. Are you familiar with the term "doctor shopper?" If you are, explain what this means and explain how you and/or this pharmacy identify and handle doctor shoppers. "Yes.

Patients that received controlled medications from different doctors. These patients are identified via PDMP/CURES program. We reserve the right to refuse service."

9. If you took special notes on a patient or prescription, where do you store the notes (i.e. on the computer patient profile, documented on the prescription hard copy, other documentation?) "Documented on hard copy and patients profiles."

10. Does this pharmacy have policy on dispensing controlled substance prescriptions from out of the area doctors? According to the practice of this pharmacy, what is an acceptable distance from the doctor's office to the pharmacy to allow dispensing of controlled substance prescriptions? "This pharmacy follows the legal limitations when dispensing controlled substances from out of the area doctors."

11. Does this pharmacy have policy on dispensing controlled substance prescriptions to out of the area patients? According to the practice of this pharmacy, what is an acceptable distance from the patient's home to the pharmacy to allow dispensing of controlled substance prescriptions? "This pharmacy follows the legal limitations when dispensing controlled substances from out of the area patients."

12. List and describe any training, continuing education, certification or the like you or your pharmacy has in the field of pain management. Include any and all documentation to support this training, continuing education credit, certificate or the like. "We are retail pharmacy only."

13. Based on your education and professional experience, what is the appropriate starting dose for the following medications:

a. Alprazolam — "Alprazolam 0.25-0.5 mg tid"

b. Hydrocodone/acetaminophen — "Hydrocodone/apap 5/325 mg q4-6h prn"

c. Oxycodone immediate release — "Oxycodone ir 10-20 mg q 4 h prn"

d. Oxycodone extended release — "Oxycodone ext. release 10 mg bid prn"

14. How does this pharmacy determine if a patient is naïve to benzodiazepine and opiate therapy? How is this information documented? "According to patient and physician. This information is recorded in the hard copy of RX."

15. Are you familiar with the nature of the practice of the following prescribers?

a. Dr. S.W.? Internal medicine. Cease from practice

b. Dr. C.A.? General practitioner

c. Dr. M.P.? Podiatrist

d. Dr. D.W.? Internal medicine cardiology

e. Dr. M.G.? General Practice.

16. Have you called and spoken to anyone at the above prescribers offices? If so, who did you speak with and why?

"Yes. Drs. S.W., C.A., M.P., D.W., and M.G., to verify prescriptions"

29. On September 2, 2015, after an initial review of the prescription documents collected during the inspection, Inspector N.R. sent PIC TRAN a second questionnaire and a request for additional prescription documents. On September 19, 2015, Inspector N.R. received a response from PIC Tran along with the requested prescription documents from Dr. S.W. and M.G. Inspector N.R.'s questions and PIC Tran's responses included the following:

1. Many of the prescription documents collected during the inspection on 05/05/2015 have verifications initialed by "KS". Who is "KS"? "[Technician] K.S."

2. Many of the prescription documents have a notation reading "C-Verified". What does that statement indicate? "We checked patients with cures program make sure patients not filled control substance somewhere else."

3. During the inspection on 05/05/2015, the prescription documents (hard copies) for Drs. M.G., S.O., C.A., and D.W. were filed separately from other prescriptions, by prescriber. Why does LA's Pharmacy use this filing convention? "The owner wanted to keep them separately for checking cash patients and keeping track of cash payments"

30. On December 1, 2015, Inspector N.R. sent PIC TRAN and the owner of SGP, Mr. Long, another email. She asked if there were additional documentations of verifications or

prescriber conversations regarding the prescriptions in her possession. On December 2, 2015, PIC TRAN replied via email and stated, "We do not have any additional records of verification."

## REVIEW OF THE ELECTRONIC DISPENSING DATA

31. After Inspector N.R. reviewed the electronic dispensing data provided by PIC TRAN and Mr. Long, the majority of the prescriptions filled at SGP during the query period were purchased using drug insurance. 88.25% of the prescriptions in the dispensing data showed prescription insurance as the payment method while 11.72% of the prescriptions showed "cash" as the payment method. Typically, patients do not desire to pay high out-of-picket costs for medications; therefore, using the financial aid of insurance is normally desired. As a baseline measure, the percentage of payment methods seemed standard. Further, the top 20 drugs dispensed by the pharmacy consisted of a mixture of drugs treating a variety of conditions. (Inspector Noelle is attempting to establish a baseline measure of normalcy which she then uses to argue the prescriptions from the suspect prescribers were abnormal in that they were predominantly cash and mostly controlled substances lacking in variety.) Inspector N.R. prepared the below chart:

| Medication | Controlled Substance? | Number of Prescriptions Dispensed | Percent of Total Prescriptions Dispensed |
|---|---|---|---|
| OMEPRAZOLE DR 20 MG CAPSULE | No | 2274 | 2.28% |
| PROMETHAZINE-CODEINE SYRUP | Yes – Schedule V per HSC 11058(c)(1) | 2165 | 2.17% |
| IBUPROFEN 600 MG TABLET | No | 1687 | 1.69% |
| ASPIRIN EC 81 MG TABLET | No | 1681 | 1.68% |
| PROMETHAZINE-DM SYRUP | No | 1535 | 1.54% |
| METFORMIN HCL 1,000 MG TABLET | No | 1426 | 1.43% |
| PROAIR HFA 90 MCG INHALER | No | 1425 | 1.43% |
| LORATADINE 10 MG TABLET | No | 1421 | 1.42% |
| FLUTICASONE PROP 50 MCG SPRAY | No | 1305 | 1.31% |
| ASPIR-LOW EC 81 MG TABLET | No | 1256 | 1.26% |
| FERROUS SULFATE 325 MG TABLET | No | 1154 | 1.16% |
| TRAMADOL HCL 50 MG TABLET | Yes – Schedule IV per 21 CFR 1308 as of 08/18/2014 | 1025 | 1.03% |
| HYDROCODON-ACETAMINOPHN 10-325 | Yes – Schedule III per H&SC 11056(e)(4) and | 992 | 0.99% |

| | Schedule II per 21 CFR 1308 as of 10/6/14 | | |
|---|---|---|---|
| SIMVASTATIN 20 MG TABLET | No | 974 | 0.98% |
| LISINOPRIL 40 MG TABLET | No | 959 | 0.96% |
| METFORMIN HCL 500 MG TABLET | No | 938 | 0.94% |
| TRIAMCINOLONE 0.1% CREAM | No | 932 | 0.93% |
| AMLODIPINE BESYLATE 10 MG TAB | No | 865 | 0.87% |
| AMOXICILLIN 500 MG CAPSULE | No | 837 | 0.84% |
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II per HSC 11055(b)(1)(M) | 815 | 0.82% |

**CORRESPONDING RESPONSIBILITY(ANALYSIS OF DISPENSING DATA-PRESCRIBER STATISTICS AND PRESCRIPTIONS OF IRREGULARITY)**

32. Inspector N.R. reviewed the dispensing profiles for several prescribers at SGP. She identified irregularities in the prescribing profiles of Drs. S.W., C.A., M.G., M.P., D.W., and S.O..

33. The Board periodically publishes a newsletter, The Script, which covers topics such as pharmacy laws and regulations, pharmacy practice, and Board of Pharmacy news. This background information establishes the importance of a pharmacist's and a pharmacy's corresponding responsibility to fully use available resources to actively scrutinize and evaluate controlled substance prescriptions. The Script has addressed the topic of corresponding responsibility 10 times in the previous 16 years.

34. On March 4,2013, the DEA presented a Power Point presentation entitled "DEA Update & Perspectives on Prescription Drug Trafficking & Abuse Trends." The presentation covered commonly abused prescription medications. Drugs included were hydrocodone, carisoprodol, oxycodone 30 mg and alprazolam. The presentation explained these medications are often taken in combinations. The combination or "drug cocktail" consisting of a hydrocodone-containing product, carisoprodol, and a benzodiazepine (typically alprazolam) became so prevalent it was referred to as "The Trinity". It is important to note each of these drugs exhibit high potential for abuse when used alone.

35. The National Institute on Drug Abuse (NIDA) monitors and publishes summaries of emerging trends in drugs of abuse. NIDA identified promethazine with codeine syrup as a drug of abuse with risk of fatal overdose. Street slang for the drug includes Purple Drank, Sizzurp and Lean.

36. The Spring 2014 issue of The Script as well as the Board's Corresponding Responsibility Brochure listed the following, "**red flags** that could alert a pharmacist that a prescription ordered for a controlled drug may not be appropriate."

- Irregularities on the face of the prescription itself
- Nervous patient demeanor
- Age or presentation of patient (e.g., youthful patients seeking chronic pain medications)
- Multiple patients at the same address
- Cash payments
- Requests for early refills of prescriptions
- Prescriptions written for an unusually large quantity of drugs
- Prescriptions written for potentially duplicative drugs
- The same combinations of drugs prescribed for multiple patients
- Initial prescriptions written for strong opiates (e.g., OxyContin 80mg)
- Long distances traveled from the patient's home, to the prescriber's office or pharmacy
- Irregularities in the prescriber's qualifications in relation to the medication(s) prescribed
- Prescriptions that are written outside of the prescriber's medical specialty
- Prescriptions for medications with no logical connection to diagnosis or treatment

37. Pharmacists serve an important role in preventing drug diversion and limiting illegitimate use of drugs. Recognition of red flags, which have been significantly publicized as detailed above, is vital to a pharmacist's ability to evaluate the legitimacy of prescriptions. When

a pharmacist receives a prescription, the presence of one or more red flags could represent a level of irregularity which would warrant contacting the prescriber to validate the prescription.

**DISPENSING RECORD REVIEW: DR. S.W. (01/01/2012 to 02/03/2015)**[1]

| Medications | Number of Prescriptions | % of Dr. S.W. Total Prescriptions |
|---|---|---|
| **PROMETHAZINE-CODEINE SYRUP** | **610** | **32.16%** |
| CASH | 606 | 31.95% |
| OTHER | 4 | 0.21% |
| **HYDROCODON-ACETAMINOPHN 10-325** | **206** | **10.86%** |
| CASH | 205 | 10.81% |
| OTHER | 1 | 0.05% |
| **OXYCODONE HCL 30 MG TABLET** | **176** | **9.28%** |
| CASH | 176 | 9.28% |
| **ALPRAZOLAM 2 MG TABLET** | **128** | **6.75%** |
| CASH | 128 | 6.75% |
| **AMOXICILLIN 500 MG CAPSULE** | **77** | **4.06%** |
| CASH | 77 | 4.06% |
| **DOK 100 MG CAPSULE** | **69** | **3.64%** |
| CASH | 69 | 3.64% |
| **CEPHALEXIN 500 MG CAPSULE** | **40** | **2.11%** |
| CASH | 37 | 1.95% |
| OTHER | 3 | 0.16% |
| **PREVAIL WASHCLOTH 12X8** | **39** | **2.06%** |
| CASH | 39 | 2.06% |
| **PENICILLIN VK 500 MG TABLET** | **26** | **1.37%** |
| CASH | 25 | 1.32% |
| OTHER | 1 | 0.05% |
| **SENSI-CARE PERINEAL CLEANSER** | **26** | **1.37%** |
| CASH | 26 | 1.37% |
| **GLUCERNA LIQUID** | **24** | **1.27%** |
| CASH | 24 | 1.27% |
| **CALMOSEPTINE OINTMENT** | **21** | **1.11%** |
| CASH | 21 | 1.11% |
| **CARISOPRODOL 350 MG TABLET** | **20** | **1.05%** |
| CASH | 18 | 0.95% |
| OTHER | 2 | 0.11% |

[1] This table does not represent Dr. S.W's total prescribing at LA's Pharmacy. It only contains the top 20 drugs.

| | | |
|---|---|---|
| **PERIFRESH PERINEAL CLEANSER** | **18** | **0.95%** |
| CASH | 18 | 0.95% |
| **GLOVES** | **17** | **0.90%** |
| CASH | 17 | 0.90% |
| **GLOVES 1 BOX(INDIVIDUAL)** | **17** | **0.90%** |
| CASH | 17 | 0.90% |
| **AMLODIPINE BESYLATE 10 MG TAB** | **14** | **0.74%** |
| CASH | 14 | 0.74% |
| **AMLODIPINE BESYLATE 5 MG TAB** | **12** | **0.63%** |
| CASH | 12 | 0.63% |
| **CA-REZZ CREAM** | **11** | **0.58%** |
| CASH | 11 | 0.58% |
| **ENSURE** | **11** | **0.58%** |
| CASH | 11 | 0.58% |

38. 59.04% of Dr. S.W.'s prescriptions were written for one of four controlled substances; promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets and alprazolam 2 mg tablets. It was a factor of irregularity for four commonly abused controlled substances to make up over half of one prescriber's prescriptions.

39. 98.42% of the prescriptions written by Dr. S.W. were purchased in cash, meaning without the assistance of prescription insurance. Patients typically prefer to pay for prescription medications with the aid of prescription insurance and 88.25% of the prescriptions filled at LA's Pharmacy and Medical Equipment during the query period were billed to insurance. Therefore, this payment pattern was a factor of irregularity.

40. The majority of the controlled substances written by Dr. S.W. were for the highest available strength. Hydrocodone is available in combination products containing 5, 7.5, and 10 mg of hydrocodone per tablet. During the query period, Dr. S.W. wrote 207 prescriptions for hydrocodone/acetaminophen 10/325 mg tablets and 13 prescriptions for the other strengths combined. Alprazolam is available in 0.25, 0.5, 1, and 2 mg tablets. Dr. S.W. prescribed only alprazolam 2 mg tablets during the query period. Oxycodone immediate release is available in 5, 10, 15, 20, and 30 mg tablets. During the query period, Dr. S.W. wrote 175 prescriptions for oxycodone 30 mg tablets and two prescriptions for the other strengths combined.

Prescribers commonly aim to treat patients with the lowest effective dose of medications in order to minimize the risk of side effects and toxicity from the medications. It is standard practice to initiate therapy on a low dose of medication and increase the dose if necessary. Therefore, Dr. S.W.'s frequent prescribing of the highest available dose of these medications was a factor of irregularity.

41. In question 13 of the questionnaire, PIC Tran identified the starting dose of alprazolam as 0.25 -0.5 mg three times per day and the starting dose of hydrocodone/acetaminophen as 5/325 mg every 4 to 6 hours as needed. Therefore, PIC Tran had the clinical knowledge necessary to recognize this red flag.

42. Dr. S.W.'s address listed in the majority of the entries in the dispensing record was 820 S. Cottontail Ln., Anaheim, California 92808. According to Google Maps, Dr. S.W.'s address was 31.8 miles away from SGP. The Los Angeles metropolitan area is well served by pharmacies and physicians. It was a factor of irregularity for Dr. S.W.'s patients to travel over thirty miles, one way, between his office and SGP while many other physicians and pharmacies would have been available.

43. During the query period, SGP filled 399 prescriptions for opioid agonists and only three prescriptions for oral anti-inflammatories under Dr. S.W.'s prescribing authority. This limited prescribing of medications to treat pain other than opioid agonists was a factor of irregularity.

44. An accusation was filed by the Medical Board of California on October 6, 2014 in an attempt to revoke Dr. S.W.'s physician and surgeon license. The accusation stated causes for discipline included federal convictions of charges related to healthcare fraud and conspiracy to pay and receive kickbacks. Effective 09/29/2014; "United States District Court, Central District of California issued an order in case No. CR 12-00905-R, The United States of America vs. S.W. who shall have his bond reinstated under the conditions previously imposed; shall not practice medicine and shall be subject to home detention with electronic monitoring. Effective 11/06/2014; "The Superior Court of California, County of Riverside issued an order in case No. RIF 1403899, The People of California vs. [S.W.]. Dr. [S.W.] shall cease and desist from the

practice of medicine. SGP filled 167 prescriptions under Dr. S.W.'s prescribing authority after the first court order was issued.

