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

In the Matter of the Accusation Against: **THE MEDICINE SHOPPE** **PETER K. KWOK, PARTNER** **CHERYL L. CHIN, PARTNER** **OWNERS** **3507 W. Walnut Avenue** **Visalia, CA 93277** **Pharmacy Permit No. PHY 40626** **and** **CHERYL KWOK,** **aka CHERYL CHIN KWOK,** **PHARMACIST-IN-CHARGE** **3507 W. Walnut Avenue** **Visalia, CA 93277** **Pharmacist License No. RPH 43606** Respondents.	Case No. 6013 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about January 4, 1995, the Board issued Pharmacy Permit Number PHY 40626 to The Medicine Shoppe ("Respondent The Medicine Shoppe"), with Peter K. Kwok and Cheryl

L. Chin as partners and owners. On or about April 4, 2010, Cheryl Kwok, also known as Cheryl Chin Kwok ("Respondent Kwok"), became the pharmacist-in-charge. The pharmacy permit was in full force and effect at all times relevant to the charges brought herein and will expire on January 1, 2018, unless renewed.

3. On or about July 31, 1990, the Board issued Pharmacist License Number RPH 43606 to Respondent Kwok. The pharmacist license was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2017, unless renewed.

JURISDICTION

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

5. Code section 4300 states, in pertinent part:

> (a) Every license issued may be suspended or revoked.
>
> (b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:
>
> (1) Suspending judgment.
>
> (2) Placing him or her upon probation.
>
> (3) Suspending his or her right to practice for a period not exceeding one year.
>
> (4) Revoking his or her license.
>
> (5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper . . .

6. Code section 4300.1 states:

> The expiration, cancellation, forfeiture, or suspension of a board-issued license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

7. Section 4307, subdivision (a), states:

> Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under

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

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

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

. . . . .

STATUTORY AND REGULATORY PROVISIONS

8. Code section 4301 states, in pertinent part:

The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . Unprofessional conduct shall include, but is not limited to, any of the following:

. . . .

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

. . . .

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

. . . .

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

9. Code section 4306.5 states, in pertinent part:

Unprofessional conduct for a pharmacist may include any of the following:

(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function . . .

10. Code section 4113, subdivision (c), states that "[t]he pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

11. Health and Safety Code section 11153, subdivision (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.

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12. Health and Safety Code section 11162.1 states, in pertinent part:

(a) The prescription forms for controlled substances shall be printed with the following features:

(1) A latent, repetitive "void" pattern shall be printed across the entire front of the prescription blank; if a prescription is scanned or photocopied, the word "void" shall appear in a pattern across the entire front of the prescription.

(2) A watermark shall be printed on the backside of the prescription blank; the watermark shall consist of the words "California Security Prescription."

. . . .

(6) A description of the security features included on each prescription form.

(7)(A) Six quantity check off boxes shall be printed on the form so that the prescriber may indicate the quantity by checking the applicable box where the following quantities shall appear:

1-24

25-49

50-74

75-100

101-150

151 and over . . .

. . . .

(8) Prescription blanks shall contain a statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted."

. . . .

(10) Check boxes shall be printed on the form so that the prescriber may indicate the number of refills ordered.

. . . .

(13) An identifying number assigned to the approved security printer by the Department of Justice.

. . . .

(b) Each batch of controlled substance prescription forms shall have the lot number printed on the form and each form within that batch shall be numbered sequentially beginning with the numeral one . . .

13. Health and Safety Code section 11164 states, in pertinent part:

Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 . . .

14. Health and Safety Code section 111255 states that "[a]ny drug or device is adulterated if it has been produced, prepared, packed, or held under conditions whereby it may have been contaminated with filth, or whereby it may have been rendered injurious to health."

15. Health and Safety Code section 111295 states that "[i]t is unlawful for any person to manufacture, sell, deliver, hold, or offer for sale any drug or device that is adulterated."

16. Title 21, Code of Federal Regulations ("CFR"), section 1301.75, subdivision (b), states that "[c]ontrolled substances listed in Schedules II, III, IV, and V shall be stored in a securely locked, substantially constructed cabinet. However, pharmacies and institutional

practitioners may disperse such substances throughout the stock of noncontrolled substances in such a manner as to obstruct the theft or diversion of the controlled substances."

