BILL LOCKYER, Attorney General
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Attorneys for Complainant

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

In the Matter of the Accusation Against: VICTORIA VILLAGE PHARMACY 1413 Victoria Avenue Ventura, CA 93003 Pharmacy Permit No. PHY 32497 and RICHARD OZAR 6556 Zumarez Drive Malibu, CA 90265 Pharmacist License No. RPH 26283 Respondents.	Case No. 2684 OAH No. L-2003120196 **STIPULATED SURRENDER OF PHARMACY PERMIT AND PHARMACIST LICENSE; AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding that the following matters are true:

PARTIES

1. Virginia K. Herold, (Complainant) is the interim Executive Officer of the the Board of Pharmacy. She brought this action solely in her official capacity and is represented in this matter by Bill Lockyer, Attorney General of the State of California, by Michel W. Valentine, Deputy Attorney General.

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2. Victoria Village and Richard Ozar (Respondents) are represented in this proceeding by attorney Ronald S. Marks, Esq., whose address is 21900 Burbank Blvd., Ste. 300, Woodland Hills, CA 91367.

3. On or about December 2, 1985, the Board of Pharmacy issued Pharmacy License No. PHY 32497 to Respondent Victoria Village Pharmacy. The License was in full force and effect and at all times relevant to the charges brought herein and will expire on December 1, 2006, unless renewed.

4 On or about August 5, 1969, the Board of Pharmacy issued Pharmacist Permit No. RPH 26283 to Respondent Richard Ozar. The License was in full force and effect and at all times relevant to the charges brought in Accusation No. 2684 and will expire on December 31, 2007 unless renewed.

JURISDICTION

5. The First Amended Accusation No. 2684 was filed before the Board of Pharmacy (Board), Department of Consumer Affairs, and is currently pending against Respondents. The First Amended Accusation and all other statutorily required documents were properly served on Respondents and Ronald S. Marks, Esq., attorney for Respondents on March 26, 2004. The First Supplemental and First Amended Accusation along with other statutorily requested documents were properly served on Respondents on July 28, 2006 and Ronald S. Marks, Esq. Respondents timely filed their Notices of Defense contesting the Accusation. A copy of the First Amended Accusation No. 2684 and First Supplemental and Amended Accusation are attached as Exhibit "A" and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondents have carefully read, fully discussed with counsel, and understand the charges and allegations in the First Amended Accusation and the First Supplemental Accusation No. 2684. Respondents also have carefully read, fully discussed with counsel, and understand the effects of this Stipulated Surrender of Pharmacy Permit and Pharmacist License and Order.

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7. Respondents are fully aware of their legal rights in this matter, including the right to a hearing on the charges and allegations in all Accusations filed; the right to be represented by counsel, at their own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondents voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent Ozar admits prospectively that in the event he applies for reinstatement of his pharmacist license or application for a permit that results in a hearing on a Statement of Issues that Causes for Discipline designated as First, fifth, Sixth, Seventh, Eighth, Ninth, Tenth and Eleventh, as contained in the First Amended and First Supplemental Amended Accusation no. 2684, may be deemed true.

10. Respondents understands that by signing this stipulation they enable the Board to issue an order accepting the surrender of their Pharmacy Permit and Pharmacist License without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board of Pharmacy. Respondents understand and agree that counsel for Complainant and the staff of the Board of Pharmacy may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondents or their counsel. By signing the stipulation, Respondents understand and agree that they may not withdraw this agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having

considered this matter.

12. The admissions are to resolve the issues in this matter only and shall not be admissible in any civil, criminal or administrative proceeding not involving the board of Pharmacy.

13. The parties understand and agree that facsimile copies of this Stipulated Surrender and Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Pharmacy Permit No PHY 32497, issued to Victoria Village Pharmacy and Pharmacist License No. 26283, issued to Respondent, Richard Ozar are surrendered and accepted by the Board of Pharmacy.

15. The surrender of Respondents' Pharmacy Permit and Pharmacist License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondents. This stipulation constitutes a record of the discipline and shall become a part of Respondents' license history with the Board.

16. Respondent Ozar shall lose all rights and privileges as a Pharmacist in California as of the effective date of the Board's Decision and Order.

17. Respondent Ozar shall cause to be delivered to the Board both their wall and pocket license certificate on or before the effective date of the Decision and Order.