**DISPENSING RECORD REVIEW: DR. C.A. (01/01/2012 to 02/03/2015)**

| Row Labels | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. C.A.'s Total Prescriptions |
|---|---|---|---|---|
| PROMETHAZINE-CODEINE SYRUP | Yes – Schedule V | CASH | 477 | 49.07% |
| HYDROCODON-ACETAMINOPHN 10-325 | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 324 | 33.33% |
| | | OTHER | 1 | 0.10% |
| ALPRAZOLAM 2 MG TABLET | Yes – Schedule IV | CASH | 87 | 8.95% |
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II | CASH | 64 | 6.58% |
| IBUPROFEN 800 MG TABLET | Non-controlled | CASH | 6 | 0.62% |
| CARISOPRODOL 350 MG TABLET | Yes – Schedule IV | CASH | 3 | 0.31% |
| BISACODYL EC 5 MG TABLET | Non-controlled | CASH | 3 | 0.31% |
| HYDROCODONE-APAP 10-325MG TAB | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 2 | 0.21% |
| HYDROCODON-ACETAMINOPH 7.5-750 | Yes—Schedule III | CASH | 2 | 0.21% |
| CLOPIDOGREL 75 MG TABLET | Non-controlled | CASH | 1 | 0.10% |
| AMOXICILLIN 500 MG CAPSULE | Non-controlled | CASH | 1 | 0.10% |
| DIPHENHYDRAMINE 50 MG CAPSULE | Non-controlled | CASH | 1 | 0.10% |
| | | CASH Count | 971 | 99.90% |
| | | OTHER Count | 1 | 0.10% |
| **Grand Total** | | | **972** | **100.00%** |

45. SGP dispensed 972 prescriptions under Dr. C.A.'s prescribing authority during the query period. The majority of Dr. C.A.'s prescriptions dispensed at SGP were written for controlled substances. 98.77% or 960 out of 972 of Dr. C.A.'s prescriptions were controlled substances. A prescriber profile consisting almost entirely of controlled substances was a factor of irregularity.

46. All but one of Dr. C.A.'s prescriptions were purchased in cash, meaning not billed to prescription insurance. As previously discussed, a prescribing profile purchased almost entirely in cash was a factor of irregularity.

47. Dr. C.A. frequently prescribed the highest available dose of controlled substances. Examples included: his prescribing history included 87 prescriptions for alprazolam 2 mg tablets, the highest available strength of alprazolam and no prescriptions for the lower strengths. Dr. C.A.'s prescribing history included 327 prescriptions for hydrocodone/acetaminophen 10/325 mg and two prescriptions for a lower strength of hydrocodone. Dr. C.A.'s prescribing history included 64 prescriptions for oxycodone 30 mg and no prescriptions for the lower strengths.

48. The Medical Board of California filed an accusation against Dr. C.A. on 12/15/2014. The accusation alleged Dr. C.A. prescribed controlled substances for patients without establishing a legitimate medical need for the medications and without performing a medical examination.

**DISPENSING RECORD REVIEW: DR. M.P. (01/01/2012 to 02/03/2015)**

| Medications | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. M.P.'s Total Prescriptions |
|---|---|---|---|---|
| OXYCODONE HCL 30 MG TABLET | Yes -- Schedule II | CASH | 176 | 34.17% |
| IBUPROFEN 800 MG TABLET | No | CASH | 73 | 14.17% |
| | | OTHER | 1 | 0.19% |
| HYDROCODON-ACETAMINOPHN 10-325 | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 67 | 13.01% |
| | | OTHER | 1 | 0.19% |
| MELOXICAM 7.5 MG TABLET | No | CASH | 42 | 8.16% |
| | | OTHER | 2 | 0.39% |
| KETOCONAZOLE 2% CREAM | No | CASH | 35 | 6.80% |
| NAPROXEN 500 MG TABLET | No | CASH | 22 | 4.27% |
| IBUPROFEN 600 MG TABLET | No | CASH | 16 | 3.11% |
| AMOXICILLIN 500 MG CAPSULE | No | CASH | 14 | 2.72% |
| NAPROXEN 375 MG TABLET | No | CASH | 10 | 1.94% |
| CLOTRIMAZOLE 1% SOLUTION | No | CASH | 9 | 1.75% |
| | | OTHER | 1 | 0.19% |
| IBUPROFEN 400 MG TABLET | No | CASH | 9 | 1.75% |

| | | | | |
|---|---|---|---|---|
| **MELOXICAM 15 MG TABLET** | No | CASH | 9 | 1.75% |
| **METRONIDAZOLE 500 MG TABLET** | No | CASH | 5 | 0.97% |
| **CEPHALEXIN 500 MG CAPSULE** | No | CASH | 5 | 0.97% |
| **CLOTRIMAZOLE 1% CREAM** | No | CASH | 3 | 0.58% |
| | | OTHER | 1 | 0.19% |
| **CARISOPRODOL 350 MG TABLET** | Yes – Schedule IV | CASH | 3 | 0.58% |
| **BACITRACIN 500 UNIT/GM OINTMNT** | No | CASH | 2 | 0.39% |
| **VOLTAREN 1% GEL** | No | CASH | 2 | 0.39% |
| **ECONAZOLE NITRATE 1% CREAM** | No | CASH | 2 | 0.39% |
| **PHENTERMINE 37.5 MG TABLET** | Yes – Schedule IV | OTHER | 1 | 0.19% |
| **HYDROCODON-ACETAMINOPH 7.5-325** | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 1 | 0.19% |
| **DOK 250 MG CAPSULE** | No | CASH | 1 | 0.19% |
| **DOK 100 MG CAPSULE** | No | CASH | 1 | 0.19% |
| **ALPRAZOLAM 2 MG TABLET** | Yes – Schedule IV | CASH | 1 | 0.19% |
| | | CASH Count | 508 | 98.64% |
| | | OTHER Count | 7 | 1.36% |
| **Grand Total** | | | **515** | **100.00%** |

49. SGP filled 515 prescriptions under Dr. M.P.'s prescribing authority during the query period. 34.17% of Dr. M.P.'s prescriptions were written for oxycodone 30 mg tablets. 136 patients received prescriptions from Dr. M.P. during the query period. 113 of those patients (or 83.09%) received at least one prescription for oxycodone 30 mg. The remaining 23 patients received at least one prescription for hydrocodone/acetaminophen 10/325 mg tablets. 98.64% of the prescriptions in Dr. M.P.'s prescribing history were purchased in "cash". A prescribing profile purchased almost entirely in cash and in which every patient received a narcotic pain reliever was a factor of irregularity. Majority of the Dr. M.P.'s controlled substance prescriptions were written for the highest available dose. Dr. M.P. wrote 176 prescriptions for oxycodone 30 mg tablets and no prescriptions for any lower strength of oxycodone. Dr. M.P. wrote 67 prescriptions for hydrocodone/acetaminophen 10/325 mg and one prescription for a lower dose, hydrocodone/acetaminophen 7.5/325 mg.

**DISPENSING RECORD REVIEW: DR. M.G. (01/01/2012 to 02/03/2015)**

| Medication | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. M.G.'s Total Prescriptions |
|---|---|---|---|---|
| PROMETHAZINE-CODEINE SYRUP | Yes – Schedule IV | CASH | 180 | 31.09% |
| CEPHALEXIN 500 MG CAPSULE | No | CASH | 105 | 18.13% |
| HYDROCODON-ACETAMINOPHN 10-325 | Yes-- Schedule II (Schedule III prior to 10/6/2014) | CASH | 82 | 14.16% |
| ALPRAZOLAM 2 MG TABLET | Yes – Schedule IV | CASH | 70 | 12.09% |
| AZITHROMYCIN 250 MG TABLET | No | CASH | 35 | 6.04% |
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II | CASH | 33 | 5.70% |
| AMOXICILLIN 500 MG CAPSULE | No | CASH | 20 | 3.45% |
| VENTOLIN HFA 90 MCG INHALER | No | CASH | 13 | 2.25% |
| HYDROCODON-ACETAMINOPHN 10-500 | Yes – Schedule II | CASH | 10 | 1.73% |
| IBUPROFEN 800 MG TABLET | No | CASH | 9 | 1.55% |
| ZOLPIDEM TARTRATE 10 MG TABLET | Yes – Schedule IV | CASH | 6 | 1.04% |
| NAPROXEN 500 MG TABLET | No | CASH | 4 | 0.69% |
| LORATADINE 10 MG TABLET | No | CASH | 4 | 0.69% |
| CIPROFLOXACIN HCL 500 MG TAB | No | CASH | 3 | 0.52% |
| CARISOPRODOL 350 MG TABLET | Yes— Schedule IV | CASH | 3 | 0.52% |
| PROAIR HFA 90 MCG INHALER | No | CASH | 2 | 0.35% |
| | | CASH Count | 579 | 100.00% |
| | | OTHER Count | | 0.00% |
| Grand Total | | | 579 | 100.00% |

50. SPG filled 579 prescriptions under Dr. M.G.'s prescribing authority during the query period. Dr. M.G.'s most commonly prescribed medication was promethazine/codeine syrup, which represented 31.09% of Dr. M.G.'s total prescribing. Given the wide variety of medications available to prescribe, it was a factor of irregularity for a commonly abused controlled substance to represent over 31% of one physician's prescribing at SGP. 75.47% of

Dr. M.G.'s prescribing consisted of four medications: promethazine/codeine syrup, cephalexin 500 mg capsules, hydrocodone/acetaminophen 10/325 mg tablets, and alprazolam 2 mg tablets. As previously stated, given the multitude of medications on the market, it was a factor of irregularity for the majority of one physician's prescribing at SGP to consist of only four medications. All of Dr. M.G.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were purchased in cash. As set forth above, a prescribing profile purchased entirely in cash was another factor of irregularity.

51. Dr. M.G. prescribed controlled substances exclusively at the highest available dose. Dr. M.G. wrote 92 prescriptions for hydrocodone combinations containing 10 mg of hydrocodone and no prescriptions for lower strengths. Dr. M.G. wrote 70 prescriptions for alprazolam 2 mg tablets and no prescriptions for lower strengths. Dr. M.G. wrote 33 prescriptions for oxycodone 30 mg tablets and no prescriptions for lower strengths. Dr. M.G.'s dispensing history at SGP contained 55 instances amongst 45 patients in which a patient received the following four medications on the same day; promethazine/codeine syrup, alprazolam 2 mg tablets, hydrocodone/acetaminophen 10/325 mg tablets, and cephalexin 500 mg capsules. Additionally, Dr. M.G.'s profile contained four instances in which patients received promethazine/codeine syrup, alprazolam 2 mg tablets, hydrocodone/acetaminophen 10/325 mg tablets and a different antibiotic. It would be unusual for a large number of patients to require treatment for cough, anxiety, pain, and infection at the same time. Additionally, no two patients are exactly alike. Because of this inter-patient variability, a prescriber would often choose different medications or different doses to treat different patients with the same ailments. Therefore, Dr. M.G.'s use of the same four medications at the same strengths to treat 45 different patients was another factor of irregularity.

52. On October 13, 2015, Inspector N.R. accessed the Medical Board of California database and searched for Dr. M.G.'s licensing information. Dr. M.G.'s license status was "revoked" as of December 6, 2013. The underlying accusation filed against Dr. M.G. included a cause for discipline for self-use of controlled substances.

**DISPENSING RECORD REVIEW: DR. D.W. (01/01/2012 to 02/03/2015)**

| Medications | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. D.W.'s Total Prescriptions |
|---|---|---|---|---|
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II | CASH | 149 | 31.24% |
| | | OTHER | 1 | 0.21% |
| DOK 100 MG CAPSULE | No | CASH | 115 | 24.11% |
| | | OTHER | 1 | 0.21% |
| ALPRAZOLAM 2 MG TABLET | Yes – Schedule IV | CASH | 72 | 15.09% |
| | | OTHER | 1 | 0.21% |
| PROMETHAZINE-CODEINE SYRUP | Yes – Schedule V | CASH | 69 | 14.47% |
| AMOXICILLIN 500 MG CAPSULE | No | CASH | 23 | 4.82% |
| CIPROFLOXACIN HCL 500 MG TAB | No | CASH | 14 | 2.94% |
| IBUPROFEN 600 MG TABLET | No | CASH | 11 | 2.31% |
| SENNA LAXATIVE 8.6 MG TABLET | No | CASH | 6 | 1.26% |
| PROAIR HFA 90 MCG INHALER | No | CASH | 3 | 0.63% |
| CARISOPRODOL 350 MG TABLET | Yes – Schedule IV | CASH | 3 | 0.63% |
| IBUPROFEN 800 MG TABLET | No | CASH | 3 | 0.63% |
| DOCUSATE SODIUM 100MG | No | CASH | 1 | 0.21% |
| AMLODIPINE BESYLATE 10 MG TAB | No | CASH | 1 | 0.21% |
| AZITHROMYCIN 250 MG TABLET | No | CASH | 1 | 0.21% |
| LORATADINE 10 MG TABLET | No | CASH | 1 | 0.21% |
| LISINOPRIL 20 MG TABLET | No | CASH | 1 | 0.21% |
| HYDROCODON-ACETAMINOPH 7.5-750 | Yes— Schedule III | CASH | 1 | 0.21% |
| | | CASH Count | 474 | 99.37% |
| | | OTHER Count | 3 | 0.63% |
| Grand Total | | | 477 | 100.00% |

53. SPG filled 477 prescriptions under Dr. D.W.'s prescribing authority during the query period. Dr. D.W.'s most commonly prescribed medication was oxycodone 30 mg, which represented 31.45% of his total prescriptions. Dr. D.W.'s next most commonly prescribed medication, "DOK 100 mg", was a stool softener. Constipation is a common adverse effect of narcotic pain relievers, therefore these medications are sometimes prescribed with stool softeners. 55 patients at SPG received prescriptions from Dr. D.W. during the query period. 49 of these patients received at least one prescription for oxycodone 30 mg. Additionally, three medications,

oxycodone 30 mg, alprazolam 2 mg, and promethazine/codeine made up 61.22% of Dr. D.W.'s total prescribing. 99.37% of Dr. D.W.'s prescriptions were purchased in cash. Dr. D.W.'s frequent prescribing of oxycodone 30 mg and other controlled substances along with the majority of his prescriptions being purchased in cash were both factors of irregularity.

54. Dr. D.W.'s self-reported primary area of practice was "Cardiology", with secondary areas of practice listed as, "Internal Medicine," "Pain Medicine," and "Public Health and General Preventative Medicine." Dr. D.W.'s prescribing profile contained only two prescriptions typically used to treat cardiovascular conditions; one prescription for lisinopril and one prescription for amlodipine which are both used to treat high blood pressure. One would expect a more varied dispensing profile for internal medicine practitioners and pain medicine specialists. Dr. D.W.'s prescribing profile, in which three controlled substances used to treat pain, anxiety and cough made up 61.22% of the prescriptions, would not by typical for a prescriber in any of these areas of practice.