17. Title 16, California Code of Regulations ("CCR"), section 1714 states, in pertinent part:

> . . . .
>
> (b) Each pharmacy licensed by the board shall maintain its facilities, space, fixtures, and equipment so that drugs are safely and properly prepared, maintained, secured and distributed. The pharmacy shall be of sufficient size and unobstructed area to accommodate the safe practice of pharmacy.
>
> . . . .
>
> (d) Each pharmacist while on duty shall be responsible for the security of the prescription department, including provisions for effective control against theft or diversion of dangerous drugs and devices, and records for such drugs and devices . . .

18. Title 16, CCR, section 1761, subdivision (a), states:

> 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.

COST RECOVERY

19. Code section 125.3 provides, in pertinent part, that a 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.

DRUG CLASSIFICATIONS

20. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Code section 4022. Oxycodone is used to treat pain. "Roxicodone" is a brand of oxycodone.

21. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to Code section 4022. Alprazolam is used to treat anxiety. "Xanax" is a brand of alprazolam.

22. Promethazine with codeine is a Schedule V controlled substance pursuant to Health

and Safety Code section 11058, subdivision (c)(1), and a dangerous drug pursuant to Code section 4022. Promethazine with codeine is used to treat cough. "Phenergan with codeine" is a brand of promethazine with codeine.

23. Hydrocodone/acetaminophen is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a Schedule II controlled substance pursuant to Title 21, CFR, section 1308.12, subdivision (b)(1)(vi).[1] Hydrocodone/acetaminophen is also a dangerous drug pursuant to Code section 4022. Hydrocodone/acetaminophen is used to treat pain. "Norco" is a brand of hydrocodone/acetaminophen.

24. Carisoprodol is a Schedule IV Controlled Substance pursuant to Title 21, CFR, section 1308.14, subdivision (c)(6), and a dangerous drug pursuant to Code section 4022. Carisoprodol is used as a muscle relaxant. "Soma" is a brand of carisoprodol.

CURES Program

25. The Controlled Substance Utilization Review and Evaluation System (CURES) program was initiated in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances. The program was amended in January 2005 to include mandatory weekly reporting of Schedule II to IV medications. The data is collected statewide and can be used by healthcare professionals, such as pharmacists and prescribers, to evaluate and determine whether their patients are utilizing their controlled substances safely and appropriately.

26. The component of CURES which is accessible to pharmacists and prescribers is called the Prescription Drug Monitoring Program (PDMP). Registration for access to the PDMP has been available since February 2009. The data may be used to aid in determining if a patient sees multiple prescribers, frequents multiple pharmacies to fill controlled substance prescriptions, and/or obtains early refills of controlled substance prescriptions.

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[1] Hydrocodone/acetaminophen was rescheduled to a Schedule II controlled substance effective October 6, 2014.

FACTUAL ALLEGATIONS

27. Board Inspector I. T. analyzed CURES data for Respondent The Medicine Shoppe ("TMS") and found certain "red flags" or irregularities indicating that various doctors were potentially issuing prescriptions for controlled substances for other than a legitimate medical purpose and that TMS was dispensing the drugs indiscriminately; i.e., without exercising its corresponding responsibility with regard to the dispensing or furnishing of the drugs.

28. On or about July 1, 2016, Board Inspectors I. T. and S. K. conducted an inspection at TMS and were assisted by Respondent Kwok ("Kwok") and pharmacy technician M. H. The inspectors observed returned or used blister pack cards containing medications for patient F. W., lying in a bin within an open closet. The inspectors asked Kwok about the blister pack cards. Kwok admitted that the pharmacy takes the cards back from two assisted living facilities when a patient has a dose change or the prescriber discontinues any of the medications contained inside the cards. Kwok also admitted that the returned medications which remained the same were re-dispensed by the pharmacy to the same patient using a new blister pack card.