18. Respondents must prepare a discontinuance of business for the Victoria Village Pharmacy and file it with the Board of Pharmacy according to their guidelines.

19. Respondent Ozar fully understands and agrees that if he ever files a Petition for Reinstatement or Application for a pharmacy permit, the First, Fifth Sixth, Seventh, Eighth, Ninth, Tenth, and Eleventh Causes for Discipline in the First Supplemental and Amended Accusation No. 2684 shall be deemed true, correct and admitted by Respondent Ozar.

These prospective admissions shall also apply to any application for licensure by Respondent Ozar for any other health care licensing agency in the State of California.

20. Respondents also agree that as a condition of Re-Licensure of any of the above described licenses, Respondents shall pay cost recovery in amount of $25,000.00.

21. Respondent Ozar cannot submit a petition for reinstatement for three years from the effective date of the Decision.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of Pharmacy Permit and Pharmacist License and Order and have fully discussed it with my attorney, Ronald S. Marks, Esq. I understand the stipulation and the effect it will have on my Pharmacy Permit and Pharmacist License. I enter into this Stipulated Surrender and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board of Pharmacy.

DATED: 10-6-06.

VITORIA VILLAGE
By RICHARD OZAR, Owner
Pharmacy Permit No. PHY 32497

DATED: 10-6-06.

RICHARD OZAR
Pharmacist License No. RPH 26283

I have read and fully discussed with Respondents the terms and conditions and other matters contained in this Stipulated Surrender and Order. I approve its form and content.

DATED: 10/6/06.

RONALD S. MARKS
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Surrender and Order is hereby respectfully submitted for consideration by the Board of Pharmacy of the Department of Consumer Affairs.

DATED: 10/6/06

BILL LOCKYER, Attorney General
of the State of California

MICHEL W. VALENTINE
Deputy Attorney General

Attorneys for Complainant

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

In the Matter of the Accusation Against: VICTORIA VILLAGE PHARMACY 1413 Victoria Avenue Ventura, CA 93003 Pharmacy Permit No. PHY 32497 and RICHARD OZAR 6556 Zumarez Dr Malibu, CA 90265 Pharmacist License No. RPH 26283 Respondent.	Case No. 2684 **OAH No. L2003120196**

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Pharmacy of the Department of Consumer Affairs, as its Decision in the above-entitled matter.

This decision shall become effective on December 28, 2006.

It is so ORDERED on November 28, 2006.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By William Powers
WILLIAM POWERS
Board President

Exhibit A

Accusation No. 2684

BILL LOCKYER, Attorney General
of the State of California
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BEFORE THE
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In the Matter of the Accusation Against: VICTORIA VILLAGE PHARMACY 1413 Victoria Ave. Ventura, CA 93003 Pharmacy License No. PHY 32497 and RICHARD OZAR 1413 S. Victoria Ave. Ventura, CA 93003 6556 Zumirez Dr., Malibu, 90265 Pharmacist License No. RPH 26283 Respondents.	Case No. 2684 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Patricia F. Harris (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 December 2, 1985, the Board of Pharmacy issued Pharmacy License No. PHY 32497 to Victoria Village Pharmacy (Respondent Pharmacy). The license was in full force and effect at all times relevant to the charges brought herein and will expire on

December 1, 2003, unless renewed.

3. On or about August 5, 1969, the Board of Pharmacy issued Pharmacist License No. RPH 26283 to Richard Ozar (Respondent Ozar). The license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2003, unless renewed.

JURISDICTION

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

5. Section 4300 permits the Board to take disciplinary action to suspend or revoke a license or permit.

6. Section 118(b) 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 (Section 4096), or reinstated, deprive the Board of its authority to institute or continue a disciplinary proceeding against the licensee.

7. Section 4301 states that the Board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

"(b) Incompetence.

"(c) Gross negligence.

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

"(e) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153.5 of the Health and Safety Code. Factors to be considered in determining whether the furnishing of controlled substances is clearly excessive shall include,

but not be limited to, the amount of controlled substances furnished, the previous ordering pattern of the customer (including size and frequency of orders), the type and size of the customer, and where and to whom the customer distributes its product.

"(f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or corruption, whether the act is committed in the course of relations as a licensee or otherwise, and whether the act is a felony or misdemeanor or not.

"(g) Knowingly making or signing any certificate or other document that falsely represents the existence or nonexistence of a state of facts.