**DISPENSING RECORD REVIEW: DR. S.O. (01/01/2012 to 02/03/2015)**

| Row Labels | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. S.O.'s Total Prescriptions |
|---|---|---|---|---|
| **PROMETHAZINE-CODEINE SYRUP** | Yes – Schedule V | CASH | 209 | 61.47% |
| | | OTHER | 4 | 1.18% |
| **ALPRAZOLAM 2 MG TABLET** | Yes – Schedule IV | CASH | 45 | 13.24% |
| **LISINOPRIL 20 MG TABLET** | No | CASH | 22 | 6.47% |
| **CARISOPRODOL 350 MG TABLET** | Yes –Schedule IV | CASH | 16 | 4.71% |
| **AMLODIPINE BESYLATE 10 MG TAB** | No | CASH | 9 | 2.65% |
| | | OTHER | 1 | 0.29% |
| **VENTOLIN HFA 90 MCG INHALER** | No | CASH | 5 | 1.47% |
| | | OTHER | 1 | 0.29% |
| **HYDROCODON-ACETAMINOPH 7.5-325** | Yes-- Schedule II (Schedule III prior to 10/6/2014) | CASH | 5 | 1.47% |
| **HYDROCODON-ACETAMINOPHN 10-325** | Yes-- Schedule II (Schedule III prior to 10/6/2014) | CASH | 3 | 0.88% |

| | | | | |
|---|---|---|---|---|
| **DIAZEPAM 10 MG TABLET** | Yes – Schedule IV | CASH | 3 | 0.88% |
| **LORATADINE 10 MG TABLET** | No | CASH | 3 | 0.88% |
| **HYDROCODON-ACETAMINOPH 7.5-750** | Yes – Schedule III | CASH | 2 | 0.59% |
| **ACETAMINOPHEN-COD #4 TABLET** | Yes – Schedule III | CASH | 2 | 0.59% |
| **TRIAMCINOLONE 0.025% CREAM** | No | CASH | 1 | 0.29% |
| **CLOTRIMAZOLE 1% CREAM** | No | CASH | 1 | 0.29% |
| **FLUTICASONE PROP 50 MCG SPRAY** | No | CASH | 1 | 0.29% |
| **AMOXICILLIN 500 MG CAPSULE** | No | CASH | 1 | 0.29% |
| **SIMVASTATIN 20 MG TABLET** | No | OTHER | 1 | 0.29% |
| **FAMOTIDINE 20 MG TABLET** | No | OTHER | 1 | 0.29% |
| **HYDROCHLOROTHIAZIDE 50 MG TAB** | No | OTHER | 1 | 0.29% |
| **ZOLPIDEM TARTRATE 10 MG TABLET** | Yes – Schedule IV | CASH | 1 | 0.29% |
| **OXYCODONE HCL 30 MG TABLET** | Yes – Schedule II | CASH | 1 | 0.29% |
| **MELOXICAM 7.5 MG TABLET** | No | CASH | 1 | 0.29% |
| | | CASH Count | 331 | 97.35% |
| | | OTHER Count | 9 | 2.65% |
| **Grand Total** | | | **340** | **100.00%** |

55. SGP filled 340 prescriptions under Dr. S.O.'s prescribing authority during the query period. 85% of Dr. S.O.'s prescriptions were written for controlled substances. 97.35% of Dr. S.O.'s prescriptions were purchased in cash. A prescribing profile purchased almost entirely in cash with the majority of prescriptions written for controlled substances were both factors of irregularity.

56. Dr. S.O.'s self-reported areas of practice were "Thoracic Surgery" and "General Practice" with Board Certifications in "Surgery" and "Female Pelvic Medicine and Reconstructive Surgery." 61.47% of Dr. S.O.'s prescriptions filled at SGP were for promethazine/codeine syrup. Additionally, 98 patients received a prescription from Dr. S.O. at SGP during the query period. All but two of these patients received at least one prescription for promethazine/codeine. It would be unusual for a general practitioner or a surgeon to prescribe

promethazine/codeine for over half of his or her total prescriptions and to almost all of his or her patients. Dr. S.O.'s frequent prescribing of promethazine/codeine was a factor of irregularity. Despite prescribing a cough syrup for almost all of his patients, Dr. S.O.'s next most commonly prescribed medication was alprazolam 2 mg tablets used to treat anxiety. It was a factor of irregularity for many of Dr. S.O.'s patients to require treatment for both cough and anxiety.

57. Dr. S.O.'s license information also indicated the Medical Board of California filed an accusation in attempt to revoke Dr. S.O..'s license on June 11, 2015. The accusation alleged Dr. S.O. prescribed controlled substances "without medical indication.,"

**ANALYSIS OF DISPENSING DATA – OUT OF POCKET PAYMENTS**

57. The dispensing data provided by PIC TRAN contained many instances in which patients paid high out of pocket costs for oxycodone 30 mg tablets. For example, the dispensing data included:

- 185 instances when patients paid $900 for 100 oxycodone 30 mg tablets
- 180 instances when patients paid $1,000 for 100 oxycodone 30 mg tablets
- 12 instances when patients paid $1,100 for 100 oxycodone 30 mg tablets
- 35 instances when patients paid $810 for 90 oxycodone 30 mg tablets
- 35 instances when patients paid $900 for 90 oxycodone 30 mg tablets

58. On October 13, 2015, Inspector N.R. contacted Wal-Mart Pharmacy located in South Gate, CA 90280. Wal-Mart Pharmacy 10-3180 was located 0.9 miles from SGP. The inspector was informed that Wal-Mart Pharmacy's dispensing software listed the price for 100 oxycodone 30 mg tablets as $114.97. Inspector N.R. further called CVS Pharmacy near SGP and was informed that the price for 100 oxycodone 30 mg tablets was $158.99. There were 447 instances where SGP's patients paid between nine and 11 dollars per tablet for oxycodone 30 mg tablets. Wal-Mart Pharmacy and CVS Pharmacy quoted their prices for oxycodone 30 mg tablets as $1.15 and $1.59 per tablet respectively. Further, on April 9, 2015, SGP's purchase price for oxycodone 30 mg tablets was about 35 cents per tablet. This was a factor of irregularity for patients at SGP to be able and willing to pay significantly higher prices than what would have been charged at neighboring pharmacies.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY S.W.**

59. After analyzing the dispensing data, Inspector N.R. reviewed the prescription documents collected during the inspection and provided by PIC TRAN following the inspection. She reviewed all 33 prescription documents in her possession written by Dr. S.W. and noted the following trends: (1) Dr. S.W.'s patients would have travelled long distances to obtain controlled substance prescriptions from his office in Anaheim, California; (2) Dr. S.W.'s patients paid high out of pocket prices for controlled substance prescriptions; and (3) Many of Dr. S.W.'s prescriptions, especially for promethazine/codeine, were dated months before they were filled.

60. Other irregularities identified in Dr. S.W.'s prescription documents and verifications included: (1) Patient FB's address on file at other pharmacies was "homeless" however he purchased promethazine/codeine syrup from SGP for $100; (2) JW and AR both received prescriptions for promethazine/codeine syrup which were written 09/04/2014 and filled on 01/20/2015. Pharmacy Technician "KS" verified both prescriptions with Dr. S.W. at 10:34 am on 01/20/2015; (3) CA, LL, and DF received prescriptions for promethazine/codeine syrup which were written on 09/12/2014 and filled on 02/02/2015. "KS" verified all three prescriptions with Dr. S.W. at 10:32 am on 02/02/2015; (4) NS and JS received prescriptions for promethazine/codeine syrup and carisoprodol 350 mg tablets which were written on 10/02/2014 and filled on 12/23/2014 and 12/26/2014; (5) TP and DG received prescriptions for hydrocodone/acetaminophen 10/325 mg and promethazine/codeine syrup which were written and filled on 11/15/2013. "KS" verified both prescriptions with Dr. S.W. on 11/15/2013 at 2:07 pm; (6) GP and GSP had the same address on file at SGP and both received prescriptions for promethazine/codeine syrup from Dr. S.W.; (7) JD received a prescription for oxycodone 30 mg tablets, the highest available dose, and the prescription verification sheet indicated she had not received a controlled substance prescription in at least the previous three months.

61. SGP staff frequently checked Patient Activity Reports for Dr. S.W.'s patients and frequently made copies of the patients' identification cards. However PIC TRAN's statements

indicated both of these steps were completed by pharmacy technicians KS[2] and EH2. Additionally, the prescription verification sheets indicated a pharmacy technician, KS or EH2, called Dr. S.W. to "OK" the prescriptions. However, there was no documentation of conversations between Dr. S.W. and a pharmacist at SGP to attempt to resolve the irregularities listed above or establish the medical legitimacy of his prescriptions. For example, a pharmacist could have spoken with Dr. S.W. to ask if he was aware of previous controlled substance prescriptions reflected in PARs, to question prescribing a potentially opioid naive patient the highest available strength of oxycodone, and to ask if prescriptions for promethazine/codeine syrup were medically necessary months after they were written. Dr. S.W.'s answers to these questions could have helped the pharmacists at SGP to evaluate the medical legitimacy of these prescriptions. Further, 11 of the prescriptions described above were written after 09/29/2014 when a court order was issued prohibiting Dr. S.W. from practicing medicine. An additional 20 of the prescriptions listed above were written prior to the court order but verified by Dr. S.W. after the court order.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. M.G.**

62. Inspector N.R. reviewed all 31 prescription documents from Dr. M.G. and noticed the following: (1) Dr. M.G.'s patients paid high out of pocket prices for their prescriptions; (2) Many of Dr. M.G.'s patients received prescriptions for promethazine/codeine, cephalexin, alprazolam, and hydrocodone/acetaminophen which are used to treat cough, infection, anxiety, and pain; (3) Some of Dr. M.G.'s patients travelled long distances to obtain controlled substance prescriptions. Fourteen of said prescription documents reviewed were for patients who would have travelled 40 miles or more from the address on file at SGP to Dr. M.G.'s office, to SGP and back home; (4)

[2] It should be noted, Business and Professions Code Section 4115 allows in part, (a) A pharmacy technician may perform packaging, manipulative, repetitive, or other nondiscretionary tasks... and (c) This section does not authorize a pharmacy technician to perform any act requiring the exercise of professional judgment by a pharmacist. Therefore, a pharmacy technician is allowed to call a prescriber to confirm he or she did in fact write a prescription. However, a pharmacy technician may not have a clinical conversation with a prescriber to evaluate the legitimacy and/or appropriateness of a prescription. That evaluation and determination requires the professional judgment of the pharmacist.

Six of the prescription documents had an associated Patient Activity Report indicating the most recent controlled substance prescriptions the patient in question were prescribed by another physician, not Dr. M.G.; (5) Ten of the prescription documents indicated the patients' Patient Activity Report showed no previous controlled substances in the previous six months although these patients received the highest available strengths of alprazolam, hydrocodone/ acetaminophen, and/or oxycodone.

63. SGP's staff took steps to verify the legitimacy of Dr. M.G.'s prescriptions including copying the patients' identification cards and reviewing the Prescription Drug Monitoring Program. Additionally, a pharmacy technician spoke with "Betty" to verify each of the prescriptions filled. However, SGP failed to produce documentation of conversations between Dr. M.G. and a pharmacist at SGP to attempt to resolve the irregularities listed above or establish the medical legitimacy of her prescriptions. For example, a pharmacist could have spoken with Dr. M.G. to inquire about her frequent prescribing of the combination of promethazine/codeine, cephalexin, alprazolam, and hydrocodone/acetaminophen. A pharmacist could have questioned the prescribing of high doses of alprazolam and oxycodone to patients who had not received a similar medication in the previous six months or asked if Dr. M.G. was aware of previous controlled substance prescriptions written by other prescribers. Business and Professions Code Section 4115 does not allow these clinical discussions to be delegated to a pharmacy technician. Further, all the documented verifications of Dr. M.G.'s prescriptions were conversations with "Betty" at Dr. M.G.'s office, rather than Dr. M.G.. These conversations between "Betty" and pharmacy technicians at SGP were insufficient to resolve the irregularities described above. Had pharmacists at SGP had substantive discussions with Dr. Garg regarding her prescribing, they could have better evaluated the medical legitimacy of the prescriptions in question.

64. Further, SGP filled 64 prescriptions under Dr. M.G.'s prescribing authority after 12/06/2013 when Dr. M.G.'s license to practice medicine was revoked. Review of the prescription documents indicated 36 of these prescriptions were actually written after 12/06/2013.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. M.P.**

65. Investigator N.R. reviewed all six prescription documents and associated verifications in her possession from Dr. M.P.. All six prescription documents included one prescription for oxycodone 30 mg tablets and one prescription for a non-steroidal anti-inflammatory. One of the prescription documents contained a third prescription for an antifungal solution.

66. For each prescription document, SGP staff faxed an image of the prescription document, sometimes with an image of the patient's identification card, to Dr. M.P.'s office. Dr. M.P.'s office responded with a list of ICD-9 diagnosis codes. SGP also printed a Patient Activity Report for each patient. Investigator N.R. noted the following: (1) Dr. M.P. listed three or four diagnoses for each patient. Examples included: 719.57 (stiffness of joint, ankle and foot), 715.97 (osteoarthritis, ankle and foot), 729.5 (pain in limb), 719.7 (difficulty in walking), 718.87 (other joint derangement, ankle and foot), 718.47 (contracture of joint, ankle and foot). It was a factor of irregularity for Dr. M.P. to prescribe oxycodone 30 mg, to take 1 or 2 tablets every four to six hours for six patients each with a different combination of foot and ankle ailments.

67. Some of Dr. M.P.'s patients travelled long distances to obtain controlled substances from SGP. Patient E.T.would have travelled 69 miles from her address in Lake Elsinore, CA to SGP. Patient SR would have travelled 43 miles from her address in Canoga Park, CA to SGP. It was a factor of irregularity for these patients to travel over 40 miles, one direction from home to SGP to obtain controlled substances.

68. Dr. M.P.'s patients paid very high out of pocket costs for their prescriptions for oxycodone 30 mg. Patients WH, TR, GK, and ET paid $990 for 90 tablets. Patients SR and KB paid $1,100 for 100 tablets. It would not be typical for multiple patients to be willing and able to pay approximately $1,000 for a single prescription. This was another factor of irregularity.

69. The Patient Activity Report for Patient ET found she had not received a controlled substance prescription in the previous six months. However, one of Patient ET's prescriptions from Dr. M.P. was written for oxycodone 30 mg, the highest available strength. The Patient Activity Report for Patient KB indicated he received carisoprodol 350 mg, acetaminophen/ codeine 300/60 mg, and alprazolam 2 mg from Dr. S.O. at Ramona Professional two days before his prescription from Dr. M.P. was written and 15 days before it was filled by SGP.

70. SGP's records do not contain documentation of conversations between a pharmacist and Dr. M.P.. A pharmacist could have spoken with Dr. M.P. to address such irregularities as his frequent prescribing of the same dose of oxycodone 30 mg and his patients' frequent cash payments, or questioned prescribing the highest available dose of oxycodone to a patient who had not received a narcotic prescription in the previous six months, or questioned if Dr. M.P. was aware of Patient KB's prescriptions written by Dr. S.O.. Dr. M.P.'s answers to these questions could have helped the pharmacist make a determination regarding the medical legitimacy of these prescriptions.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. S.O.**

71. Inspector N.R. reviewed all four prescription documents in her possession from Dr. S.O.. For each prescription document, SGP staff attached the prescription document to a verification sheet including a copy of the prescription document with handwritten statements indicating a pharmacy staff member, either unidentified or "KS", spoke with "Kassydra" or "Kassandra" to verify the prescriptions, and a printout of the patient's Patient Activity Report.

72. The following irregularities were noted: (1) All four of the prescription documents contained prescriptions for promethazine/codeine syrup, 8 oz, to take one teaspoonful every 6 hours; (2) Patient DJ received a prescription for promethazine/codeine syrup from Dr. S.O. on 03/31/2015 and filled the prescription over a month later on 05/04/2015. There were no documentations to indicate a pharmacist spoke with Dr. S.O. to discuss the legitimacy or appropriateness of these prescriptions. For example, a pharmacist could have inquired if Patient DJ still needed treatment for cough over a month after the prescription was written.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. D.W.**

73. Inspector N.R. reviewed all six prescription documents in her possession from Dr. D.W. for three patients. For each prescription document, SGP staff attached the prescription document to a verification sheet including a copy of the prescription document with handwritten

statements indicating KS and EH2 verified the prescriptions with Dr. D.W., and a printout of each patient's Patient Activity Report.