29. Inspector I. T. requested and obtained TMS' books containing controlled substance prescription documents, and she and Inspector S. K. pulled certain prescriptions, from the books, which were identified during I. T.'s review of the pharmacy's CURES data. Later, the inspectors noticed M. H. retrieving a Schedule II controlled substance from an unlocked file cabinet. Kwok stated that she was unaware the cabinet needed to be locked at all times and admitted that it was only locked at the end of the day. At the conclusion of the inspection, Inspector I. T. requested that Kwok provide her with the pharmacy's electronic records of dispensed prescriptions for all patients and all drugs for the time period from February 1, 2012 to July 1, 2016.

30. On or about July 12, 2016 and July 19, 2016, Inspector I. T. received copies of TMS' electronic dispensing records. CURES searches were conducted for various patients by the pharmacy and the reports were stapled to the prescription documents, which were collected during the inspection. The CURES reports were attached to prescriptions issued by R. G., MD and S. K., MD. Inspector I. T. found that Kwok utilized the PDMP (Prescription Drug Monitoring Program) to check the dispensing histories of controlled substances of certain

patients; however, she failed to appropriately scrutinize the reports for proper spelling of patient names, and failed to investigate further if patients had multiple addresses, if the records indicated the patients were doctor or pharmacy shopping; i.e., obtaining prescriptions for the same controlled substances from different physicians and having them filled at different pharmacies, or when the report produced no records even though Kwok knew, or should have known, she had filled controlled substances for those patients in the past several months and a dispensing history should have come up in her searches.

31. Inspector I. T. reviewed records specifically pertaining to prescriptions written by physician's assistant S. D. R. and doctors S. W., MD, K. T., MD, D. C., MD, R. G., MD, S. D., DO, C. A., MD, and S. K. MD. Inspector I. T. determined based on her examination of the CURES data, the electronic pharmacy records, and the prescription documents that from February 1, 2012 to July 1, 2016, TMS dispensed numerous prescriptions for the controlled substances oxycodone, alprazolam, promethazine with codeine, hydrocodone/acetaminophen, and carisoprodol, issued by the above prescribers, without regard to certain irregularities or factors, as set forth below. Inspector I. T. also found that TMS dispensed controlled substance prescriptions written by Drs. R. G., D on prescription forms that were not in compliance with the law.

FIRST CAUSE FOR DISCIPLINE

(Sell, Deliver, Hold, or Offer for Sale Adulterated Drugs)

32. Respondent The Medicine Shoppe is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent sold, delivered, held, and/or offered for sale drugs that were adulterated, in violation of Health and Safety Code sections 111295 and 111255, as follows: Respondent took back used blister pack cards containing medications from assisted living facilities when a patient had a dose change or the prescriber discontinued a medication contained in the cards. Further, Respondent re-dispensed the unchanged medications to the same patient using a new blister pack card, as set forth in paragraph 27 above.

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SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Pharmacy, Fixtures, and Equipment so that Drugs Were Safely and Properly Secured)

33. Respondent The Medicine Shoppe is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, in violation of Title 16, CCR, section 1714, subdivision (b), and failed to store Schedule II controlled substances in securely locked, substantially constructed cabinets, in violation of Title 21, CFR, section 1301.75, subdivision (b), as follows: Respondent kept the file cabinet where Schedule II controlled substances were stored unlocked during pharmacy hours.

THIRD CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

34. Respondent The Medicine Shoppe is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (d), in that Respondent clearly excessively furnished the controlled substances oxycodone, alprazolam, promethazine with codeine, hydrocodone/acetaminophen, and carisoprodol, in violation of Health and Safety Code section 11153, subdivision (a), and dispensed numerous prescriptions containing significant errors, omissions, irregularities, uncertainties, ambiguities and/or alterations, in violation of Title 16, CCR, section 1761, subdivision (a), as follows:

a. On and between February 1, 2012 and July 1, 2016, Respondent dispensed numerous prescriptions for the above controlled substances without regard to the following irregularities or factors:

1. Prescribing trends were incongruent with the primary area of practice listed on the Medical Board of California's website by each prescriber. Physician's assistant S. D. R. and Dr. S. K. practiced internal medicine, Drs. S. W., D. C., and C. A. practiced general medicine, and Dr. R. D. practiced family medicine; Drs. K. T. and S. D. did not identify a primary area of

practice. Greater than 90% of each of these prescriber's prescriptions were written for highly abused controlled substances, such as alprazolam 2 mg, oxycodone 30 mg, promethazine/codeine, hydrocodone/acetaminophen 10/325 mg and/or carisoprodol 350 mg. Drs. R. G. and C. A. exclusively wrote prescriptions for alprazolam 2 mg, oxycodone 30 mg, and promethazine/codeine. Dr. S. D. only wrote prescriptions for oxycodone 30 mg and promethazine/codeine.

