

1 KAMALA D. HARRIS
Attorney General of California
2 JAMES M. LEDAKIS
Supervising Deputy Attorney General
3 NICOLE R. TRAMA
Deputy Attorney General
4 State Bar No. 263607
110 West "A" Street, Suite 1100
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 645-2143
7 Facsimile: (619) 645-2061
Attorneys for Complainant

8
9 **BEFORE THE**
BOARD OF PHARMACY
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Statement of Issues
12 Against:
13 **WEST PACIFIC PHARMACY, INC.,**
14 **DBA WEST PACIFIC PHARMACY**
Nasser Fathi, President
15 **Community Pharmacy Permit Application**
16 Respondent.

Case No. 5092

STATEMENT OF ISSUES

17
18 Complainant alleges:

19 PARTIES

- 20 1. Virginia Herold (Complainant) brings this Statement of Issues solely in her official
21 capacity as the Executive Officer of the Board of Pharmacy, Department of Consumer Affairs.
- 22 2. On or about July 12, 2013, the Board of Pharmacy, Department of Consumer Affairs
23 received an application for a Community Pharmacy Permit Application from West Pacific
24 Pharmacy, Inc., dba West Pacific Pharmacy with Nasser Fathi as President and Pharmacist-in-
25 Charge (Respondent). On or about June 20, 2013, Nasser Fathi certified under penalty of perjury
26 to the truthfulness of all statements, answers, and representations in the application. The Board
27 denied the application on October 22, 2013.

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JURISDICTION

3. This Statement of Issues 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.

4. Business and Professions Code section 480, subdivision (a)(3) states:

(a) A board may deny a license regulated by this code on the grounds that the applicant has one of the following:

....

(3) (A) Done any act that if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

....

5. California Code of Regulations, title 16, section 1770, states:

For the purpose of denial, suspension, or revocation of a personal or facility license pursuant to Division 1.5 (commencing with Section 475) of the Business and Professions Code, a crime or act shall be considered substantially related to the qualifications, functions or duties of a licensee or registrant if to a substantial degree it evidences present or potential unfitness of a licensee or registrant to perform the functions authorized by his license or registration in a manner consistent with the public health, safety, or welfare.

CAUSE FOR DENIAL OF APPLICATION

(Acts Done by Licentiate)

6. Respondent's application is subject to denial under section 480, subdivision (a)(3) in that, Respondent engaged in acts which, if done by a licentiate, would constitute grounds for a suspension or revocation of licensure. The circumstances are as follows:

a. Since January 20, 1997, Nasser Fathi (Pharmacist License No. RPH 48441) has been the President and Pharmacist-in-Charge of Irvine Medical Pharmacy, Inc., dba Irvine Medical Pharmacy (Pharmacy Permit No. PHY 42046) located at 14130 Culver Drive, Suite D, in Irvine, CA 92714.

b. On or about July 12, 2013, the Board of Pharmacy, Department of Consumer Affairs received an application for a Community Pharmacy Permit Application from West Pacific

1 Pharmacy, Inc., dba West Pacific Pharmacy with Nasser Fathi as President and Pharmacist-in-
2 Charge (Respondent). The Board denied the application on October 22, 2013.

3 c. Respondent's application is subject to denial based on the following acts, as
4 more fully set forth in Accusation No. 4969 filed by the Board of Pharmacy against Nasser Fathi
5 (Pharmacist License No. RPH 48441) and Irvine Medical Pharmacy, dba Irvine Medical
6 Pharmacy (Pharmacy Permit No. PHY 42046) on March 12, 2014:

7 1. Failing to implement their corresponding responsibility to ensure that
8 controlled substances are dispensed for a legitimate medical purpose in violation of Code section
9 4301, subdivision (j), and Health and Safety Code section 11153, subdivision (a).

10 2. Unprofessional conduct for excessively furnishing controlled substances
11 in violation Code section 4301, subdivision (d).