74. Inspector N.R. noted the following irregularities: (1) Dr. D.W.'s patients paid out of pocket costs for the prescriptions, between $1,160 and $1,175 for the total order; (2) Dr. D.W.'s prescription document read, "Internal Medicine – Adult Cardiology;" (3) Diagnoses codes written by Dr. D.W. on the prescription documents included: DL–LBP (low back pain)and anxiety/ insomnia, BF–ankle FX, LBP (low back pain) and anxiety/insomnia, DG–knee FX and anxiety/ insomnia. As with the previous prescribers discussed, there was not documentation indicating a pharmacist spoke with Dr. D.W. to address the legitimacy and/or appropriateness of these prescriptions.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. C.A.**

75. Inspector N.R. reviewed all nine prescription documents in my possession from Dr. C.A.. For each prescription document, SGP Staff attached the prescription document to one or more of the following; a verification sheet including a copy of the patient's identification card, a copy of the prescription document, and a printout of each patient's Patient Activity Report. Additionally, SGP Staff, EH, KS, EH2, documented verbal verifications with "Nora" and "Shawn". The following irregularities were noted: (1) Patient AJ's California Driver License and address on file at SGP indicated she lived in Fresno, California, 228 miles from SGP; (2) The verification sheet for Patient AB indicated there were, "No Records Found" on his Patient Activity Report. However, AB received alprazolam 2 mg tablets, the highest available dose; (3) Dr. C.A.'s patients paid high out of pocket costs for their prescriptions, between $125 and $320 for the total order.

76. There was no documentation regarding conversations between a pharmacist at SGP and Dr. C.A. to discuss the factors of irregularity present in these prescriptions and gather information to make a decision about the medical legitimacy of the prescriptions.

**FIRST CAUSE FOR DISCIPLINE**

**(Responsibility for Legitimacy of Prescription; Corresponding Responsibility of Pharmacist)**

77. Respondent SGP is subject to disciplinary action under Health and Safety Code Section 11153(a) in conjunction with California Code of Regulations section 1761, in that from approximately January 1/2012 to approximately February 3, 2015, SGP filled 4,462 prescriptions under the prescribing authority of Drs. S.W., C.A., M.G., M.P., D.W., and S.O.. These prescriptions contained significant irregularities suggesting their medical illegitimacy including the following:

a. The majority of the prescriptions written by the listed prescribers were purchased in cash, meaning without the assistance of prescription insurance. During the query period, 98.42% of Dr. S.W.'s prescriptions, 99.90% of Dr. C.A.'s Prescriptions, 98.64% of Dr. M.P.'s prescriptions, 100% of Dr. M.G.'s prescriptions, 99.37% of Dr. D.W.'s prescriptions, and 97.35% of Dr. S.O.'s prescriptions were purchased in cash.

b. Dr. C.A.'s prescribing profile consisting almost entirely of controlled substances. 98.77% of the prescriptions filled under Dr. C.A.'s prescribing authority during the query period were controlled substances.

c. Many patients of the listed prescribers paid exceptionally high prices for oxycodone prescriptions. During the query period, 377 patients paid between $900 and $1,100 for 100 oxycodone 30 mg tablets.

d. The majority of the prescriptions written by the listed prescribers for oxycodone, alprazolam, and hydrocodone-containing products contained the highest available dose of each medication. For example, Dr. S.W. wrote 508 prescriptions for oxycodone 30 mg tablets, alprazolam 2 mg tablets, and hydrocodone/acetaminophen 10/325 mg tablets and wrote a total of 14 prescriptions for any other strength of these three medications.

e. The prescribing profiles of the listed prescribers were unusually limited with a small number of controlled substances accounting for a relatively large percentage of their total prescribing:

1. 61.47% of Dr. S.O.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were for promethazine/codeine syrup.

2. 31.45% of Dr. D.W.'s prescriptions were for oxycodone 30 mg tablets.

3. 31.09% of Dr. M.G.'s prescriptions were for promethazine/codeine syrup.

4. 34.17% of Dr. M.P.'s prescriptions were for oxycodone 30 mg tablets.

5. 98.05% of Dr. C.A.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg.

6 59.04% of Dr. S.W.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets, and alprazolam 2 mg tablets.

f. Dr. S.W.'s patients travelled excessive distances, 31 miles between his office and the pharmacy, to obtain controlled substances from SGP.

g. SGP did not produce any documentations indicating that a pharmacist conferred with the prescriber to address the irregularities described above.

78. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 20 through 76, inclusive, as though set forth fully.

## SECOND CAUSE FOR DISCIPLINE

**(Responsibility for Legitimacy of Prescription; Corresponding Responsibility of Pharmacist)**

79. Respondent PIC TRAN is subject to disciplinary action under Health and Safety Code Section 11153(a) in conjunction with California Code of Regulations section 1761, in that approximately January 1, 2012 to approximately February 3, 2015, PIC TRAN while acting as Pharmacist-in-Charge of SGP, where 4,462 prescriptions were filled under the prescribing authority of Drs. S.W., C.A., M.G., M.P., D.W., and S.O.. These prescriptions contained significant irregularities suggesting their medical illegitimacy including the following:

a. The majority of the prescriptions written by the listed prescribers were purchased in cash, meaning without the assistance of prescription insurance. During the query period, 98.42%

of Dr. S.W.'s prescriptions, 99.90% of Dr.C.A.'s Prescriptions, 98.64% of Dr. M.P.'s prescriptions, 100% of Dr. M.G.'s prescriptions, 99.37% of Dr. D.W.'s prescriptions, and 97.35% of Dr. S.O.'s prescriptions were purchased in cash.

b. Dr. C.A.'s prescribing profile consisting almost entirely of controlled substances. 98.77% of the prescriptions filled under Dr. C.A.'s prescribing authority during the query period were controlled substances.

c. Many patients of the listed prescribers paid exceptionally high prices for oxycodone prescriptions. During the query period, 377 patients paid between $900 and $1,100 for 100 oxycodone 30 mg tablets.

d. The majority of the prescriptions written by the listed prescribers for oxycodone, alprazolam, and hydrocodone-containing products contained the highest available dose of each medication. For example, Dr. S.W. wrote 508 prescriptions for oxycodone 30 mg tablets, alprazolam 2 mg tablets, and hydrocodone/acetaminophen 10/325 mg tablets and wrote a total of 14 prescriptions for any other strength of these three medications.

e. The prescribing profiles of the listed prescribers were unusually limited with a small number of controlled substances accounting for a relatively large percentage of their total prescribing.

1. 61.47% of Dr. S.O.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were for promethazine/codeine syrup.

2. 31.45% of Dr. D.W.'s prescriptions were for oxycodone 30 mg tablets.

3. 31.09% of Dr. M.G.'s prescriptions were for promethazine/codeine syrup.

4. 34.17% of Dr. M.P.'s prescriptions were for oxycodone 30 mg tablets.

5. 98.05% of Dr. C.A.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg.

6. 59.04% of Dr. S.W.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets, and alprazolam 2 mg tablets.

f. Dr. S.W.'s patients travelled excessive distances, 31 miles between his office and the pharmacy, to obtain controlled substances from LA's Pharmacy and Medical Equipment.

g. SGP did not have any documentations indicating that a pharmacist conferred with the prescriber to address the irregularities described above.

80. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 20 through 76, inclusive, as though set forth fully.

**THIRD CAUSE FOR DISCIPLINE**

81. Respondent PIC TRAN is subject to disciplinary action under sections 4081[3], 4113, subdivision (c) and 4036.5 of the Code, in that PIC TRAN is strictly liable as a Pharmacist in charge for SGP, for filled 4,462 prescriptions under the prescribing authority of Drs. S.W., C.A., M.G., M.P., D.W., and S.O.. These prescriptions contained significant irregularities suggesting their medical illegitimacy including the following:

a. The majority of the prescriptions written by the listed prescribers were purchased in cash, meaning without the assistance of prescription insurance. During the query period, 98.42% of Dr. S.W.'s prescriptions, 99.90% of Dr.C.A.'s Prescriptions, 98.64% of Dr. M.P.'s prescriptions, 100% of Dr. M.G.'s prescriptions, 99.37% of Dr. D.W.'s prescriptions, and 97.35% of Dr. S.O.'s prescriptions were purchased in cash.

b. Dr. C.A.'s prescribing profile consisting almost entirely of controlled substances. 98.77% of the prescriptions filled under Dr. C.A.'s prescribing authority during the query period were controlled substances.

c. Many patients of the listed prescribers paid exceptionally high prices for oxycodone prescriptions. During the query period, 377 patients paid between $900 and $1,100 for 100 oxycodone 30 mg tablets.

d. The majority of the prescriptions written by the listed prescribers for oxycodone, alprazolam, and hydrocodone-containing products contained the highest available dose of each medication. For example, Dr. S.W. wrote 508 prescriptions for oxycodone 30 mg tablets,

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[3] *Sternberg v. California Board of Pharmacy* (2015) 239 Cal.App.4th 1159.

alprazolam 2 mg tablets, and hydrocodone/acetaminophen 10/325 mg tablets and wrote a total of 14 prescriptions for any other strength of these three medications.

e. The prescribing profiles of the listed prescribers were unusually limited with a small number of controlled substances accounting for a relatively large percentage of their total prescribing.

1. 61.47% of Dr. S.O.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were for promethazine/codeine syrup.

2. 31.45% of Dr. D.W.'s prescriptions were for oxycodone 30 mg tablets.

3. 31.09% of Dr. M.G.'s prescriptions were for promethazine/codeine syrup.

4. 34.17% of Dr. M.P.'s prescriptions were for oxycodone 30 mg tablets.

5. 98.05% of Dr. C.A.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg.

6. 59.04% of Dr. S.W.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets, and alprazolam 2 mg tablets.

f. Dr. S.W.'s patients travelled excessive distances, 31 miles between his office and the pharmacy, to obtain controlled substances from LA's Pharmacy and Medical Equipment.

g. SGP did not have any documentations indicating that a pharmacist conferred with the prescriber to address the irregularities described above.

82. As the pharmacist-in-charge, PIC TRAN was responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. A Pharmacist-in-charge as the supervisor or manager of a pharmacy is responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. The pharmacist-in-charge is responsible for acts of the owner, officer, partner, or employee that violate this section and of which the pharmacist-in-charge, responsible manager, or designated representative-in-charge had no knowledge, or in which he or she did not knowingly participate. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 123 through 165, 210 through 215, as though set forth fully.

83. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 20 through 76, inclusive, as though set forth fully.

**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 License Number PHY 49169, issued to SGP Inc dba LA's Pharmacy & Medical Equipment.

2. Revoking or suspending Pharmacist License Number 44467 to Roger Tran, PIC.

3. Ordering SGP 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: 1/16/17

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

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

| In the Matter of the Accusation Against: | Case No. 5768 |
|---|---|
| **SGP INC DBA LA'S PHARMACY & MEDICAL EQUIPMENT**<br>**7903 S. Atlantic Ave., Ste. E**<br>**Cudahy, CA 90201** | **A C C U S A T I O N** |
| **Pharmacy Permit License No. PHY 49169** | |
| **ROGER TRAN**<br>**31 Bell Pasture**<br>**Ladera Ranch, Orange CA 92694** | |
| **Pharmacist License No. RPH 44467** | |
| Respondents. | |

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 September 8, 2008, the Board of Pharmacy issued Pharmacy Permit License Number PHY 49169 to SGP Inc dba LA's Pharmacy & Medical Equipment (SGP). The Pharmacy Permit License was in full force and effect at all times relevant to the charges brought herein and will expire on September 1, 2017, unless renewed.

3. On or about August 9, 1991, the Board of Pharmacy issued Pharmacist License Number 44467 to Roger Tran (TRAN). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 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.

## STATUTORY AUTHORITIES

5. **Section 118, subdivision (b),** of the Code states:

" The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

6. **Section 4006** of the Code states:

"The board may adopt regulations consistent with this chapter and Section 111485 of the Health and Safety Code or regulations adopted thereunder, limiting or restricting the furnishing of a particular drug upon a finding that the otherwise unrestricted retail sale of the drug pursuant to Section 4057 is dangerous to the public health or safety."

7. **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:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self use, except veterinary drugs that are labeled as such, 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

. . . .

"(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. **Health and Safety Code section (HSC) 11153(a)** states:

"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 PROVISIONS

9. 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; and

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

## CONTROLLED SUBSTANCES AND/OR DANGEROUS DRUGS

10. "**Controlled substance**" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

11. **Phenergan with Codeine Syrup** is a Schedule V controlled substance as designated by Health and Safety Code section 11058(c)(1) and a dangerous drug as designated by

Business and Professions Code section 4022. The generic name is promethazine with codeine syrup.

12. **Norco** is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), a dangerous drug as designated by Business and Professions Code section 4022, and Schedule II per 21 CFR 1308 as of October 6, 2014. The generic name is hydrocodone/acetaminophen.

13. **Roxicodone** is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M) and a dangerous drug as designated by Business and Professions Code section 4022. The generic name is oxycodone.

14. **Xanax** is a Schedule IV controlled substance as designated by Health and Safety Code section 11057(d)(1) and a dangerous drug as designated by Business and Professions Code section 4022. The generic name is alprazolam.

15. **Kelfex** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is cephalexin.

16. **DOK** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is docusate.

17. **Motrin** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is Ibuprofen.

18. **Mobic** is a dangerous drug as designated by Business and Professions Code section 4022. The generic name is Meloxicam.

## COST RECOVERY

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

## ARREST OF DR. M.G. FOR SELLING ILLEGAL PRESCRIPTIONS

20. The Board of Pharmacy became aware of the arrest and federal indictment of Dr. M.G. as described by the United States Attorney's Office. The federal authorities arrested five

defendants, including Dr. M.G., linked to a narcotics trafficking ring, "that sold illegal prescriptions for cash and obtained drugs that were shipped to Texas for sale on the black market." The operation was based in the Southfork Medical Clinic and alleged the clinic was a "pill mill" where Dr. M.G. wrote prescriptions "without a legitimate medical purpose." Dr. M.G. issued more than 10,000 prescriptions over a 15 month period and nearly 80 percent of the prescriptions were for hydrocodone or alprazolam. The undercover operations conducted at Southfork Medical Clinic in which Dr. M.G. gave undercover cooperators prescriptions for oxycodone and promethazine/codeine syrup, "in exchange for the person returning to the clinic with the bottles of the prescribed cough syrup."

21. The Board reviewed the California Controlled Substance Utilization and Review and Evaluation System (CURES) database which contains information about controlled substance prescriptions filled in California, as reported by pharmacies. Review of CURES data indicated SGP filled a portion of Dr. M.G.'s controlled substances prescriptions. The Board initiated an investigation at SGP based on this information.

**REVIEW OF CURES DATA FOR SGP**

22. Board's Inspector N.R. reviewed CURES data for SGP showing controlled substance prescriptions dispensed at SGP from 01/01/2012 to 02/03/2015. In addition to Dr. M.G., Inspector N.R. noted the following prescribers with seemingly irregular controlled substance dispensing profiles:

| Prescriber | Number of Prescriptions Dispensed | Payment Method | Summary of Prescribing at LA's Pharmacy & Medical Equipment |
|---|---|---|---|
| Dr. S. W. | 550 | 99.45% Cash | 88.18% of controlled substance prescriptions reported to CURES during the query period were oxycodone 30 mg, hydrocodone/acetaminophen 10/325 mg, or alprazolam 2 mg. |
| Dr. C.A. | 457 | 99.78% Cash | 98.91% of controlled substance prescriptions reported to CURES were hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg. |
| Dr. M.P. | 222 | 100% Cash | 55.65% of the controlled substance prescriptions reported to CURES were for oxycodone 30 mg. |

| Dr. D.W. | 210 | 99.05% Cash | 66.67% of the controlled substance prescriptions reported to CURES were for oxycodone 30 mg. |
|---|---|---|---|
| Dr. S.O. | 78 | 100% Cash | 56.41% of the controlled substance prescriptions reported to CURES were for alprazolam 2 mg. |

**BOARD'S INSPECTION**

23. On May 5, 2015, Inspectors A.N. and N.R. conducted an inspection at SGP. Pharmacist-in-charge (PIC) Roger Tran was not present, however, staff pharmacist R.N. was present and assisted in the inspection. RPH Nguyen explained that SGP filled about 100-150 prescriptions per day. The inspectors requested to review prescription documents for filled prescriptions which are usually filed sequentially in "books" by prescription number. Pharmacy Technician K.S. provided several "books" of completed prescription documents. The books contained prescription documents for schedule II controlled substances, schedules III-V controlled substances, and non-controlled substances, comingled.