2. 100% of the prescriptions written by the above prescribers were paid for with cash. Further, patients paid cash for high retail cost medications without the financial benefit of insurance.

3. Multiple patients' prescriptions for identical controlled substances, written by the above prescribers, were filled by the pharmacy around the same time. Prescriptions were written on the same day, had identical batch numbers, and were either sequential or close in script number. The prescriptions were either consecutively numbered or very close in number.

4. All of the patients of the above prescribers receiving prescriptions for oxycodone and alprazolam received the highest tablet strength of both drugs, 30 mg and 2 mg respectively (some patients received two tablets per dose), with no evidence of upward titration from a lower dose.

5. The above prescribers' medical offices were located long distances (over 100 miles in many instances) from The Medicine Shoppe.

6. Patients traveled far distances (over 100 miles in many instances) to receive controlled substance prescriptions from the above prescribers and to have those prescriptions filled at The Medicine Shoppe.

7. Multiple patients of the above prescribers resided at the same address and received either identical or very similar prescriptions for controlled substances.

8. Multiple prescriptions were written by Drs. R. G., S. D., S. P., E. S., R. P., and R. A. on prescription forms which contained significant errors and omissions and were not in compliance with Health and Safety Code section 11162.1, as more particularly set forth in paragraph 34 below.

b. Respondent failed to assume its corresponding responsibility when it failed to appropriately scrutinize patients' drug therapy with readily available tools such as the PDMP and its own pharmacy records, resulting in the dispensing of controlled substances in certain instances to patients who engaged in "doctor shopping" and poly-pharmacy activity and to potentially opioid naïve patients.

FOURTH CAUSE FOR DISCIPLINE

(Dispensing of Controlled Substances Based on Prescription Forms Not in Compliance with the Law)

35. Respondent The Medicine Shoppe is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent violated Health and Safety Code section 11164, subdivision (a), when it dispensed prescriptions for controlled substances based on prescription forms that were not in compliance with Health and Safety Code Section 11162.1, as set forth below. A total of 375 prescriptions for controlled substances (approximately 28,590 tablets of oxycodone 30 mg, 6,150 tablets of alprazolam 2 mg and 67,200 ml of promethazine with codeine) were written on prescription forms that were not in compliance with the law and dispensed by Respondent. The pharmacy dispensed 33 controlled substance prescriptions (approximately 2160 tablets of oxycodone 30mg, 810 tablets of alprazolam 2mg, and 5760 mL of promethazine with codeine), written by S. K., MD, which were not dated. A total of approximately 30,750 tablets of oxycodone 30 mg, 6,960 tablets of alprazolam 2 mg, and 72,960 mL of promethazine with codeine were dispensed to patients, who presented invalid controlled substance prescriptions to Respondent.

R. G., MD

a. Prescriptions written by Dr. R. G. and dispensed by the pharmacy on February 25, 2015 and February 27, 2015, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but the second check off box incorrectly stated "25-50" instead of "25-49"; and the lot numbers were not printed on the prescription forms.

b. Prescriptions written by Dr. R. G. and dispensed by the pharmacy on June 23, 2015, June 24, 2015, June 26, 2015, June 29, 2015, July 25, 2015, July 27, 2015, July 28, 2015, July 31, 2015, and August 1, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms.

c. Prescriptions written by Dr. R. G. and dispensed by the pharmacy on April 5, 2016, April 11, 2016, April 13, 2016, and April 19, 2016, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice.

d. A total of 134 prescriptions, written by Dr. R. G. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. D., MD

e. Prescriptions written by Dr. S. D. and dispensed by the pharmacy on November 7, 2012 and November 19, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot and batch numbers were not printed on the prescription forms. A total of 66 prescriptions, written by Dr. S. D. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