12 3. Gross negligence in dispensing controlled substances in violation of Code
13 section 4301, subdivision (c).

14 4. Negligence in dispensing controlled substances in violation of Code
15 section 4301.

16 5. Failing to submit data to CURES on a weekly basis in violation of Code
17 section 4301(j) and (o), and Health and Safety Code section 11165, subdivision (d).

18 d. A true and correct copy of Accusation No. 4969 is attached hereto as Exhibit
19 "A," and incorporated herein by reference.

20 PRAYER

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

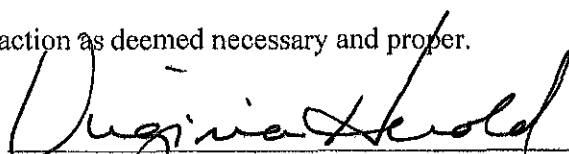
23 1. Denying the Community Pharmacy Permit Application of West Pacific Pharmacy,
24 Inc., dba West Pacific Pharmacy West Pacific Pharmacy with Nasser Fathi as President
25 (Respondent).

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

DATED:

4/24/14



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

SD2014706611
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Exhibit A

Accusation No. 4969

1 KAMALA D. HARRIS
Attorney General of California
2 JAMES M. LEDAKIS
Supervising Deputy Attorney General
3 NICOLE R. TRAMA
Deputy Attorney General
4 State Bar No. 263607
110 West "A" Street, Suite 1100
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 645-2143
7 Facsimile: (619) 645-2061
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9 **BEFORE THE**
BOARD OF PHARMACY
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the Accusation Against:

Case No. 4969

12 **IRVINE MEDICAL PHARMACY, INC.**
13 **DBA IRVINE MEDICAL PHARMACY**
14 **14130 Culver Drive, Suite D**
Irvine, CA 92714

A C C U S A T I O N

15 **Pharmacy Permit No. PHY 42046**

16 **and**

17 **NASSER FATHI**
18 **25652 Nellie Gail Road**
Laguna Hills, CA 92653

19 **Pharmacist License No. RPH 48441**

20 Respondents.

21
22 Complainant alleges:

23 **PARTIES**

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

26 2. On or about January 20, 1997, the Board of Pharmacy issued Pharmacy Permit
27 Number PHY 42046 to Irvine Medical Pharmacy, Inc., dba Irvine Medical Pharmacy
28 (Respondent) with Nasser Fathi as President and Pharmacist-in-Charge (PIC). The Pharmacy

1 Permit was in full force and effect at all times relevant to the charges brought herein and will
2 expire on January 1, 2015, unless renewed.

3 3. On or about December 6, 1995, the Board of Pharmacy issued Pharmacist License
4 Number RPH 48441 to Nasser Fathi (Respondent). The Pharmacist License was in full force and
5 effect at all times relevant to the charges brought herein and will expire on October 31, 2015,
6 unless renewed.

7 JURISDICTION

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

11 5. Section 4011 of the Code provides that the Board shall administer and enforce both
12 the Pharmacy Law [Bus. & Prof. Code, § 4000 et seq.] and the Uniform Controlled Substances
13 Act [Health & Safety Code, § 11000 et seq.].

14 6. Section 4300(a) of the Code provides that every license issued by the Board may be
15 suspended or revoked.

16 7. Section 4300.1 of the Code states:

17 The expiration, cancellation, forfeiture, or suspension of a board-issued
18 license by operation of law or by order or decision of the board or a court of law,
19 the placement of a license on a retired status, or the voluntary surrender of a
20 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.

21 STATUTORY PROVISIONS

22 8. Section 4022 of the Code states:

23 "Dangerous drug" or "dangerous device" means any drug or device unsafe
24 for self-use in humans or animals, and includes the following:

25 (a) Any drug that bears the legend: "Caution: federal law prohibits
dispensing without prescription," "Rx only," or words of similar import.

26 (b) Any device that bears the statement: "Caution: federal law restricts this
27 device to sale by or on the order of a _____," "Rx only," or words of similar import,
28 the blank to be filled in with the designation of the practitioner licensed to use or
order use of the device.