24. The board inspectors reviewed the completed prescription documents, however, they were unable to find any prescription documents from the prescribers identified in the above chart. RPH Nguyen spoke with Pharmacy Technician K.S. who informed the inspectors that a portion of the pharmacy's prescription documents were filed separately in the back of the pharmacy. Technician Sanchez produced one rubber-banded stack of prescription for Drs. S.W., M.P., D.W. and S.O., and M.G.

25. Inspector A.N. inquired about the procedure for filing and retaining prescription documents at SGP.. It is common practice for pharmacies to assign prescription numbers to the prescription documents and file them numerically by prescription number. However, the inspectors had not seen a pharmacy organize prescription documents by prescriber. Further, it seemed unusual that prescriptions written by the prescribers the inspectors identified as having potentially irregular dispensing profiles were separated from the majority of the pharmacy's prescription documents. Technician Sanchez and RPH Nguyen were not able to explain why the pharmacy filed prescription documents from these prescribers separately.

26. The board inspectors reviewed and collected a sample of prescription documents. The majority of the prescription documents were stapled to a sheet of paper containing one or more of the following elements: a photocopy of the prescription itself, a photocopy of the patient's identification card, and/or a printout of a Patient Activity Report from the California Prescription Drug Monitoring Program which showed a patient's recent controlled substance dispensing history from pharmacies in California. The inspectors collected prescription documents and associated verifications from Drs. S.W., M.P., D.W., S.O., and M.G..

27. Inspector N.R. asked RPH Nguyen if he was familiar with the prescribers listed above. RPH Nguyen stated he believed Dr. S.W. had restrictions placed on his license by the Board of Medicine or the Drug Enforcement Administration (DEA) and he explained that SGP had stopped filling Dr. S.W.'s prescriptions. The inspectors reviewed and collected a sample of invoices for sales of medications from Cardinal Health to SGP. At the conclusion of the inspection, Inspector N.R. (1) left a questionnaire regarding corresponding responsibility and requested PIC Tran complete the questionnaire and provide it to her; and (2) asked SGP to provide their complete dispensing data for controlled and non-controlled substances in an excel file. She issued a correction for non-compliance with the Code of Federal Regulations Section 1304.04(f)(1) which states in part, Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all of the records of the registrant. She explained to RPH Tran that the prescription documents for Schedule II controlled substances should be filed separately from prescription documents for Schedules III-V and non-controlled substances.

**COMMUNICATIONS WITH PIC TRAN**

28. On May 15, 2015, Inspector N.R. received a fax from PIC TRAN which included PIC Tran's responses to the questions she left during the inspection on May 5, 2015. Inspector N.R.'s questions and PIC TRAN's responses were as follows:

1. Is your computer software the primary method of record keeping and maintenance in the pharmacy? If not, what is? "Yes".

2. Is the following statement true or false: The electronic computer record of dispensed prescriptions stored in the pharmacy software system is a true and accurate representation of the hard copy (paper) prescription record? "Yes".

3. Describe the sequential steps this pharmacy takes to satisfy its corresponding responsibility to dispense only medically legitimate controlled substance prescriptions. In other words, what criteria/criterion must a controlled substance prescription satisfy before this pharmacy decides to fill and dispense the medication? "Controlled prescriptions must be written on secure prescription form, Copy patient id and check patient address, DOB, Phone number, Verify MD with Physician Board, Patient is checked on PDMP/CURES to verify if the prescription was filled recently usually within 30 days, Profile on PDMP/CURES is checked for last 3 months. If the profile looks okay the doctor's office is called to verify that the prescription is okay, then the prescription is filled and dispensed."

4. Does this pharmacy have to capability to access information provided by the Prescription Drug Monitoring Program (PDMP) (sometimes referred to as CURES data) which is provided freely to pharmacists? If yes, provide a sample. "Yes. See sample."

5. If yes, explain the instances in which this pharmacy checks the PDMP. "Every controlled substance medications"

6. When the pharmacy does check the PDMP, how does the review of information affect the outcome of dispensing the controlled substance prescription? "Last fill date; how often controlled medications are filled, doctors that prescribe the medication; If there are discrepancies for any of the above mention; the prescription will be return to patient."

7. What is your and/or your pharmacy's policy on filling a controlled substance prescription early? In your opinion. How many days are too soon to fill a controlled substance prescription early? "Controlled substances are rarely filled early unless otherwise requested by the doctor with valid reason. Controlled substances are filled on or after the day supply of the last time the medication was received by the patient."

8. Are you familiar with the term "doctor shopper?" If you are, explain what this means and explain how you and/or this pharmacy identify and handle doctor shoppers. "Yes.

Patients that received controlled medications from different doctors. These patients are identified via PDMP/CURES program. We reserve the right to refuse service."

9. If you took special notes on a patient or prescription, where do you store the notes (i.e. on the computer patient profile, documented on the prescription hard copy, other documentation?) "Documented on hard copy and patients profiles."

10. Does this pharmacy have policy on dispensing controlled substance prescriptions from out of the area doctors? According to the practice of this pharmacy, what is an acceptable distance from the doctor's office to the pharmacy to allow dispensing of controlled substance prescriptions? "This pharmacy follows the legal limitations when dispensing controlled substances from out of the area doctors."

11. Does this pharmacy have policy on dispensing controlled substance prescriptions to out of the area patients? According to the practice of this pharmacy, what is an acceptable distance from the patient's home to the pharmacy to allow dispensing of controlled substance prescriptions? "This pharmacy follows the legal limitations when dispensing controlled substances from out of the area patients."

12. List and describe any training, continuing education, certification or the like you or your pharmacy has in the field of pain management. Include any and all documentation to support this training, continuing education credit, certificate or the like. "We are retail pharmacy only."

13. Based on your education and professional experience, what is the appropriate starting dose for the following medications:

| | | |
|---|---|---|
| a. | Alprazolam | "Alprazolam 0.25-0.5 mg tid" |
| b. | Hydrocodone/acetaminophen | "Hydrocodone/apap 5/325 mg q4-6h prn" |
| c. | Oxycodone immediate release | "Oxycodone ir 10-20 mg q 4 h prn" |
| d. | Oxycodone extended release | "Oxycodone ext. release 10 mg bid prn" |

14. How does this pharmacy determine if a patient is naïve to benzodiazepine and opiate therapy? How is this information documented? "According to patient and physician. This information is recorded in the hard copy of RX."

15. Are you familiar with the nature of the practice of the following prescribers?

a. Dr. S.W.? Internal medicine. Cease from practice

b. Dr. C.A.? General practitioner

c. Dr. M.P.? Podiatrist

d. Dr. D.W.? Internal medicine cardiology

e. Dr. M.G.? General Practice.

16. Have you called and spoken to anyone at the above prescribers offices? If so, who did you speak with and why?

"Yes. Drs. S.W., C.A., M.P., D.W., and M.G., to verify prescriptions"

29. On September 2, 2015, after an initial review of the prescription documents collected during the inspection, Inspector N.R. sent PIC TRAN a second questionnaire and a request for additional prescription documents. On September 19, 2015, Inspector N.R. received a response from PIC Tran along with the requested prescription documents from Dr. S.W. and M.G. Inspector N.R.'s questions and PIC Tran's responses included the following:

1. Many of the prescription documents collected during the inspection on 05/05/2015 have verifications initialed by "KS". Who is "KS"? "[Technician] K.S."

2. Many of the prescription documents have a notation reading "C-Verified". What does that statement indicate? "We checked patients with cures program make sure patients not filled control substance somewhere else."

3. During the inspection on 05/05/2015, the prescription documents (hard copies) for Drs. M.G., S.O., C.A., and D.W. were filed separately from other prescriptions, by prescriber. Why does LA's Pharmacy use this filing convention? "The owner wanted to keep them separately for checking cash patients and keeping track of cash payments"

30. On December 1, 2015, Inspector N.R. sent PIC TRAN and the owner of SGP, Mr. Long, another email. She asked if there were additional documentations of verifications or prescriber conversations regarding the prescriptions in her possession. On December 2, 2015, PIC TRAN replied via email and stated, "We do not have any additional records of verification."

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## REVIEW OF THE ELECTRONIC DISPENSING DATA

2 31. After Inspector N.R. reviewed the electronic dispensing data provided by PIC TRAN
3 and Mr. Long, the majority of the prescriptions filled at SGP during the query period were
4 purchased using drug insurance. 88.25% of the prescriptions in the dispensing data showed
5 prescription insurance as the payment method while 11.72% of the prescriptions showed "cash"
6 as the payment method. Typically, patients do not desire to pay high out-of-picket costs for
7 medications; therefore, using the financial aid of insurance is normally desired. As a baseline
8 measure, the percentage of payment methods seemed standard. Further, the top 20 drugs
9 dispensed by the pharmacy consisted of a mixture of drugs treating a variety of conditions.
10 Inspector N.R. prepared the below chart:

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| Medication | Controlled Substance? | Number of Prescriptions Dispensed | Percent of Total Prescriptions Dispensed |
|---|---|---|---|
| OMEPRAZOLE DR 20 MG CAPSULE | No | 2274 | 2.28% |
| PROMETHAZINE-CODEINE SYRUP | Yes – Schedule V per HSC 11058(c)(1) | 2165 | 2.17% |
| IBUPROFEN 600 MG TABLET | No | 1687 | 1.69% |
| ASPIRIN EC 81 MG TABLET | No | 1681 | 1.68% |
| PROMETHAZINE-DM SYRUP | No | 1535 | 1.54% |
| METFORMIN HCL 1,000 MG TABLET | No | 1426 | 1.43% |
| PROAIR HFA 90 MCG INHALER | No | 1425 | 1.43% |
| LORATADINE 10 MG TABLET | No | 1421 | 1.42% |
| FLUTICASONE PROP 50 MCG SPRAY | No | 1305 | 1.31% |
| ASPIR-LOW EC 81 MG TABLET | No | 1256 | 1.26% |
| FERROUS SULFATE 325 MG TABLET | No | 1154 | 1.16% |
| TRAMADOL HCL 50 MG TABLET | Yes – Schedule IV per 21 CFR 1308 as of 08/18/2014 | 1025 | 1.03% |
| HYDROCODON-ACETAMINOPHN 10-325 | Yes – Schedule III per H&SC 11056(e)(4) and Schedule II per 21 CFR 1308 as of 10/6/14 | 992 | 0.99% |
| SIMVASTATIN 20 MG TABLET | No | 974 | 0.98% |
| LISINOPRIL 40 MG TABLET | No | 959 | 0.96% |
| METFORMIN HCL 500 MG TABLET | No | 938 | 0.94% |
| TRIAMCINOLONE 0.1% CREAM | No | 932 | 0.93% |
| AMLODIPINE BESYLATE 10 MG TAB | No | 865 | 0.87% |

| | | | |
|---|---|---|---|
| AMOXICILLIN 500 MG CAPSULE | No | 837 | 0.84% |
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II per HSC 11055(b)(1)(M) | 815 | 0.82% |

**CORRESPONDING RESPONSIBILITY(ANALYSIS OF DISPENSING DATA-PRESCRIBER STATISTICS AND PRESCRIPTIONS OF IRREGULARITY)**

32. Inspector N.R. reviewed the dispensing profiles for several prescribers at SGP. She identified irregularities in the prescribing profiles of Drs. S.W., C.A., M.G., M.P., D.W., and S.O..

33. The Board periodically publishes a newsletter, The Script, which covers topics such as pharmacy laws and regulations, pharmacy practice, and Board of Pharmacy news. This background information establishes the importance of a pharmacist's and a pharmacy's corresponding responsibility to fully use available resources to actively scrutinize and evaluate controlled substance prescriptions. The Script has addressed the topic of corresponding responsibility 10 times in the previous 16 years.

34. On March 4, 2013, the DEA presented a Power Point presentation entitled "DEA Update & Perspectives on Prescription Drug Trafficking & Abuse Trends." The presentation covered commonly abused prescription medications. Drugs included were hydrocodone, carisoprodol, oxycodone 30 mg and alprazolam. The presentation explained these medications are often taken in combinations. The combination or "drug cocktail" consisting of a hydrocodone-containing product, carisoprodol, and a benzodiazepine (typically alprazolam) became so prevalent it was referred to as "The Trinity". It is important to note each of these drugs exhibit high potential for abuse when used alone.

35. The National Institute on Drug Abuse (NIDA) monitors and publishes summaries of emerging trends in drugs of abuse. NIDA identified promethazine with codeine syrup as a drug of abuse with risk of fatal overdose. Street slang for the drug includes Purple Drank, Sizzurp and Lean.

36. The Spring 2014 issue of The Script as well as the Board's Corresponding Responsibility Brochure listed the following, "**red flags** that could alert a pharmacist that a prescription ordered for a controlled drug may not be appropriate."

- Irregularities on the face of the prescription itself
- Nervous patient demeanor
- Age or presentation of patient (e.g., youthful patients seeking chronic pain medications)
- Multiple patients at the same address
- Cash payments
- Requests for early refills of prescriptions
- Prescriptions written for an unusually large quantity of drugs
- Prescriptions written for potentially duplicative drugs
- The same combinations of drugs prescribed for multiple patients
- Initial prescriptions written for strong opiates (e.g., OxyContin 80mg)
- Long distances traveled from the patient's home, to the prescriber's office or pharmacy
- Irregularities in the prescriber's qualifications in relation to the medication(s) prescribed
- Prescriptions that are written outside of the prescriber's medical specialty
- Prescriptions for medications with no logical connection to diagnosis or treatment

37. Pharmacists serve an important role in preventing drug diversion and limiting illegitimate use of drugs. Recognition of red flags, which have been significantly publicized as detailed above, is vital to a pharmacist's ability to evaluate the legitimacy of prescriptions. When a pharmacist receives a prescription, the presence of one or more red flags could represent a level of irregularity which would warrant contacting the prescriber to validate the prescription.

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**DISPENSING RECORD REVIEW: DR. S.W. (01/01/2012 to 02/03/2015)[1]**

| Medications | Number of Prescriptions | % of Dr. S.W. Total Prescriptions |
|---|---|---|
| **PROMETHAZINE-CODEINE SYRUP** | **610** | **32.16%** |
| CASH | 606 | 31.95% |
| OTHER | 4 | 0.21% |
| **HYDROCODON-ACETAMINOPHN 10-325** | **206** | **10.86%** |
| CASH | 205 | 10.81% |
| OTHER | 1 | 0.05% |
| **OXYCODONE HCL 30 MG TABLET** | **176** | **9.28%** |
| CASH | 176 | 9.28% |
| **ALPRAZOLAM 2 MG TABLET** | **128** | **6.75%** |
| CASH | 128 | 6.75% |
| **AMOXICILLIN 500 MG CAPSULE** | **77** | **4.06%** |
| CASH | 77 | 4.06% |
| **DOK 100 MG CAPSULE** | **69** | **3.64%** |
| CASH | 69 | 3.64% |
| **CEPHALEXIN 500 MG CAPSULE** | **40** | **2.11%** |
| CASH | 37 | 1.95% |
| OTHER | 3 | 0.16% |
| **PREVAIL WASHCLOTH 12X8** | **39** | **2.06%** |
| CASH | 39 | 2.06% |
| **PENICILLIN VK 500 MG TABLET** | **26** | **1.37%** |
| CASH | 25 | 1.32% |
| OTHER | 1 | 0.05% |
| **SENSI-CARE PERINEAL CLEANSER** | **26** | **1.37%** |
| CASH | 26 | 1.37% |
| **GLUCERNA LIQUID** | **24** | **1.27%** |
| CASH | 24 | 1.27% |
| **CALMOSEPTINE OINTMENT** | **21** | **1.11%** |
| CASH | 21 | 1.11% |
| **CARISOPRODOL 350 MG TABLET** | **20** | **1.05%** |
| CASH | 18 | 0.95% |
| OTHER | 2 | 0.11% |
| **PERIFRESH PERINEAL CLEANSER** | **18** | **0.95%** |
| CASH | 18 | 0.95% |
| **GLOVES** | **17** | **0.90%** |
| CASH | 17 | 0.90% |

[1] This table does not represent Dr. S.W's total prescribing at LA's Pharmacy. It only contains the top 20 drugs.

| | | |
|---|---|---|
| **GLOVES 1 BOX(INDIVIDUAL)** | **17** | **0.90%** |
| CASH | 17 | 0.90% |
| **AMLODIPINE BESYLATE 10 MG TAB** | **14** | **0.74%** |
| CASH | 14 | 0.74% |
| **AMLODIPINE BESYLATE 5 MG TAB** | **12** | **0.63%** |
| CASH | 12 | 0.63% |
| **CA-REZZ CREAM** | **11** | **0.58%** |
| CASH | 11 | 0.58% |
| **ENSURE** | **11** | **0.58%** |
| CASH | 11 | 0.58% |

38. 59.04% of Dr. S.W.'s prescriptions were written for one of four controlled substances; promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets and alprazolam 2 mg tablets. It was a factor of irregularity for four commonly abused controlled substances to make up over half of one prescriber's prescriptions.