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S. P., MD

f. Prescriptions written by Dr. S. P. and dispensed by the pharmacy on November 30, 2012 and December 4, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-210" instead of "151 and over"; the prescription forms did not contain a statement printed on the bottom that the "Prescription is void if the number of drugs prescribed is not noted"; and lot and batch numbers were not printed on the prescription forms. A total of 38 prescriptions, written by Dr. S. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

E. S., MD

g. Prescriptions written by Dr. E. S. and dispensed by the pharmacy on May 20, 2013 and May 28, 2013, did not have the complete statement printed on the bottom of the forms that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing). Further, there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refill NR 1 2 3 4 5" without any check boxes). A total of 91 prescriptions, written by Dr. E. S. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. P., MD

h. Prescriptions written by Dr. R. P. and dispensed by the pharmacy on December 13, 2012 and January 18, 2013, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-over" instead of "151 and over"; the forms did not have the complete statement printed on the bottom that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing); there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms

showed "Refill NR 1 2 3 4 5" without any check boxes); and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice. A total of 22 prescriptions, written by Dr. R. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. A., MD

i. Prescriptions written by Dr. R. A. and dispensed by the pharmacy on March 3, 2015, March 4, 2015, and March 9, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and 151+" instead of "151 and over"; the forms did not have the correct statement printed on the bottom that the "Prescription is void if the number of drugs prescribed is not *noted*" (the statement was included, but the word "indicated" was used instead of "noted"); there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refills 0 1 2 3 4 PRN" without any check boxes); the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms. A total of 8 prescriptions, written by Dr. R. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

A. A., MD

j. Prescriptions written by Dr. A. A. and dispensed by the pharmacy on April 21, 2016, April 22, 2016, May 9, 2016, May 11, 2016, May 13, 2016, May 17, 2016, June 8, 2016, June 10, 2016, and June 13, 2016, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; there were two sets of different descriptions of the security features on the backs of the forms (one of them was printed on top of the other); six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "Over 151" instead of "151 and over"; there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered

(the forms showed "Refills 0-1-2-3-4-5" without any check boxes); and lot numbers were not printed on the prescription forms. A total of 16 prescriptions, written by Dr. A. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. K., MD

k. Respondent Kwok dispensed 33 controlled substance prescriptions (a total of approximately 2,160 tablets of oxycodone 30 mg, 810 tablets of alprazolam 2 mg and 5,760 ml of promethazine with codeine) written by Dr. S. K. that were not dated.

FIFTH CAUSE FOR DISCIPLINE

(Sell, Deliver, Hold, or Offer for Sale Adulterated Drugs)

36. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of The Medicine Shoppe, sold, delivered, held, and/or offered for sale drugs that were adulterated, in violation of Health and Safety Code sections 111295 and 111255, as follows: Respondent took back used blister pack cards containing medications from assisted living facilities when a patient had a dose change or the prescriber discontinued a medication contained in the cards. Further, Respondent re-dispensed the unchanged medications to the same patient using a new blister pack card, as set forth in paragraph 27 above.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Pharmacy, Fixtures, and Equipment so that Drugs Were Safely and Properly Secured)

37. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivisions (o) and (j), in that Respondent, as pharmacist-in-charge of The Medicine Shoppe, failed to maintain the pharmacy and its facilities, space, fixtures and/or equipment so that drugs were safely and properly secured, in violation of Title 16, CCR, section 1714, subdivision (d), and failed to store Schedule II controlled substances in securely locked, substantially constructed cabinets, in violation of Title 21, CFR, section 1301.75,

subdivision (b), as follows: Respondent kept the file cabinet where Schedule II controlled substances were stored unlocked during pharmacy hours.