1 (c) Any other drug or device that by federal or state law can be lawfully
2 dispensed only on prescription or furnished pursuant to Section 4006.

3 9. Section 4113, subdivision (c) of the Code states: "The pharmacist-in-charge shall be
4 responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining
5 to the practice of pharmacy."

6 10. Section 4301 of the Code states:

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

11

12 (c) Gross negligence.

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

15

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

18

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

24

25 11. Health and Safety Code section 11153 states in pertinent part:

26 (a) A prescription for a controlled substance shall only be issued for a
27 legitimate medical purpose by an individual practitioner acting in the usual course
28 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

1 program, for the purpose of providing the user with controlled substances,
2 sufficient to keep him or her comfortable by maintaining customary use.

3 12. Health and Safety Code section 11165 states:

4 (a) To assist law enforcement and regulatory agencies in their efforts to
5 control the diversion and resultant abuse of Schedule II, Schedule III, and
6 Schedule IV controlled substances, and for statistical analysis, education, and
7 research, the Department of Justice shall, contingent upon the availability of
8 adequate funds from the Contingent Fund of the Medical Board of California, the
9 Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of
10 Registered Nursing Fund, and the Osteopathic Medical Board of California
11 Contingent Fund, maintain the Controlled Substance Utilization Review and
12 Evaluation System (CURES) for the electronic monitoring of, and Internet access
13 to information regarding, the prescribing and dispensing of Schedule II, Schedule
14 III, and Schedule IV controlled substances by all practitioners authorized to
15 prescribe or dispense these controlled substances.

16 (b) The reporting of Schedule III and Schedule IV controlled substance
17 prescriptions to CURES shall be contingent upon the availability of adequate funds
18 from the Department of Justice. The department may seek and use grant funds to
19 pay the costs incurred from the reporting of controlled substance prescriptions to
20 CURES. Funds shall not be appropriated from the Contingent Fund of the Medical
21 Board of California, the Pharmacy Board Contingent Fund, the State Dentistry
22 Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, or
23 the Osteopathic Medical Board of California Contingent Fund to pay the costs of
24 reporting Schedule III and Schedule IV controlled substance prescriptions to
25 CURES.

26 (c) CURES shall operate under existing provisions of law to safeguard the
27 privacy and confidentiality of patients. Data obtained from CURES shall only be
28 provided to appropriate state, local, and federal persons or public agencies for
disciplinary, civil, or criminal purposes and to other agencies or entities, as
determined by the Department of Justice, for the purpose of educating practitioners
and others in lieu of disciplinary, civil, or criminal actions. Data may be provided
to public or private entities, as approved by the Department of Justice, for
educational, peer review, statistical, or research purposes, provided that patient
information, including any information that may identify the patient, is not
compromised. Further, data disclosed to any individual or agency as described in
this subdivision shall not be disclosed, sold, or transferred to any third party.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV
controlled substance, as defined in the controlled substances schedules in federal
law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14,
respectively, of Title 21 of the Code of Federal Regulations, the dispensing
pharmacy or clinic shall provide the following information to the Department of
Justice on a weekly basis and in a format specified by the Department of Justice:

1 (1) Full name, address, and the telephone number of the ultimate user or
2 research subject, or contact information as determined by the Secretary of the
3 United States Department of Health and Human Services, and the gender, and date
4 of birth of the ultimate user.

5 (2) The prescriber's category of licensure and license number; federal
6 controlled substance registration number; and the state medical license number of
7 any prescriber using the federal controlled substance registration number of a
8 government-exempt facility.

9 (3) Pharmacy prescription number, license number, and federal controlled
10 substance registration number.

11 (4) NDC (National Drug Code) number of the controlled substance
12 dispensed.

13 (5) Quantity of the controlled substance dispensed.

14 (6) ICD-9 (diagnosis code), if available.