39. 98.42% of the prescriptions written by Dr. S.W. were purchased in cash, meaning without the assistance of prescription insurance. Patients typically prefer to pay for prescription medications with the aid of prescription insurance and 88.25% of the prescriptions filled at LA's Pharmacy and Medical Equipment during the query period were billed to insurance. Therefore, this payment pattern was a factor of irregularity.

40. The majority of the controlled substances written by Dr. S.W. were for the highest available strength. Hydrocodone is available in combination products containing 5, 7.5, and 10 mg of hydrocodone per tablet. During the query period, Dr. S.W. wrote 207 prescriptions for hydrocodone/acetaminophen 10/325 mg tablets and 13 prescriptions for the other strengths combined. Alprazolam is available in 0.25, 0.5, 1, and 2 mg tablets. Dr. S.W. prescribed only alprazolam 2 mg tablets during the query period. Oxycodone immediate release is available in 5, 10, 15, 20, and 30 mg tablets. During the query period, Dr. S.W. wrote 175 prescriptions for oxycodone 30 mg tablets and two prescriptions for the other strengths combined. Prescribers commonly aim to treat patients with the lowest effective dose of medications in order to minimize the risk of side effects and toxicity from the medications. It is standard practice to initiate therapy on a low dose of medication and increase the dose if necessary. Therefore, Dr.

S.W.'s frequent prescribing of the highest available dose of these medications was a factor of irregularity.

41. In question 13 of the questionnaire, PIC Tran identified the starting dose of alprazolam as 0.25 -0.5 mg three times per day and the starting dose of hydrocodone/acetaminophen as 5/325 mg every 4 to 6 hours as needed. Therefore, PIC Tran had the clinical knowledge necessary to recognize this red flag.

42. Dr. S.W.'s address listed in the majority of the entries in the dispensing record was 820 S. Cottontail Ln., Anaheim, California 92808. According to Google Maps, Dr. S.W.'s address was 31.8 miles away from SGP. The Los Angeles metropolitan area is well served by pharmacies and physicians. It was a factor of irregularity for Dr. S.W.'s patients to travel over thirty miles, one way, between his office and SGP while many other physicians and pharmacies would have been available.

43. During the query period, SGP filled 399 prescriptions for opioid agonists and only three prescriptions for oral anti-inflammatories under Dr. S.W.'s prescribing authority. This limited prescribing of medications to treat pain other than opioid agonists was a factor of irregularity.

44. An accusation was filed by the Medical Board of California on October 6, 2014 in an attempt to revoke Dr. S.W.'s physician and surgeon license. The accusation stated causes for discipline included federal convictions of charges related to healthcare fraud and conspiracy to pay and receive kickbacks. Effective 09/29/2014; "United States District Court, Central District of California issued an order in case No. CR 12-00905-R, The United States of America vs. S.W. who shall have his bond reinstated under the conditions previously imposed; shall not practice medicine and shall be subject to home detention with electronic monitoring. Effective 11/06/2014; "The Superior Court of California, County of Riverside issued an order in case No. RIF 1403899, The People of California vs. [S.W.]. Dr. [S.W.] shall cease and desist from the practice of medicine. SGP filled 167 prescriptions under Dr. S.W.'s prescribing authority after the first court order was issued.

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**DISPENSING RECORD REVIEW: DR. C.A. (01/01/2012 to 02/03/2015)**

| Row Labels | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. C.A.'s Total Prescriptions |
|---|---|---|---|---|
| **PROMETHAZINE-CODEINE SYRUP** | Yes – Schedule V | CASH | 477 | 49.07% |
| **HYDROCODON-ACETAMINOPHN 10-325** | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 324 | 33.33% |
| | | OTHER | 1 | 0.10% |
| **ALPRAZOLAM 2 MG TABLET** | Yes – Schedule IV | CASH | 87 | 8.95% |
| **OXYCODONE HCL 30 MG TABLET** | Yes – Schedule II | CASH | 64 | 6.58% |
| **IBUPROFEN 800 MG TABLET** | Non-controlled | CASH | 6 | 0.62% |
| **CARISOPRODOL 350 MG TABLET** | Yes – Schedule IV | CASH | 3 | 0.31% |
| **BISACODYL EC 5 MG TABLET** | Non-controlled | CASH | 3 | 0.31% |
| **HYDROCODONE-APAP 10-325MG TAB** | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 2 | 0.21% |
| **HYDROCODON-ACETAMINOPH 7.5-750** | Yes—Schedule III | CASH | 2 | 0.21% |
| **CLOPIDOGREL 75 MG TABLET** | Non-controlled | CASH | 1 | 0.10% |
| **AMOXICILLIN 500 MG CAPSULE** | Non-controlled | CASH | 1 | 0.10% |
| **DIPHENHYDRAMINE 50 MG CAPSULE** | Non-controlled | CASH | 1 | 0.10% |
| | | CASH Count | 971 | 99.90% |
| | | OTHER Count | 1 | 0.10% |
| Grand Total | | | 972 | 100.00% |

45. SGP dispensed 972 prescriptions under Dr. C.A.'s prescribing authority during the query period. The majority of Dr. C.A.'s prescriptions dispensed at SGP were written for controlled substances. 98.77% or 960 out of 972 of Dr. C.A.'s prescriptions were controlled substances. A prescriber profile consisting almost entirely of controlled substances was a factor of irregularity.

46. All but one of Dr. C.A.'s prescriptions were purchased in cash, meaning not billed to prescription insurance. As previously discussed, a prescribing profile purchased almost entirely in cash was a factor of irregularity.

47. Dr. C.A. frequently prescribed the highest available dose of controlled substances. Examples included: his prescribing history included 87 prescriptions for alprazolam 2 mg tablets, the highest available strength of alprazolam and no prescriptions for the lower strengths. Dr. C.A.'s prescribing history included 327 prescriptions for hydrocodone/acetaminophen 10/325 mg and two prescriptions for a lower strength of hydrocodone. Dr. C.A.'s prescribing history included 64 prescriptions for oxycodone 30 mg and no prescriptions for the lower strengths.

48. The Medical Board of California filed an accusation against Dr. C.A. on 12/15/2014. The accusation alleged Dr. C.A. prescribed controlled substances for patients without establishing a legitimate medical need for the medications and without performing a medical examination.

**DISPENSING RECORD REVIEW: DR. M.P. (01/01/2012 to 02/03/2015)**

| Medications | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. M.P.'s Total Prescriptions |
|---|---|---|---|---|
| **OXYCODONE HCL 30 MG TABLET** | Yes -- Schedule II | CASH | 176 | 34.17% |
| **IBUPROFEN 800 MG TABLET** | No | CASH | 73 | 14.17% |
| | | OTHER | 1 | 0.19% |
| **HYDROCODON-ACETAMINOPHN 10-325** | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 67 | 13.01% |
| | | OTHER | 1 | 0.19% |
| **MELOXICAM 7.5 MG TABLET** | No | CASH | 42 | 8.16% |
| | | OTHER | 2 | 0.39% |
| **KETOCONAZOLE 2% CREAM** | No | CASH | 35 | 6.80% |
| **NAPROXEN 500 MG TABLET** | No | CASH | 22 | 4.27% |
| **IBUPROFEN 600 MG TABLET** | No | CASH | 16 | 3.11% |
| **AMOXICILLIN 500 MG CAPSULE** | No | CASH | 14 | 2.72% |
| **NAPROXEN 375 MG TABLET** | No | CASH | 10 | 1.94% |
| **CLOTRIMAZOLE 1% SOLUTION** | No | CASH | 9 | 1.75% |
| | | OTHER | 1 | 0.19% |
| **IBUPROFEN 400 MG TABLET** | No | CASH | 9 | 1.75% |
| **MELOXICAM 15 MG TABLET** | No | CASH | 9 | 1.75% |
| **METRONIDAZOLE 500 MG TABLET** | No | CASH | 5 | 0.97% |
| **CEPHALEXIN 500 MG CAPSULE** | No | CASH | 5 | 0.97% |

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|---|---|---|---|---|
| **CLOTRIMAZOLE 1% CREAM** | No | CASH | 3 | 0.58% |
| | | OTHER | 1 | 0.19% |
| **CARISOPRODOL 350 MG TABLET** | Yes – Schedule IV | CASH | 3 | 0.58% |
| **BACITRACIN 500 UNIT/GM OINTMNT** | No | CASH | 2 | 0.39% |
| **VOLTAREN 1% GEL** | No | CASH | 2 | 0.39% |
| **ECONAZOLE NITRATE 1% CREAM** | No | CASH | 2 | 0.39% |
| **PHENTERMINE 37.5 MG TABLET** | Yes – Schedule IV | OTHER | 1 | 0.19% |
| **HYDROCODON-ACETAMINOPH 7.5-325** | Yes—Schedule II (Schedule III prior to 10/6/2014) | CASH | 1 | 0.19% |
| **DOK 250 MG CAPSULE** | No | CASH | 1 | 0.19% |
| **DOK 100 MG CAPSULE** | No | CASH | 1 | 0.19% |
| **ALPRAZOLAM 2 MG TABLET** | Yes – Schedule IV | CASH | 1 | 0.19% |
| | | CASH Count | 508 | 98.64% |
| | | OTHER Count | 7 | 1.36% |
| **Grand Total** | | | **515** | **100.00%** |

49. SGP filled 515 prescriptions under Dr. M.P.'s prescribing authority during the query period. 34.17% of Dr. M.P.'s prescriptions were written for oxycodone 30 mg tablets. 136 patients received prescriptions from Dr. M.P. during the query period. 113 of those patients (or 83.09%) received at least one prescription for oxycodone 30 mg. The remaining 23 patients received at least one prescription for hydrocodone/acetaminophen 10/325 mg tablets. 98.64% of the prescriptions in Dr. M.P.'s prescribing history were purchased in "cash". A prescribing profile purchased almost entirely in cash and in which every patient received a narcotic pain reliever was a factor of irregularity. Majority of the Dr. M.P.'s controlled substance prescriptions were written for the highest available dose. Dr. M.P. wrote 176 prescriptions for oxycodone 30 mg tablets and no prescriptions for any lower strength of oxycodone. Dr. M.P. wrote 67 prescriptions for hydrocodone/acetaminophen 10/325 mg and one prescription for a lower dose, hydrocodone/acetaminophen 7.5/325 mg.

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# DISPENSING RECORD REVIEW: DR. M.G. (01/01/2012 to 02/03/2015)

| Medication | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. M.G.'s Total Prescriptions |
|---|---|---|---|---|
| PROMETHAZINE-CODEINE SYRUP | Yes – Schedule IV | CASH | 180 | 31.09% |
| CEPHALEXIN 500 MG CAPSULE | No | CASH | 105 | 18.13% |
| HYDROCODON-ACETAMINOPHN 10-325 | Yes-- Schedule II (Schedule III prior to 10/6/2014) | CASH | 82 | 14.16% |
| ALPRAZOLAM 2 MG TABLET | Yes – Schedule IV | CASH | 70 | 12.09% |
| AZITHROMYCIN 250 MG TABLET | No | CASH | 35 | 6.04% |
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II | CASH | 33 | 5.70% |
| AMOXICILLIN 500 MG CAPSULE | No | CASH | 20 | 3.45% |
| VENTOLIN HFA 90 MCG INHALER | No | CASH | 13 | 2.25% |
| HYDROCODON-ACETAMINOPHN 10-500 | Yes – Schedule II | CASH | 10 | 1.73% |
| IBUPROFEN 800 MG TABLET | No | CASH | 9 | 1.55% |
| ZOLPIDEM TARTRATE 10 MG TABLET | Yes – Schedule IV | CASH | 6 | 1.04% |
| NAPROXEN 500 MG TABLET | No | CASH | 4 | 0.69% |
| LORATADINE 10 MG TABLET | No | CASH | 4 | 0.69% |
| CIPROFLOXACIN HCL 500 MG TAB | No | CASH | 3 | 0.52% |
| CARISOPRODOL 350 MG TABLET | Yes— Schedule IV | CASH | 3 | 0.52% |
| PROAIR HFA 90 MCG INHALER | No | CASH | 2 | 0.35% |
| | | CASH Count | 579 | 100.00% |
| | | OTHER Count | | 0.00% |
| Grand Total | | | 579 | 100.00% |

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50. SPG filled 579 prescriptions under Dr. M.G.'s prescribing authority during the query period. Dr. M.G.'s most commonly prescribed medication was promethazine/codeine syrup, which represented 31.09% of Dr. M.G.'s total prescribing. Given the wide variety of medications available to prescribe, it was a factor of irregularity for a commonly abused controlled substance to represent over 31% of one physician's prescribing at SGP. 75.47% of

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Dr. M.G.'s prescribing consisted of four medications: promethazine/codeine syrup, cephalexin 500 mg capsules, hydrocodone/acetaminophen 10/325 mg tablets, and alprazolam 2 mg tablets. As previously stated, given the multitude of medications on the market, it was a factor of irregularity for the majority of one physician's prescribing at SGP to consist of only four medications. All of Dr. M.G.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were purchased in cash. As set forth above, a prescribing profile purchased entirely in cash was another factor of irregularity.

51. Dr. M.G. prescribed controlled substances exclusively at the highest available dose. Dr. M.G. wrote 92 prescriptions for hydrocodone combinations containing 10 mg of hydrocodone and no prescriptions for lower strengths. Dr. M.G. wrote 70 prescriptions for alprazolam 2 mg tablets and no prescriptions for lower strengths. Dr. M.G. wrote 33 prescriptions for oxycodone 30 mg tablets and no prescriptions for lower strengths. Dr. M.G.'s dispensing history at SGP contained 55 instances amongst 45 patients in which a patient received the following four medications on the same day; promethazine/codeine syrup, alprazolam 2 mg tablets, hydrocodone/acetaminophen 10/325 mg tablets, and cephalexin 500 mg capsules. Additionally, Dr. M.G.'s profile contained four instances in which patients received promethazine/codeine syrup, alprazolam 2 mg tablets, hydrocodone/acetaminophen 10/325 mg tablets and a different antibiotic. It would be unusual for a large number of patients to require treatment for cough, anxiety, pain, and infection at the same time. Additionally, no two patients are exactly alike. Because of this inter-patient variability, a prescriber would often choose different medications or different doses to treat different patients with the same ailments. Therefore, Dr. M.G.'s use of the same four medications at the same strengths to treat 45 different patients was another factor of irregularity.

52. On October 13, 2015, Inspector N.R. accessed the Medical Board of California database and searched for Dr. M.G.'s licensing information. Dr. M.G.'s license status was "revoked" as of December 6, 2013. The underlying accusation filed against Dr. M.G. included a cause for discipline for self-use of controlled substances.