SEVENTH CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

38. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (d), in that Respondent, as pharmacist-in-charge of The Medicine Shoppe, clearly excessively furnished the controlled substances oxycodone, alprazolam, promethazine with codeine, hydrocodone/acetaminophen, and carisoprodol, in violation of Health and Safety Code section 11153, subdivision (a), and dispensed numerous prescriptions containing significant errors, omissions, irregularities, uncertainties, ambiguities and/or alterations, in violation of Title 16, CCR, section 1761, subdivision (a), as follows:

a. On and between February 1, 2012 and July 1, 2016, Respondent dispensed numerous prescriptions for the above controlled substances without regard to the following irregularities or factors:

1. Prescribing trends were incongruent with the primary area of practice listed on the Medical Board of California's website by each prescriber. Physician's assistant S. D. R. and Dr. S. K. practiced internal medicine, Drs. S. W., D. C., and C. A. practiced general medicine, and Dr. R. D. practiced family medicine; Drs. K. T. and S. D. did not identify a primary area of practice. Greater than 90% of each of these prescriber's prescriptions were written for highly abused controlled substances, such as alprazolam 2 mg, oxycodone 30 mg, promethazine/codeine, hydrocodone/acetaminophen 10/325 mg and/or carisoprodol 350 mg. Drs. R. G. and C. A. exclusively wrote prescriptions for alprazolam 2 mg, oxycodone 30 mg, and promethazine/codeine. Dr. S. D. only wrote prescriptions for oxycodone 30 mg and promethazine/codeine.

2. 100% of the prescriptions written by the above prescribers were paid for with cash. Further, patients paid cash for high retail cost medications without the financial benefit of insurance.

3. Multiple patients' prescriptions for identical controlled substances, written by

the above prescribers, were filled by Respondent Kwok around the same time. Prescriptions were written on the same day, had identical batch numbers, and were either sequential or close in script number. The prescriptions were either consecutively numbered or very close in number.

4. All of the patients of the above prescribers receiving prescriptions for oxycodone and alprazolam received the highest tablet strength of both drugs, 30 mg and 2 mg respectively (some patients received two tablets per dose), with no evidence of upward titration from a lower dose.

5. The above prescribers' medical offices were located long distances (over 100 miles in many instances) from The Medicine Shoppe.

6. Patients traveled far distances (over 100 miles in many instances) to receive controlled substance prescriptions from the above prescribers and to have those prescriptions filled at The Medicine Shoppe.

7. Multiple patients of the above prescribers resided at the same address and received either identical or very similar prescriptions for controlled substances.

8. Multiple prescriptions were written by Drs. R. G., S. D., S. P., E. S., R. P., and R. A., on prescription forms which contained significant errors and omissions and were not in compliance with Health and Safety Code section 11162.1, as more particularly set forth in paragraph 41 below.

b. Respondent failed to assume her corresponding responsibility when she failed to appropriately scrutinize patients' drug therapy with readily available tools such as the PDMP and pharmacy records, resulting in the dispensing of controlled substances in certain instances to patients who engaged in "doctor shopping" and poly-pharmacy activity and to potentially opioid naïve patients.

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EIGHTH CAUSE FOR DISCIPLINE

(Inappropriate Exercise of Respondent's Education, Training, or Experience as a Pharmacist)

39. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, as defined by Code section 4306.5, subdivision (a), for inappropriately exercising her education, training or experience as a pharmacist, as set forth in paragraph 37 above.

NINTH CAUSE FOR DISCIPLINE

(Failure to Exercise or Implement Best Professional Judgment or Corresponding Responsibility)

40. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, as defined by Code section 4306.5, subdivision (b), for failing to exercise or implement her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, as set forth in paragraph 37 above.

TENTH CAUSE FOR DISCIPLINE

(Failure to Consult Appropriate Records)

41. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, as defined by Code section 4306.5, subdivision (c), for failing to consult appropriate records, including, but not limited to, the PDMP and The Medicine Shoppe's pharmacy records, pertaining to the dispensing or furnishing of controlled substances, as set forth in paragraph 37 above.

ELEVENTH CAUSE FOR DISCIPLINE

(Dispensing of Controlled Substances Based on Prescription Forms Not in Compliance with the Law)