15 (7) Number of refills ordered.

16 (8) Whether the drug was dispensed as a refill of a prescription or as a
17 first-time request.

18 (9) Date of origin of the prescription.

19 (10) Date of dispensing of the prescription.

20 (e) This section shall become operative on January 1, 2005.

21 REGULATORY PROVISIONS

22 13. Code of Federal Regulations, title 21, section 1306.04 states in pertinent part:

23 (a) A prescription for a controlled substance to be effective must be issued for
24 a legitimate medical purpose by an individual practitioner acting in the usual
25 course of his professional practice. The responsibility for the proper prescribing
26 and dispensing of controlled substances is upon the prescribing practitioner, but a
27 corresponding responsibility rests with the pharmacist who fills the prescription.
28 An order purporting to be a prescription issued not in the usual course of
professional treatment or in legitimate and authorized research is not a prescription
within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the
person knowingly filling such a purported prescription, as well as the person
issuing it, shall be subject to the penalties provided for violations of the provisions
of law relating to controlled substances.

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14. California Code of Regulations, title 16, section 1707.5(d) states in pertinent part:

(a) Labels on drug containers dispensed to patients in California shall conform to the following format:

....

(d) The pharmacy shall have policies and procedures in place to help patients with limited or no English proficiency understand the information on the label as specified in subdivision (a) in the patient's language. The pharmacy's policies and procedures shall be specified in writing and shall include, at minimum, the selected means to identify the patient's language and to provide interpretive services in the patient's language. The pharmacy shall, at minimum, provide interpretive services in the patient's language, if interpretive services in such language are available, during all hours that the pharmacy is open, either in person by pharmacy staff or by use of a third-party interpretive service available by telephone at or adjacent to the pharmacy counter.

....

15. California Code of Regulations, title 16, section 1761 states:

(a) No pharmacist shall compound or dispense any prescription which contains any significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any such prescription, the pharmacist shall contact the prescriber to obtain the information needed to validate the prescription.

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

COST RECOVERY

16. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

1 **DRUGS**

2 17. Alprazolam is a Schedule IV controlled substance pursuant to Health and Safety Code
3 section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code
4 section 4022.

5 18. Carisoprodol, the generic name for Soma, is a Schedule IV controlled substance
6 pursuant to Health and Safety Code section 11057, and is a dangerous drug pursuant to Business
7 and Professions Code section 4022.

8 19. Opana, a brand name for oxymorphone hydrochloride, is a Schedule II controlled
9 substance as designated by Health and Safety Code section 11055, subdivision (b), and is a
10 dangerous drug pursuant to Business and Professions Code section 4022.

11 20. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code
12 section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code
13 section 4022.

14 21. Vicodin, a brand name for acetaminophen and hydrocodone bitartrate, is a Schedule
15 III controlled substance pursuant to Health and Safety Code section 11056, subdivision (c), and a
16 dangerous drug pursuant to Business and Professions Code section 4022.

17 **FACTUAL ALLEGATIONS**

18 22. At all times mentioned herein and since January 20, 1997, Nasser Fathi (Respondent
19 Fathi), has been the President and Pharmacist-in-Charge (PIC) of Irvine Medical Pharmacy, Inc.,
20 dba Irvine Medical Pharmacy (Respondent Irvine Medical Pharmacy).

21 23. In or around January 2013, the Board of Pharmacy initiated an investigation of
22 Respondents. The Board inspector discovered that most Schedule II controlled substance
23 prescriptions filled by Respondents came from the same five doctors, that patients traveled a
24 distance to have their Schedule II prescriptions filled at the pharmacy, and that patients always
25 paid in cash for controlled substances. The Board inspector also discovered that some patients
26 came to Respondent Irvine Medical Pharmacy as a group in a van or SUV in order for them all to
27 obtain controlled substances.