"(j) The violation of any of the statutes of this 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.

8. Section 4022 defines "Dangerous Drugs" as any drug that is unsafe for self-medication and which by federal or state law can be lawfully dispensed only on prescription.

9. Section 4059(a) states, in pertinent part, that no person shall furnish any dangerous drug, except on the prescription of a physician.

10. Section 4063 provides that no prescription for any dangerous drug or dangerous device may be refilled except on authorization of the prescriber. The authorization may be given orally or at the time of giving the original prescription. No prescription for any dangerous drug that is a controlled substance may be designated refillable as needed.

11. Section 4081(a) states, in pertinent part, that records of manufacture and of sale, acquisition, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every pharmacy, or establishment holding a currently valid and unrevoked certificate, license, permit, registration who maintains a stock of dangerous drugs or dangerous devices.

12. Section 4081(b) states, in pertinent part, that the owner, officer, and partner of any pharmacy shall be jointly responsible, with the pharmacist-in-charge or exemptee, for maintaining the records and inventory described in this section.

13. Section 4113(b) states that the 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.

14. Health and Safety Code section 11153(a), states in part that 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.

15. Health and Safety Code section 11165(a), states, in pertinent part, that to assist law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, and the Osteopathic Medical Board of California Contingent Fund, establish the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

16. Health and Safety Code section 11166 states, in pertinent part, that to assist no person shall fill a prescription for a controlled substance classified in Schedule II 14 or more days after the date written on the prescription by the prescriber. No person shall knowingly fill a mutilated or forged or altered prescription for a controlled substance except for the addition of the address of the person for whom the controlled substance is prescribed.

17. Health & Safety Code section 11158(a) states that except as provided in Section 11159 or in subdivision (b) of this section, no controlled substance classified in Schedule

II shall be dispensed without a prescription meeting the requirements of this chapter. Except as provided in Section 11159 or when dispensed directly to an ultimate user by a practitioner, other than a pharmacist or pharmacy, no controlled substance classified in Schedule III, IV, or V may be dispensed without a prescription meeting the requirements of this chapter.

18. Health & Safety Code section 11200(c) states that no prescription for a Schedule II substance may be refilled.

19. Health & Safety Code section 11208 provides, in pertinent part, that an individual received or has had in his possession at any time a greater amount of controlled substances than is accounted for by any record required by law or that the amount of controlled substances possessed by the individual is a lesser amount than is accounted for by law is prima facie evidence of guilt.

20. California Code of Regulations, title 16, section 1707.1, a pharmacy shall maintain medication profiles on all patients who have prescriptions filled.

21. California Code of Regulations, title 16, section 1707.3, states a pharmacist shall review a patient's drug therapy and medication record before each prescription drug is delivered. The review shall include screening for severe potential drug therapy problems.

22. California Code of Regulations, title 16, section1715.5(a) states, in pertinent part, that each prescription for a Schedule II controlled substance, the dispensing pharmacy shall provide the following information: the full name and address of the patient; the gender and date of birth of the patient; the DEA (Drug Enforcement Administration) number of the prescriber; the triplicate prescription number; the pharmacy prescription number; the pharmacy license number; the NDC (National Drug Code) number and the quantity of the controlled substance; the ICD-9 (diagnosis code), if available; the date of issue of the prescription, the date of dispensing of the prescription, and the state medical license number of any prescriber using the DEA number of a government exempt facility.

23. California Code of Regulations, title 16, section 1716 states, in pertinent part, that Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with section 4047.6.

24. California Code of Regulations, title 16, 1718, states "Current Inventory" shall be considered to include complete accountability for all dangerous drugs handled by every licensee.

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

CONTROLLED SUBSTANCES

26. Actiq (generic - Fentanyl) which is a dangerous drug as defined in section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(c)(8). It is used in the treatment of break-through cancer pain in patients with malignancies.

27. Dilaudid (generic - Hydromorphone) which is a dangerous drug as defined in section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(b)(1)(K). It is used in the treatment of moderate to severe pain.

28. Methadone (generic - Methadone) which is a dangerous drug as defined in section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(c)(14). It is used in the treatment of severe pain and detoxification.

29. OxyContin SR (generic - Oxycodone HCL) which is a dangerous drug as defined in section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(b)(1)(N). It is used in the treatment of moderate to severe pain.