42. Respondent Kwok is subject to disciplinary action for unprofessional conduct pursuant to Code section 4301, subdivision (j), in that Respondent, as pharmacist-in-charge of The Medicine Shoppe, violated Health and Safety Code section 11164, subdivision (a), when she dispensed prescriptions for controlled substances based on prescription forms that were not in

compliance with Health and Safety Code Section 11162.1, as set forth below. A total of 375 prescriptions for controlled substances (approximately 28,590 tablets of oxycodone 30 mg, 6,150 tablets of alprazolam 2 mg and 67,200 ml of promethazine with codeine) were written on prescription forms that were not in compliance with the law and dispensed by Respondent. Respondent Kwok dispensed 33 controlled substance prescriptions (approximately 2,160 tablets of oxycodone 30 mg, 810 tablets of alprazolam 2 mg, and 5,760 mL of promethazine with codeine), written by S. K., MD, which were not dated. A total of approximately 30,750 tablets of oxycodone 30 mg, 6,960 tablets of alprazolam 2 mg and 72,960 ml of promethazine with codeine were dispensed to patients, who presented invalid controlled substance prescriptions to Respondent.

R. G., MD

a. Prescriptions written by Dr. R. G. and dispensed by Respondent Kwok on February 25, 2015 and February 27, 2015, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but the second check off box incorrectly stated "25-50" instead of "25-49"; and the lot numbers were not printed on the prescription forms.

b. Prescriptions written by Dr. R. G. and dispensed by Respondent Kwok on June 23, 2015, June 24, 2015, June 26, 2015, June 29, 2015, July 25, 2015, July 27, 2015, July 28, 2015, July 31, 2015, and August 1, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms.

c. Prescriptions written by Dr. R. G. and dispensed by Respondent Kwok on April 5, 2016, April 11, 2016, April 13, 2016, and April 19, 2016, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed

on the backside of the prescription forms consisting of the words "California Security Prescription"; and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice.

d. A total of 134 prescriptions, written by Dr. R. G. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. D., MD

e. Prescriptions written by Dr. S. D. and dispensed by Respondent Kwok on November 7, 2012 and November 19, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and over 151" instead of "151 and over"; the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot and batch numbers were not printed on the prescription forms. A total of 66 prescriptions, written by Dr. S. D. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. P., MD

f. Prescriptions written by Dr. S. P. and dispensed by Respondent Kwok on November 30, 2012 and December 4, 2012, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-210" instead of "151 and over"; the prescription forms did not contain a statement printed on the bottom of the forms that the "Prescription is void if the number of drugs prescribed is not noted"; and lot and batch numbers were not printed on the prescription forms. A total of 38 prescriptions, written by Dr. S. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

E. S., MD

g. Prescriptions written by Dr. E. S. and dispensed by Respondent Kwok on May 20, 2013 and May 28, 2013, did not have the complete statement printed on the bottom of the forms

that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing). Further, there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refill NR 1 2 3 4 5" without any check boxes). A total of 91 prescriptions, written by Dr. E. S. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. P., MD

h. Prescriptions written by Dr. R. P. and dispensed by Respondent Kwok on December 13, 2012 and January 18, 2013, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "151-over" instead of "151 and over"; the forms did not have the complete statement printed on the bottom that the "Prescription is void if the number of drugs *prescribed* is not noted" (the statement was included, but the word "prescribed" was missing); there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refill NR 1 2 3 4 5" without any check boxes); and the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice. A total of 22 prescriptions, written by Dr. R. P. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

R. A., MD

i. Prescriptions written by Dr. R. A. and dispensed by Respondent Kwok on March 3, 2015, March 4, 2015, and March 9, 2015, did not have a latent, repetitive "void" pattern printed across the entire front of the prescription forms; did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "and 151+" instead of "151 and over"; the forms did not have the correct statement printed on the bottom that the "Prescription is void if the number of drugs prescribed is not *noted*" (the statement was included, but the word "indicated" was used instead of "noted"); there were no

check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refills 0 1 2 3 4 PRN" without any check boxes); the prescription forms did not have an identifying number assigned to the approved security printer by the Department of Justice; and lot numbers were not printed on the prescription forms. A total of 8 prescriptions, written by Dr. R. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

A. A., MD

j. Prescriptions written by Dr. A. A. and dispensed by Respondent Kwok on April 21, 2016, April 22, 2016, May 9, 2016, May 11, 2016, May 13, 2016, May 17, 2016, June 8, 2016, June 10, 2016, and June 13, 2016, did not have a watermark printed on the backside of the prescription forms consisting of the words "California Security Prescription"; there were two sets of different descriptions of the security features on the backs of the forms (one of them was printed on top of the other); six quantity check off boxes were included on the prescriptions, but incorrectly stated in the sixth check off box "Over 151" instead of "151 and over"; there were no check boxes printed on the prescription forms so that the prescriber may indicate the number of refills ordered (the forms showed "Refills 0-1-2-3-4-5" without any check boxes); and lot numbers were not printed on the prescription forms. A total of 16 prescriptions, written by Dr. A. A. and reviewed by Respondent Kwok, were not in compliance with Health and Safety Code section 11162.1.