28

1 24. With respect to the verification of prescriptions, Respondents' ancillary staff
2 verified medications by contacting the patient's doctor. Staff only verified the drug, strength, and
3 quantity, and did not ask about indication or past medical history. Respondent Fathi did not
4 verify prescriptions written by Dr. W.¹ or Dr. C.² Instead, Respondents' practice was to have
5 ancillary staff call Dr. W.'s cell phone or speak with the receptionist at Dr. C.'s office, when
6 verifying prescriptions.

7 25. Some patients presented with what appeared to pharmacy staff to be "fake" IDs when
8 picking up the prescriptions from Respondents. Although this was brought to Respondent Fathi's
9 attention, Respondents instructed staff to fill prescriptions for individuals even if the IDs
10 appeared to be fake. Respondent Fathi also did not utilize the Prescription Drug Monitoring
11 Program (PDMP) or CURES³ to ensure that controlled substances were dispensed for a legitimate
12 medical purpose.

13 26. On May 30, 2012, Respondents dispensed 180 tablets of oxycodone 30 mg to a
14 person who posed as Patient MA pursuant to a prescription from Dr. C. MA's address was in
15 Inglewood, California, approximately 47 miles from Respondent Irvine Medical Pharmacy.
16 However, the Board inspector contacted the real MA and learned that MA's driver's license was
17 stolen in 2012, that someone had stolen his identity, that he has never been to Irvine before, that
18 he has never seen Dr. C. and that he has never taken oxycodone 30 mg.

19 27. Patient DG's address was approximately 45 miles from Respondent Irvine Medical
20 Pharmacy. DG did not receive any controlled substance medications from January 1, 2012
21 through October 11, 2012. However, between October 11, 2012 and March 2013, Respondents
22

23 ¹ Dr. W.'s office was located in Anaheim Hills, approximately 18 miles from Respondent
Irvine Medical Pharmacy. Dr. W. was convicted of Medicare fraud on April 14, 2013.

24 ² Dr. C. has an office in Toluca Lake and Studio City, approximately 51 miles and 49
miles from Respondent Irvine Medical Pharmacy, respectively.

25 ³ Controlled Substance Utilization Review and Evaluation System (CURES) is a database
26 in a program developed by the California Department of Justice, Bureau of Narcotic
Enforcement, which allows access to the Prescription Drug Monitoring Program system. The
27 Prescription Drug Monitoring Program allows pre-registered users including licensed healthcare
prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense
28 controlled substances, law enforcement, and regulatory boards to access patient controlled
substance history information.

1 dispensed 120 tablets of oxycodone 30 mg and 90 tablets of Norco 10mg/325 to DG pursuant to
2 prescriptions written by Dr. W. Respondents did not question the prescriber about the high
3 starting dose of oxycodone in addition to the Norco, for the treatment of an opioid naïve patient.
4 On October 11, 2012, Respondents also dispensed alprazolam 2mg to DG pursuant to a
5 prescription written by Dr. W. Respondents did not question the prescriber about why DG was
6 started on the highest dose of alprazolam before trying a low strength dose or requiring a follow-
7 up. DG was doctor and pharmacy shopping. DG also had insurance but did not use insurance to
8 pay for all of the medications.

9 28. Patient DW's address was approximately 43 miles from Respondent Irvine Medical
10 Pharmacy. From January 1, 2012 through February 21, 2012, DW did not receive any controlled
11 substance medications. However, between February 12, 2012 and January 7, 2013, DW was
12 doctor, pharmacy and medication shopping. In August 2012 and December 2012, Respondents
13 dispensed oxycodone 30 mg to DW pursuant to prescriptions written by Dr. W.

14 29. Patient RS's address was approximately 45 miles from Respondent Irvine Medical
15 Pharmacy. Between January 6, 2012 and August 2, 2013, RS was doctor, pharmacy, and
16 medication shopping. On August 24, 2012, Respondents dispensed 120 tablets of Oxycodone 30
17 mg to RS pursuant to a prescription written by Dr. W., even though RS had received a 30 day
18 supply of another pain medication from another pharmacy on August 23, 2012. On September
19 24, 2012, Respondents dispensed another 120 tablets of Oxycodone 30 mg to RS pursuant to a
20 prescription written by Dr. W., even though RS had received a 30 day supply of another pain
21 medication from another pharmacy on September 24, 2012.