## DISPENSING RECORD REVIEW: DR. D.W. (01/01/2012 to 02/03/2015)

| Medications | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. D.W.'s Total Prescriptions |
|---|---|---|---|---|
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II | CASH | 149 | 31.24% |
| | | OTHER | 1 | 0.21% |
| DOK 100 MG CAPSULE | No | CASH | 115 | 24.11% |
| | | OTHER | 1 | 0.21% |
| ALPRAZOLAM 2 MG TABLET | Yes – Schedule IV | CASH | 72 | 15.09% |
| | | OTHER | 1 | 0.21% |
| PROMETHAZINE-CODEINE SYRUP | Yes – Schedule V | CASH | 69 | 14.47% |
| AMOXICILLIN 500 MG CAPSULE | No | CASH | 23 | 4.82% |
| CIPROFLOXACIN HCL 500 MG TAB | No | CASH | 14 | 2.94% |
| IBUPROFEN 600 MG TABLET | No | CASH | 11 | 2.31% |
| SENNA LAXATIVE 8.6 MG TABLET | No | CASH | 6 | 1.26% |
| PROAIR HFA 90 MCG INHALER | No | CASH | 3 | 0.63% |
| CARISOPRODOL 350 MG TABLET | Yes – Schedule IV | CASH | 3 | 0.63% |
| IBUPROFEN 800 MG TABLET | No | CASH | 3 | 0.63% |
| DOCUSATE SODIUM 100MG | No | CASH | 1 | 0.21% |
| AMLODIPINE BESYLATE 10 MG TAB | No | CASH | 1 | 0.21% |
| AZITHROMYCIN 250 MG TABLET | No | CASH | 1 | 0.21% |
| LORATADINE 10 MG TABLET | No | CASH | 1 | 0.21% |
| LISINOPRIL 20 MG TABLET | No | CASH | 1 | 0.21% |
| HYDROCODON-ACETAMINOPH 7.5-750 | Yes— Schedule III | CASH | 1 | 0.21% |
| | | CASH Count | 474 | 99.37% |
| | | OTHER Count | 3 | 0.63% |
| Grand Total | | | 477 | 100.00% |

53. SPG filled 477 prescriptions under Dr. D.W.'s prescribing authority during the query period. Dr. D.W.'s most commonly prescribed medication was oxycodone 30 mg, which represented 31.45% of his total prescriptions. Dr. D.W.'s next most commonly prescribed medication, "DOK 100 mg", was a stool softener. Constipation is a common adverse effect of narcotic pain relievers, therefore these medications are sometimes prescribed with stool softeners.

55 patients at SPG received prescriptions from Dr. D.W. during the query period. 49 of these patients received at least one prescription for oxycodone 30 mg. Additionally, three medications, oxycodone 30 mg, alprazolam 2 mg, and promethazine/codeine made up 61.22% of Dr. D.W.'s total prescribing. 99.37% of Dr. D.W.'s prescriptions were purchased in cash. Dr. D.W.'s frequent prescribing of oxycodone 30 mg and other controlled substances along with the majority of his prescriptions being purchased in cash were both factors of irregularity.

54. Dr. D.W.'s self-reported primary area of practice was "Cardiology", with secondary areas of practice listed as, "Internal Medicine," "Pain Medicine," and "Public Health and General Preventative Medicine." Dr. D.W.'s prescribing profile contained only two prescriptions typically used to treat cardiovascular conditions; one prescription for lisinopril and one prescription for amlodipine which are both used to treat high blood pressure. One would expect a more varied dispensing profile for internal medicine practitioners and pain medicine specialists. Dr. D.W.'s prescribing profile, in which three controlled substances used to treat pain, anxiety and cough made up 61.22% of the prescriptions, would not by typical for a prescriber in any of these areas of practice.

**DISPENSING RECORD REVIEW: DR. S.O. (01/01/2012 to 02/03/2015)**

| Row Labels | Controlled Substance? | Payment Method | Number of Prescriptions | Percent of Dr. S.O.'s Total Prescriptions |
|---|---|---|---|---|
| **PROMETHAZINE-CODEINE SYRUP** | Yes – Schedule V | CASH | 209 | 61.47% |
| | | OTHER | 4 | 1.18% |
| **ALPRAZOLAM 2 MG TABLET** | Yes – Schedule IV | CASH | 45 | 13.24% |
| **LISINOPRIL 20 MG TABLET** | No | CASH | 22 | 6.47% |
| **CARISOPRODOL 350 MG TABLET** | Yes –Schedule IV | CASH | 16 | 4.71% |
| **AMLODIPINE BESYLATE 10 MG TAB** | No | CASH | 9 | 2.65% |
| | | OTHER | 1 | 0.29% |
| **VENTOLIN HFA 90 MCG INHALER** | No | CASH | 5 | 1.47% |
| | | OTHER | 1 | 0.29% |
| **HYDROCODON-ACETAMINOPH 7.5-325** | Yes-- Schedule II (Schedule III prior to 10/6/2014) | CASH | 5 | 1.47% |

| | | | | |
|---|---|---|---|---|
| HYDROCODON-ACETAMINOPHN 10-325 | Yes-- Schedule II (Schedule III prior to 10/6/2014) | CASH | 3 | 0.88% |
| DIAZEPAM 10 MG TABLET | Yes – Schedule IV | CASH | 3 | 0.88% |
| LORATADINE 10 MG TABLET | No | CASH | 3 | 0.88% |
| HYDROCODON-ACETAMINOPH 7.5-750 | Yes – Schedule III | CASH | 2 | 0.59% |
| ACETAMINOPHEN-COD #4 TABLET | Yes – Schedule III | CASH | 2 | 0.59% |
| TRIAMCINOLONE 0.025% CREAM | No | CASH | 1 | 0.29% |
| CLOTRIMAZOLE 1% CREAM | No | CASH | 1 | 0.29% |
| FLUTICASONE PROP 50 MCG SPRAY | No | CASH | 1 | 0.29% |
| AMOXICILLIN 500 MG CAPSULE | No | CASH | 1 | 0.29% |
| SIMVASTATIN 20 MG TABLET | No | OTHER | 1 | 0.29% |
| FAMOTIDINE 20 MG TABLET | No | OTHER | 1 | 0.29% |
| HYDROCHLOROTHIAZIDE 50 MG TAB | No | OTHER | 1 | 0.29% |
| ZOLPIDEM TARTRATE 10 MG TABLET | Yes – Schedule IV | CASH | 1 | 0.29% |
| OXYCODONE HCL 30 MG TABLET | Yes – Schedule II | CASH | 1 | 0.29% |
| MELOXICAM 7.5 MG TABLET | No | CASH | 1 | 0.29% |
| | | CASH Count | 331 | 97.35% |
| | | OTHER Count | 9 | 2.65% |
| **Grand Total** | | | **340** | **100.00%** |

55. SGP filled 340 prescriptions under Dr. S.O.'s prescribing authority during the query period. 85% of Dr. S.O.'s prescriptions were written for controlled substances. 97.35% of Dr. S.O.'s prescriptions were purchased in cash. A prescribing profile purchased almost entirely in cash with the majority of prescriptions written for controlled substances were both factors of irregularity.

56. Dr. S.O.'s self-reported areas of practice were "Thoracic Surgery" and "General Practice" with Board Certifications in "Surgery" and "Female Pelvic Medicine and Reconstructive Surgery." 61.47% of Dr. S.O.'s prescriptions filled at SGP were for promethazine/codeine syrup. Additionally, 98 patients received a prescription from Dr. S.O. at

SGP during the query period. All but two of these patients received at least one prescription for promethazine/codeine. It would be unusual for a general practitioner or a surgeon to prescribe promethazine/codeine for over half of his or her total prescriptions and to almost all of his or her patients. Dr. S.O.'s frequent prescribing of promethazine/codeine was a factor of irregularity. Despite prescribing a cough syrup for almost all of his patients, Dr. S.O.'s next most commonly prescribed medication was alprazolam 2 mg tablets used to treat anxiety. It was a factor of irregularity for many of Dr. S.O.'s patients to require treatment for both cough and anxiety.

57. Dr. S.O.'s license information also indicated the Medical Board of California filed an accusation in attempt to revoke Dr. S.O..'s license on June 11, 2015. The accusation alleged Dr. S.O. prescribed controlled substances "without medical indication.,"

## ANALYSIS OF DISPENSING DATA – OUT OF POCKET PAYMENTS

57. The dispensing data provided by PIC TRAN contained many instances in which patients paid high out of pocket costs for oxycodone 30 mg tablets. For example, the dispensing data included:

- 185 instances when patients paid $900 for 100 oxycodone 30 mg tablets
- 180 instances when patients paid $1,000 for 100 oxycodone 30 mg tablets
- 12 instances when patients paid $1,100 for 100 oxycodone 30 mg tablets
- 35 instances when patients paid $810 for 90 oxycodone 30 mg tablets
- 35 instances when patients paid $900 for 90 oxycodone 30 mg tablets

58. On October 13, 2015, Inspector N.R. contacted Wal-Mart Pharmacy located in South Gate, CA 90280. Wal-Mart Pharmacy 10-3180 was located 0.9 miles from SGP. The inspector was informed that Wal-Mart Pharmacy's dispensing software listed the price for 100 oxycodone 30 mg tablets as $114.97. Inspector N.R. further called CVS Pharmacy near SGP and was informed that the price for 100 oxycodone 30 mg tablets was $158.99. There were 447 instances where SGP's patients paid between nine and 11 dollars per tablet for oxycodone 30 mg tablets. Wal-Mart Pharmacy and CVS Pharmacy quoted their prices for oxycodone 30 mg tablets as $1.15 and $1.59 per tablet respectively. Further, on April 9, 2015, SGP's purchase price for oxycodone 30 mg tablets was about 35 cents per tablet. This was a factor of irregularity for patients at SGP

to be able and willing to pay significantly higher prices than what would have been charged at neighboring pharmacies.

## ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY S.W.

59. After analyzing the dispensing data, Inspector N.R. reviewed the prescription documents collected during the inspection and provided by PIC TRAN following the inspection. She reviewed all 33 prescription documents in her possession written by Dr. S.W. and noted the following trends: (1) Dr. S.W.'s patients would have travelled long distances to obtain controlled substance prescriptions from his office in Anaheim, California; (2) Dr. S.W.'s patients paid high out of pocket prices for controlled substance prescriptions; and (3) Many of Dr. S.W.'s prescriptions, especially for promethazine/codeine, were dated months before they were filled.

60. Other irregularities identified in Dr. S.W.'s prescription documents and verifications included: (1) Patient FB's address on file at other pharmacies was "homeless" however he purchased promethazine/codeine syrup from SGP for $100; (2) JW and AR both received prescriptions for promethazine/codeine syrup which were written 09/04/2014 and filled on 01/20/2015. Pharmacy Technician "KS" verified both prescriptions with Dr. S.W. at 10:34 am on 01/20/2015; (3) CA, LL, and DF received prescriptions for promethazine/codeine syrup which were written on 09/12/2014 and filled on 02/02/2015. "KS" verified all three prescriptions with Dr. S.W. at 10:32 am on 02/02/2015; (4) NS and JS received prescriptions for promethazine/codeine syrup and carisoprodol 350 mg tablets which were written on 10/02/2014 and filled on 12/23/2014 and 12/26/2014; (5) TP and DG received prescriptions for hydrocodone/acetaminophen 10/325 mg and promethazine/codeine syrup which were written and filled on 11/15/2013. "KS" verified both prescriptions with Dr. S.W. on 11/15/2013 at 2:07 pm; (6) GP and GSP had the same address on file at SGP and both received prescriptions for promethazine/codeine syrup from Dr. S.W.; (7) JD received a prescription for oxycodone 30 mg tablets, the highest available dose, and the prescription verification sheet indicated she had not received a controlled substance prescription in at least the previous three months.

61. SGP staff frequently checked Patient Activity Reports for Dr. S.W.'s patients and frequently made copies of the patients' identification cards. However PIC TRAN's statements indicated both of these steps were completed by pharmacy technicians KS[2] and EH2. Additionally, the prescription verification sheets indicated a pharmacy technician, KS or EH2, called Dr. S.W. to "OK" the prescriptions. However, there was no documentation of conversations between Dr. S.W. and a pharmacist at SGP to attempt to resolve the irregularities listed above or establish the medical legitimacy of his prescriptions. For example, a pharmacist could have spoken with Dr. S.W. to ask if he was aware of previous controlled substance prescriptions reflected in PARs, to question prescribing a potentially opioid naive patient the highest available strength of oxycodone, and to ask if prescriptions for promethazine/codeine syrup were medically necessary months after they were written. Dr. S.W.'s answers to these questions could have helped the pharmacists at SGP to evaluate the medical legitimacy of these prescriptions. Further, 11 of the prescriptions described above were written after 09/29/2014 when a court order was issued prohibiting Dr. S.W. from practicing medicine. An additional 20 of the prescriptions listed above were written prior to the court order but verified by Dr. S.W. after the court order.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. M.G.**

62. Inspector N.R. reviewed all 31 prescription documents from Dr. M.G. and noticed the following: (1) Dr. M.G.'s patients paid high out of pocket prices for their prescriptions; (2) Many of Dr. M.G.'s patients received prescriptions for promethazine/codeine, cephalexin, alprazolam, and hydrocodone/acetaminophen which are used to treat cough, infection, anxiety, and pain; (3) Some of Dr. M.G.'s patients travelled long distances to obtain controlled substance prescriptions.

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[2] It should be noted, Business and Professions Code Section 4115 allows in part, (a) A pharmacy technician may perform packaging, manipulative, repetitive, or other nondiscretionary tasks... and (c) This section does not authorize a pharmacy technician to perform any act requiring the exercise of professional judgment by a pharmacist. Therefore, a pharmacy technician is allowed to call a prescriber to confirm he or she did in fact write a prescription. However, a pharmacy technician may not have a clinical conversation with a prescriber to evaluate the legitimacy and/or appropriateness of a prescription. That evaluation and determination requires the professional judgment of the pharmacist.

Fourteen of said prescription documents reviewed were for patients who would have travelled 40 miles or more from the address on file at SGP to Dr. M.G.'s office, to SGP and back home; (4) Six of the prescription documents had an associated Patient Activity Report indicating the most recent controlled substance prescriptions the patient in question were prescribed by another physician, not Dr. M.G.; (5) Ten of the prescription documents indicated the patients' Patient Activity Report showed no previous controlled substances in the previous six months although these patients received the highest available strengths of alprazolam, hydrocodone/ acetaminophen, and/or oxycodone.

63. SGP's staff took steps to verify the legitimacy of Dr. M.G.'s prescriptions including copying the patients' identification cards and reviewing the Prescription Drug Monitoring Program. Additionally, a pharmacy technician spoke with "Betty" to verify each of the prescriptions filled. However, SGP failed to produce documentation of conversations between Dr. M.G. and a pharmacist at SGP to attempt to resolve the irregularities listed above or establish the medical legitimacy of her prescriptions. For example, a pharmacist could have spoken with Dr. M.G. to inquire about her frequent prescribing of the combination of promethazine/codeine, cephalexin, alprazolam, and hydrocodone/acetaminophen. A pharmacist could have questioned the prescribing of high doses of alprazolam and oxycodone to patients who had not received a similar medication in the previous six months or asked if Dr. M.G. was aware of previous controlled substance prescriptions written by other prescribers. Business and Professions Code Section 4115 does not allow these clinical discussions to be delegated to a pharmacy technician. Further, all the documented verifications of Dr. M.G.'s prescriptions were conversations with "Betty" at Dr. M.G.'s office, rather than Dr. M.G.. These conversations between "Betty" and pharmacy technicians at SGP were insufficient to resolve the irregularities described above. Had pharmacists at SGP had substantive discussions with Dr. Garg regarding her prescribing, they could have better evaluated the medical legitimacy of the prescriptions in question.