S. K., MD

k. Respondent Kwok dispensed 33 controlled substance prescriptions (a total of approximately 2,160 tablets of oxycodone 30 mg, 810 tablets of alprazolam 2 mg and 5,760 ml of promethazine with codeine) written by Dr. S. K. that were not dated.

MATTERS IN AGGRAVATION

43. To determine the degree of discipline to be assessed against Respondents The Medicine Shoppe and Kwok, if any, Complainant alleges as follows:

a. On or about October 26, 2016, the Board issued Citation and Fine No. CI 2015 67954 against Respondent The Medicine Shoppe for violations of Code section 4342, subdivision (a)

(actions by the Board to prevent sales of drugs lacking quality or strength) and Title 16, CCR, section 1716 (variations from a prescription). On or about January 19, 2016, during a Board inspection, it was discovered that Respondent had expired drugs on the pharmacy shelves to be dispensed to customers. Further, the pharmacy dispensed lithium to a patient when the prescription was written for lactulose. The patient took several doses and required hospitalization. The Board ordered Respondent to pay a fine of $1,000 by November 25, 2016. Respondent has failed to pay the citation.

b. On or about October 26, 2016, the Board issued Citation and Fine No. CI 2016 72480 against Respondent Kwok for violations of Code section 4342, subdivision (a) (actions by the Board to prevent sales of drugs lacking quality or strength) and Title 16, CCR, section 1716 (variations from a prescription). On or about January 19, 2016, during a Board inspection, it was discovered that Respondent, as pharmacist-in-charge of The Medicine Shoppe, had expired drugs on the pharmacy shelves to be dispensed to customers. Further, Respondent, as pharmacist-in-charge of The Medicine Shoppe, dispensed lithium to a patient when the prescription was written for lactulose. The patient took several doses and required hospitalization. The Board ordered Respondent to pay fines totaling $2,000 by November 25, 2016. Respondent has failed to pay the citation.

OTHER MATTERS

44. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 40626 issued to The Medicine Shoppe, The Medicine Shoppe shall be prohibited from serving a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 40626 is placed on probation or until Pharmacy Permit Number PHY is reinstated if it is revoked.

45. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 40626 issued to The Medicine Shoppe while Peter K. Kwok and/or Cheryl L. Chin (Kwok) have been a partner and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Peter K. Kwok and Chery L. Chin (Kwok) shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate,

or partner of a licensee for five years if Pharmacy Permit Number PHY 40626 is placed on probation or until Pharmacy Permit Number PHY 40626 is reinstated if it is revoked.

PRAYER

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

1. Revoking or suspending Pharmacy Permit Number PHY 40626, issued to The Medicine Shoppe;

2. Revoking or suspending Pharmacist License Number RPH 43606, issued to Cheryl Kwok, also known as Cheryl Chin Kwok;

3. Prohibiting The Medicine Shoppe from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 40626 is placed on probation or until Pharmacy Permit Number 40626 is reinstated if Pharmacy Permit Number 40626 issued to The Medicine Shoppe is revoked;

4. Prohibiting Peter K. Kwok from serving as a manger, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 40626 is placed on probation or until Pharmacy Permit Number 40626 is reinstated if Pharmacy Permit Number 40626 issued to The Medicine Shoppe is revoked;

5. Prohibiting Cheryl L. Chin (Kwok) from serving as a manger, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 40626 is placed on probation or until Pharmacy Permit Number 40626 is reinstated if Pharmacy Permit Number 40626 issued to The Medicine Shoppe is revoked;

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6. Ordering The Medicine Shoppe and Cheryl Kwok, also known as Cheryl Chin Kwok, to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: 7/1/17

Virginia Herold

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

SA2016104515