22 30. Patient JW's address was approximately 32 miles from Respondent Irvine Medical
23 Pharmacy. From January 8, 2008 through April 19, 2012, JW was doctor, pharmacy and
24 medication shopping. On July 27, 2012, Respondents dispensed a 90 day supply of Oxycodone
25 30 mg and a 90 day supply of Vicodin to JW pursuant to prescriptions written by Dr. W., even
26 though JW had been dispensed several other controlled substance medications from several other
27 pharmacies and doctors shortly before this date.

28

1 31. Patient MC's address was approximately 29 miles from Respondent Irvine Medical
2 Pharmacy. On March 3, 2011, MC received 240 tablets of oxycodone 30 mg from Respondent
3 Irvine Medical Pharmacy, paying \$350 cash. On April 20, 2011, MC received another 240 tablets
4 of oxycodone 30 mg from Respondent Irvine Medical Pharmacy, paying \$350 cash. On March
5 14, 2012, MC received 180 tablets of oxycodone 30 mg pursuant to a prescription written by Dr.
6 C. from Respondent Irvine Medical Pharmacy, paying \$300 cash. On May 15, 2012, MC
7 received 180 tablets of oxycodone 30 mg pursuant to a prescription written by Dr. C., from
8 Respondent Irvine Medical Pharmacy, paying \$300 cash. On June 15, 2012, MC received 180
9 tablets of oxycodone 30 mg pursuant to a prescription written by Dr. C. from Respondent Irvine
10 Medical Pharmacy, paying \$300 cash. On July 17, 2012, MC received 180 tablets of oxycodone
11 30 mg pursuant to a prescription written by Dr. C. from Respondent Irvine Medical Pharmacy,
12 paying \$300 cash. On October 1, 2012, MC received 120 tablets of oxycodone 30 mg pursuant to
13 a prescription written by Dr. C. from Respondent Irvine Medical Pharmacy, paying \$200 cash.
14 Therefore, from March 3, 2011 to October 1, 2012, MC traveled from her home in Long Beach to
15 Dr. C.'s office in Studio City and then to Respondent Irvine Medical Pharmacy in Irvine to have
16 her oxycodone 30 mg prescriptions filled, paying a total of \$2,100.00 in cash to Respondent
17 Irvine Medical Pharmacy.

18 32. Patient PE's address was approximately 50 miles from Respondent Irvine Medical
19 Pharmacy. From April 30, 2009 to May 14, 2013, PE was doctor, pharmacy and medication
20 shopping. On January 31, 2012, Respondents dispensed a 30 day supply of oxycodone 30 mg to
21 PE, even though PE had received a 30 day supply of oxycodone 30 mg on January 16, 2012 (15
22 days prior) from a different doctor and at a different pharmacy. On February 21, 2012,
23 Respondents dispensed another 30 day supply (120 tablets) of oxycodone 30 mg to PE, even
24 though PE had received a 30 day supply of oxycodone 30 mg on February 13, 2012 (8 days prior)
25 from a different doctor and at a different pharmacy. On May 25, 2012, without verifying the
26 prescription with the prescriber, Respondents dispensed a 30 day supply (180 tablets) of
27 oxycodone 30 mg to PE, even though PE had received a 30 day supply of oxycodone 30 mg and a
28 25 day supply of Vicodin on May 11, 2012 (14 days prior).

1 33. Patient RD's address was approximately 29 miles from Respondent Irvine Medical
2 Pharmacy. From January 1, 2012 through May 22, 2012, RD received no controlled medications
3 in California. However, from May 22, 2012 to June 12, 2013, RD began doctor, pharmacy and
4 medication shopping. On May 22, 2012, Respondents dispensed a 30 day supply (180 tablets) of
5 oxycodone 30 mg to RD pursuant to a prescription written by Dr. C., paying Respondents \$300
6 cash. On July 3, 2012, Respondents dispensed a 45 day supply (180 tablets) of oxycodone 30 mg
7 pursuant to a written prescription written by Dr. C., paying \$300 cash.