64. Further, SGP filled 64 prescriptions under Dr. M.G.'s prescribing authority after 12/06/2013 when Dr. M.G.'s license to practice medicine was revoked. Review of the prescription documents indicated 36 of these prescriptions were actually written after 12/06/2013.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. M.P.**

65. Investigator N.R. reviewed all six prescription documents and associated verifications in her possession from Dr. M.P.. All six prescription documents included one prescription for oxycodone 30 mg tablets and one prescription for a non-steroidal anti-inflammatory. One of the prescription documents contained a third prescription for an antifungal solution.

66. For each prescription document, SGP staff faxed an image of the prescription document, sometimes with an image of the patient's identification card, to Dr. M.P.'s office. Dr. M.P.'s office responded with a list of ICD-9 diagnosis codes. SGP also printed a Patient Activity Report for each patient. Investigator N.R. noted the following: (1) Dr. M.P. listed three or four diagnoses for each patient. Examples included: 719.57 (stiffness of joint, ankle and foot), 715.97 (osteoarthritis, ankle and foot), 729.5 (pain in limb), 719.7 (difficulty in walking), 718.87 (other joint derangement, ankle and foot), 718.47 (contracture of joint, ankle and foot). It was a factor of irregularity for Dr. M.P. to prescribe oxycodone 30 mg, to take 1 or 2 tablets every four to six hours for six patients each with a different combination of foot and ankle ailments.

67. Some of Dr. M.P.'s patients travelled long distances to obtain controlled substances from SGP. Patient E.T.would have travelled 69 miles from her address in Lake Elsinore, CA to SGP. Patient SR would have travelled 43 miles from her address in Canoga Park, CA to SGP. It was a factor of irregularity for these patients to travel over 40 miles, one direction from home to SGP to obtain controlled substances.

68. Dr. M.P.'s patients paid very high out of pocket costs for their prescriptions for oxycodone 30 mg. Patients WH, TR, GK, and ET paid $990 for 90 tablets. Patients SR and KB paid $1,100 for 100 tablets. It would not be typical for multiple patients to be willing and able to pay approximately $1,000 for a single prescription. This was another factor of irregularity.

69. The Patient Activity Report for Patient ET found she had not received a controlled substance prescription in the previous six months. However, one of Patient ET's prescriptions from Dr. M.P. was written for oxycodone 30 mg, the highest available strength. The Patient Activity Report for Patient KB indicated he received carisoprodol 350 mg, acetaminophen/

codeine 300/60 mg, and alprazolam 2 mg from Dr. S.O. at Ramona Professional two days before his prescription from Dr. M.P. was written and 15 days before it was filled by SGP.

70. SGP's records do not contain documentation of conversations between a pharmacist and Dr. M.P.. A pharmacist could have spoken with Dr. M.P. to address such irregularities as his frequent prescribing of the same dose of oxycodone 30 mg and his patients' frequent cash payments, or questioned prescribing the highest available dose of oxycodone to a patient who had not received a narcotic prescription in the previous six months, or questioned if Dr. M.P. was aware of Patient KB's prescriptions written by Dr. S.O.. Dr. M.P.'s answers to these questions could have helped the pharmacist make a determination regarding the medical legitimacy of these prescriptions.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. S.O.**

71. Inspector N.R. reviewed all four prescription documents in her possession from Dr. S.O.. For each prescription document, SGP staff attached the prescription document to a verification sheet including a copy of the prescription document with handwritten statements indicating a pharmacy staff member, either unidentified or "KS", spoke with "Kassydra" or "Kassandra" to verify the prescriptions, and a printout of the patient's Patient Activity Report.

72. The following irregularities were noted: (1) All four of the prescription documents contained prescriptions for promethazine/codeine syrup, 8 oz, to take one teaspoonful every 6 hours; (2) Patient DJ received a prescription for promethazine/codeine syrup from Dr. S.O. on 03/31/2015 and filled the prescription over a month later on 05/04/2015. There were no documentations to indicate a pharmacist spoke with Dr. S.O. to discuss the legitimacy or appropriateness of these prescriptions. For example, a pharmacist could have inquired if Patient DJ still needed treatment for cough over a month after the prescription was written.

**ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS OF PRESCRIPTIONS WRITTEN BY DR. D.W.**

73. Inspector N.R. reviewed all six prescription documents in her possession from Dr. D.W. for three patients. For each prescription document, SGP staff attached the prescription

1 document to a verification sheet including a copy of the prescription document with handwritten
2 statements indicating KS and EH2 verified the prescriptions with Dr. D.W., and a printout of each
3 patient's Patient Activity Report.

4 74. Inspector N.R. noted the following irregularities: (1) Dr. D.W.'s patients paid out of
5 pocket costs for the prescriptions, between $1,160 and $1,175 for the total order; (2) Dr. D.W.'s
6 prescription document read, "Internal Medicine – Adult Cardiology;" (3) Diagnoses codes written
7 by Dr. D.W. on the prescription documents included: DL–LBP (low back pain)and anxiety/
8 insomnia, BF–ankle FX, LBP (low back pain) and anxiety/insomnia, DG–knee FX and anxiety/
9 insomnia. As with the previous prescribers discussed, there was not documentation indicating a
10 pharmacist spoke with Dr. D.W. to address the legitimacy and/or appropriateness of these
11 prescriptions.

12 **ANALYSIS OF PRESCRIPTION DOCUMENTS AND ASSOCIATED VERIFICATIONS**
13 **OF PRESCRIPTIONS WRITTEN BY DR. C.A.**

14 75. Inspector N.R. reviewed all nine prescription documents in my possession from Dr.
15 C.A.. For each prescription document, SGP Staff attached the prescription document to one or
16 more of the following; a verification sheet including a copy of the patient's identification card, a
17 copy of the prescription document, and a printout of each patient's Patient Activity Report.
18 Additionally, SGP Staff, EH, KS, EH2, documented verbal verifications with "Nora" and
19 "Shawn". The following irregularities were noted: (1) Patient AJ's California Driver License and
20 address on file at SGP indicated she lived in Fresno, California, 228 miles from SGP; (2) The
21 verification sheet for Patient AB indicated there were, "No Records Found" on his Patient
22 Activity Report. However, AB received alprazolam 2 mg tablets, the highest available dose; (3)
23 Dr. C.A.'s patients paid high out of pocket costs for their prescriptions, between $125 and $320
24 for the total order.

25 76. There was no documentation regarding conversations between a pharmacist at SGP
26 and Dr. C.A. to discuss the factors of irregularity present in these prescriptions and gather
27 information to make a decision about the medical legitimacy of the prescriptions.
28 ///

## FIRST CAUSE FOR DISCIPLINE

**(Responsibility for Legitimacy of Prescription; Corresponding Responsibility of Pharmacist)**

77. Respondent SGP is subject to disciplinary action under Health and Safety Code Section 11153(a) in conjunction with California Code of Regulations section 1761, in that from approximately January 1, 2012 to approximately February 3, 2015, SGP filled 4,462 prescriptions under the prescribing authority of Drs. S.W., C.A., M.G., M.P., D.W., and S.O.. These prescriptions contained significant irregularities suggesting their medical illegitimacy including the following:

a. The majority of the prescriptions written by the listed prescribers were purchased in cash, meaning without the assistance of prescription insurance. During the query period, 98.42% of Dr. S.W.'s prescriptions, 99.90% of Dr. C.A.'s Prescriptions, 98.64% of Dr. M.P.'s prescriptions, 100% of Dr. M.G.'s prescriptions, 99.37% of Dr. D.W.'s prescriptions, and 97.35% of Dr. S.O.'s prescriptions were purchased in cash.

b. Dr. C.A.'s prescribing profile consisting almost entirely of controlled substances. 98.77% of the prescriptions filled under Dr. C.A.'s prescribing authority during the query period were controlled substances.

c. Many patients of the listed prescribers paid exceptionally high prices for oxycodone prescriptions. During the query period, 377 patients paid between $900 and $1,100 for 100 oxycodone 30 mg tablets.

d. The majority of the prescriptions written by the listed prescribers for oxycodone, alprazolam, and hydrocodone-containing products contained the highest available dose of each medication. For example, Dr. S.W. wrote 508 prescriptions for oxycodone 30 mg tablets, alprazolam 2 mg tablets, and hydrocodone/acetaminophen 10/325 mg tablets and wrote a total of 14 prescriptions for any other strength of these three medications.

e. The prescribing profiles of the listed prescribers were unusually limited with a small number of controlled substances accounting for a relatively large percentage of their total prescribing:

1. 61.47% of Dr. S.O.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were for promethazine/codeine syrup.

2. 31.45% of Dr. D.W.'s prescriptions were for oxycodone 30 mg tablets.

3. 31.09% of Dr. M.G.'s prescriptions were for promethazine/codeine syrup.

4. 34.17% of Dr. M.P.'s prescriptions were for oxycodone 30 mg tablets.

5. 98.05% of Dr. C.A.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg.

6 59.04% of Dr. S.W.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets, and alprazolam 2 mg tablets.

f. Dr. S.W.'s patients travelled excessive distances, 31 miles between his office and the pharmacy, to obtain controlled substances from SGP.

g. SGP did not produce any documentations indicating that a pharmacist conferred with the prescriber to address the irregularities described above.

78. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 20 through 76, inclusive, as though set forth fully.

## SECOND CAUSE FOR DISCIPLINE

**(Responsibility for Legitimacy of Prescription; Corresponding Responsibility of Pharmacist)**

79. Respondent PIC TRAN is subject to disciplinary action under Health and Safety Code Section 11153(a) in conjunction with California Code of Regulations section 1761, in that approximately January 1, 2012 to approximately February 3, 2015, PIC TRAN while acting as Pharmacist-in-Charge of SGP, where 4,462 prescriptions were filled under the prescribing authority of Drs. S.W., C.A., M.G., M.P., D.W., and S.O.. These prescriptions contained significant irregularities suggesting their medical illegitimacy including the following:

a. The majority of the prescriptions written by the listed prescribers were purchased in cash, meaning without the assistance of prescription insurance. During the query period, 98.42% of Dr. S.W.'s prescriptions, 99.90% of Dr.C.A.'s Prescriptions, 98.64% of Dr. M.P.'s

prescriptions, 100% of Dr. M.G.'s prescriptions, 99.37% of Dr. D.W.'s prescriptions, and 97.35% of Dr. S.O.'s prescriptions were purchased in cash.

b. Dr. C.A.'s prescribing profile consisting almost entirely of controlled substances. 98.77% of the prescriptions filled under Dr. C.A.'s prescribing authority during the query period were controlled substances.

c. Many patients of the listed prescribers paid exceptionally high prices for oxycodone prescriptions. During the query period, 377 patients paid between $900 and $1,100 for 100 oxycodone 30 mg tablets.

d. The majority of the prescriptions written by the listed prescribers for oxycodone, alprazolam, and hydrocodone-containing products contained the highest available dose of each medication. For example, Dr. S.W. wrote 508 prescriptions for oxycodone 30 mg tablets, alprazolam 2 mg tablets, and hydrocodone/acetaminophen 10/325 mg tablets and wrote a total of 14 prescriptions for any other strength of these three medications.

e. The prescribing profiles of the listed prescribers were unusually limited with a small number of controlled substances accounting for a relatively large percentage of their total prescribing.

1. 61.47% of Dr. S.O.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were for promethazine/codeine syrup.

2. 31.45% of Dr. D.W.'s prescriptions were for oxycodone 30 mg tablets.

3. 31.09% of Dr. M.G.'s prescriptions were for promethazine/codeine syrup.

4. 34.17% of Dr. M.P.'s prescriptions were for oxycodone 30 mg tablets.

5. 98.05% of Dr. C.A.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg.

6. 59.04% of Dr. S.W.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets, and alprazolam 2 mg tablets.

f. Dr. S.W.'s patients travelled excessive distances, 31 miles between his office and the pharmacy, to obtain controlled substances from LA's Pharmacy and Medical Equipment.

g. SGP did not have any documentations indicating that a pharmacist conferred with the prescriber to address the irregularities described above.

80. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 20 through 76, inclusive, as though set forth fully.

**THIRD CAUSE FOR DISCIPLINE**

81. Respondent PIC TRAN is subject to disciplinary action under sections 4081[3], 4113, subdivision (c) and 4036.5 of the Code, in that PIC TRAN is strictly liable as a Pharmacist in charge for SGP, for filled 4,462 prescriptions under the prescribing authority of Drs. S.W., C.A., M.G., M.P., D.W., and S.O.. These prescriptions contained significant irregularities suggesting their medical illegitimacy including the following:

a. The majority of the prescriptions written by the listed prescribers were purchased in cash, meaning without the assistance of prescription insurance. During the query period, 98.42% of Dr. S.W.'s prescriptions, 99.90% of Dr.C.A.'s Prescriptions, 98.64% of Dr. M.P.'s prescriptions, 100% of Dr. M.G.'s prescriptions, 99.37% of Dr. D.W.'s prescriptions, and 97.35% of Dr. S.O.'s prescriptions were purchased in cash.

b. Dr. C.A.'s prescribing profile consisting almost entirely of controlled substances. 98.77% of the prescriptions filled under Dr. C.A.'s prescribing authority during the query period were controlled substances.

c. Many patients of the listed prescribers paid exceptionally high prices for oxycodone prescriptions. During the query period, 377 patients paid between $900 and $1,100 for 100 oxycodone 30 mg tablets.

d. The majority of the prescriptions written by the listed prescribers for oxycodone, alprazolam, and hydrocodone-containing products contained the highest available dose of each medication. For example, Dr. S.W. wrote 508 prescriptions for oxycodone 30 mg tablets, alprazolam 2 mg tablets, and hydrocodone/acetaminophen 10/325 mg tablets and wrote a total of 14 prescriptions for any other strength of these three medications.

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[3] *Sternberg v. California Board of Pharmacy* (2015) 239 Cal.App.4th 1159.

e. The prescribing profiles of the listed prescribers were unusually limited with a small number of controlled substances accounting for a relatively large percentage of their total prescribing.

1. 61.47% of Dr. S.O.'s prescriptions at LA's Pharmacy and Medical Equipment during the query period were for promethazine/codeine syrup.

2. 31.45% of Dr. D.W.'s prescriptions were for oxycodone 30 mg tablets.

3. 31.09% of Dr. M.G.'s prescriptions were for promethazine/codeine syrup.

4. 34.17% of Dr. M.P.'s prescriptions were for oxycodone 30 mg tablets.

5. 98.05% of Dr. C.A.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg, alprazolam 2 mg, or oxycodone 30 mg.

6. 59.04% of Dr. S.W.'s prescriptions were for promethazine/codeine syrup, hydrocodone/acetaminophen 10/325 mg tablets, oxycodone 30 mg tablets, and alprazolam 2 mg tablets.

f. Dr. S.W.'s patients travelled excessive distances, 31 miles between his office and the pharmacy, to obtain controlled substances from LA's Pharmacy and Medical Equipment.

g. SGP did not have any documentations indicating that a pharmacist conferred with the prescriber to address the irregularities described above.

82. As the pharmacist-in-charge, PIC TRAN was responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. A Pharmacist-in-charge as the supervisor or manager of a pharmacy is responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. The pharmacist-in-charge is responsible for acts of the owner, officer, partner, or employee that violate this section and of which the pharmacist-in-charge, responsible manager, or designated representative-in-charge had no knowledge, or in which he or she did not knowingly participate. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 123 through 165, 210 through 215, as though set forth fully.

83. Complainant refers to and by this reference incorporates the allegations set forth above in paragraphs 20 through 76, inclusive, as though set forth fully.

## PRAYER

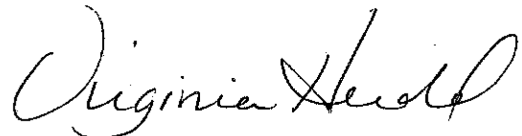
WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit License Number PHY 49169, issued to SGP Inc dba LA's Pharmacy & Medical Equipment, Roger Tran, PIC.

2. Ordering SGP 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;

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

DATED: 11/2/16



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

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