8 34. The average distance that Dr. W.'s patients traveled from their homes to Respondent
9 Irvine Medical Pharmacy was 38.8 miles. From May 21, 2011 to January 28, 2013 (20 months),
10 Respondent Irvine Medical Pharmacy dispensed the following total controlled substances for
11 prescriptions written by Dr. W.:

12

Product Name	Total Tablets Dispensed
Alprazolam 2mg	400
APAP/Hydrocodone 10/325mg	1,280
APAP/Hydrocodone 7.5/750mg	360
Carisoprodol 350mg	270
OPANA ER 40mg	90
Oxycodone 30mg	7,510
GRAND TOTAL:	9,910

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22 35. The average distance that Dr. C.'s patients traveled from their homes to Respondent
23 Irvine Medical Pharmacy was 36.7 miles.⁴ From May 21, 2011 to January 28, 2013 (20 months),
24 Respondent Irvine Medical Pharmacy dispensed a total of 10,370 tablets of oxycodone 30 mg
25 from prescriptions written by Dr. C.

26
27 ⁴ Two of Dr. C.'s patients have Louisiana addresses. Those addresses were not used in
28 calculating the average distance that Dr. C.'s patient's traveled to have their prescriptions filled at
Respondent Irvine Medical Pharmacy.

1 36. The Board inspector also obtained data from nearby pharmacies, including "big-
2 box" retail pharmacies, and discovered that Respondent Irvine Medical Pharmacy was dispensing
3 over three times the amount of oxycodone 30 mg when compared to neighboring pharmacies.

4 37. Respondents also acquired oxycodone 30 mg at an average price of \$30.12 per 100
5 tablet bottle, or \$.30 per tablet. Respondents charged their cash patients \$1.64 per tablet, for a
6 total mark-up of 546 percent.

7 38. During the first inspection on July 8, 2013, the Board inspector discussed with
8 Respondent Fathi the requirement to report to CURES on a weekly basis. The Board inspector
9 showed Respondent Fathi the report reflecting that Respondents were not reporting regularly to
10 CURES. The Board inspector also discovered that Respondents did not report to CURES from
11 January 2010 through June 2010. Respondents also did not report CURES data from July 2010 to
12 December 2010, until July 10, 2013 (after the Board inspection on July 8, 2013).

13 **FIRST CAUSE FOR DISCIPLINE**

14 **(Unprofessional Conduct - Failure to Implement Corresponding Responsibility)**

15 39. Respondent Irvine Medical Pharmacy and Respondent Fathi are subject to
16 disciplinary action for unprofessional conduct under Code section 4301, subdivision (j), for
17 violation of Health and Safety Code section 11153, subdivision (a), in that Respondents failed to
18 comply with their corresponding responsibility to ensure that controlled substances are dispensed
19 for a legitimate medical purpose. The circumstances are that Respondents failed to evaluate the
20 totality of the circumstances (information from the patient, physician, CURES and other sources)
21 to determine the prescriptions' were issued for a legitimate medical purpose in light of
22 information showing that several patients demonstrated drug seeking behaviors such as doctor,
23 pharmacy and drug shopping, numerous patients had addresses outside Respondents' normal
24 trade area, patients paid only cash for their controlled substances, pharmacy staff questioned the
25 validity of patients' identification, certain prescribers (Dr. C. and Dr. W.) wrote a
26 disproportionate number of prescriptions for oxycodone, having no personal knowledge about
27 prescribers' practice or patients' treatment histories, among other things, as set forth in
28 paragraphs 22 through 38, which are incorporated herein by reference.

1 SECOND CAUSE FOR DISCIPLINE

2 (Unprofessional Conduct - Excessive Furnishing of Controlled Substances)

3 40. Respondent Irvine Medical Pharmacy and Respondent Fathi are subject to
4 disciplinary action for unprofessional conduct under Code section 4301, subdivision (d), for
5 unprofessional conduct in that Respondents clearly excessively furnished controlled substances,
6 when from February 20, 2012 through July 17, 2012, Respondents dispensed 50 prescriptions of
7 oxycodone 30mg prescribed by Dr. C. for a total 10,370 tablets and from May 21, 2011 to
8 January 28, 2013, Respondents dispensed 93 controlled substance prescriptions prescribed by Dr.
9 W. for a total of 9,910 tablets, as set forth in paragraphs 22 through 38, which are incorporated
10 herein by reference.

11 THIRD CAUSE FOR DISCIPLINE

12 (Unprofessional Conduct -- Gross Negligence)

13 41. Respondent Fathi is subject to disciplinary action for unprofessional conduct under
14 Code section 4301, subdivision (c), in that Respondent was grossly negligent in dispensing
15 controlled substances. The circumstances are that Respondent knew or should have known that
16 the controlled substances prescribed by Dr. C. and Dr. W. were likely to be used for other than a
17 legitimate medical purpose and Respondent failed to take appropriate steps when presented with
18 numerous prescriptions for controlled substances, including oxycodone 30mg, from a small group
19 of prescribers. Respondent failed to personally contact the prescriber about the indication or past
20 medical history and perform additional investigation to determine whether the prescriptions were
21 issued for a legitimate medical purpose, as set forth in paragraphs 22 through 38, which are
22 incorporated herein by reference.

23 FOURTH CAUSE FOR DISCIPLINE

24 (Unprofessional Conduct -- Negligence)

25 42. Respondent Fathi is subject to disciplinary action for unprofessional conduct under
26 Code section 4301, in that Respondent was negligent in dispensing controlled substances when
27 Respondent knew or should have known that the controlled substances prescribed by Dr. C. and
28 Dr. W. were likely to be used for other than a legitimate medical purpose and Respondent failed

1 to take appropriate steps upon which being presented with numerous prescriptions controlled
2 substances, including oxycodone 30mg, from a small group of prescribers, including but not
3 limited to, personally contacting the prescriber about the indication or past medical history and
4 performing additional investigation to determine whether the prescriptions were issued for a
5 legitimate medical purpose, as set forth in paragraphs 22 through 38, which are incorporated
6 herein by reference.

7 **FIFTH CAUSE FOR DISCIPLINE**

8 **(Unprofessional Conduct - Failure to Report to CURES)**

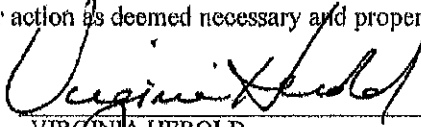
9 43. Respondent Irvine Medical Pharmacy and Respondent Fathi are subject to
10 disciplinary action for unprofessional conduct under Code section 4301(j) and (o), for violating
11 Health and Safety Code section 11165, subdivision (d), for failing to submit data to CURES on a
12 weekly basis, as set forth in paragraph 38, which is incorporated herein by reference.

13 **PRAYER**

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

- 16 1. Revoking or suspending Pharmacy Permit Number PHY 42046, issued to Irvine
17 Medical Pharmacy, Inc. dba Irvine Medical Pharmacy;
- 18 2. Revoking or suspending Pharmacist License Number RPH 48441 to Nasser Fathi;
- 19 3. Ordering Respondents to pay the Board of Pharmacy the reasonable costs of the
20 investigation and enforcement of this case, pursuant to Business and Professions Code section
21 125.3;
- 22 4. Taking such other and further action as deemed necessary and proper.

23 DATED: 3/12/14


24 VIRGINIA HEROLD
25 Executive Officer
26 Board of Pharmacy
27 Department of Consumer Affairs
28 State of California
Complainant

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