30. Roxicodone (generic - Oxycodone) which is a dangerous drug as defined in section 4022 and a Schedule II controlled substance under Health and Safety Code section 11055(b)(1)(N). It is used in the treatment of moderate to severe pain.

FIRST CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

31. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 for unprofessional conduct as defined in sections 4301(d) and (e) in that from May 19, 2001 to March 10, 2003, Respondents clearly furnished excessive

amounts of controlled substances by reason of the following facts:

Patient K.A.

32. Respondents dispensed early refills of prescriptions of OxyContin 80mg for Patient K.A. Based upon the patient's records, the consistent early filling of OxyContin 80mg would constitute an extreme departure from the standards of practice:

Date	Drug Name	Prescription Number	Days Early
09/12/02	OxyContin 80mg	255214	37
09/27/02	OxyContin 80mg	256046	25
10/10/02	OxyContin 80mg	256684	7
10/22/02	OxyContin 80mg	257244	7
11/06/02	OxyContin 80mg	258098	20
11/19/02	OxyContin 80mg	258835	12

Patient C.B.

33. Respondents dispensed early refills of prescriptions of Methadone 10mg and Actiq 1600mcg for Patient C.B. Based upon the patient's records, the consistent early filling of Methadone 10mg and Actiq 1600mcg would constitute an extreme departure from the standards of practice:

Date	Drug Name	Prescription Number	Days Early
12/11/01	MET10	239930	27
01/10/02	MET10	241620	20
02/08/02	AC16	243442	9
03/01/02	MET10	244630	27
03/15/02	AC16	245488	12
04/01/02	MET10	246074	10
04/24/02	MET10	247606	17
05/28/02	AC16	249474	12
06/12/02	AC16	250344	10
06/18/02	AC16	250661	11
07/22/02	MET10	252357	16

08/01/02	AC16	252961	13
08/01/02	MET10	252963	30
08/06/02	AC16	253152	12
09/02/02	MET10	254600	14
10/15/02	AC16	256907	14
02/19/03	AC16	263946	26

Patient F.B.

34. Respondents dispensed early refills of prescriptions of Actiq 1600mcg for Patient F.B. Based upon the patient's records, the consistent early filling of Actiq 1600mcg would constitute an extreme departure from the standards of practice:

Date	Drug Name	Prescription Number	Days Early
07/10/02	AC16	251809	15
07/19/02	AC16	252281	17
07/25/02	AC16	252549	19
07/30/02	AC16	252850	12
08/09/02	AC16	253381	7
08/19/02	AC16	253896	16
09/12/02	AC16	255180	25
09/23/02	AC16	255752	13
10/21/02	AC16	257222	13
10/28/02	AC16	257633	10
11/7/02	AC16	258191	7
11/16/02	AC16	258668	8
11/25/02	AC16	259098	8
12/02/02	AC16	259400	10
12/11/02	AC16	259964	7
12/20/02	AC16	260537	8
12/28/02	AC16	260920	9
01/03/03	AC16	261291	11
01/13/03	AC16	261839	7

Patient B.C.

35. Respondents dispensed early refills of prescriptions of Actiq 1600mcg and OxyContin 80mg for Patient B.C. Based upon the patient's records, the consistent early filling of Actiq 1600mcg and OxyContin 80mg would constitute an extreme departure from the standards of practice:

Date	Drug Name	Prescription Number	Days Early
05/29/02	AC16	249600	10
06/08/02	ROX30	250176	15
06/18/02	AC16	250307	10
07/03/02	ROX15	251466	7
07/11/02	ROX15	251844	17
07/25/02	ROX15	252584	8
07/27/02	O 80	252586	10
08/13/02	ROX15	253477	10
08/19/02	O 80	253905	8
08/26/02	O 80	254293	48
09/11/02	ROX30	255154	17
10/01/02	ROX30	256179	7
10/21/02	ROX30	257212	9
11/27/02	AC16	259100	10

Patient N.C.

36. Respondents dispensed early refills of prescriptions of Roxicodone 15mg for Patient N.C. Based upon the patient's records, the consistent early filling of Roxicodone 15mg would constitute an extreme departure from the standards of practice:

Date	Drug Name	Prescription Number	Days Early
06/28/02	ROX15	251277	21
07/19/02	ROX15	252264	17
08/05/02	O 80	253100	9

08/19/02	ROX15	253904	22

Patient C.C.

37. Respondents dispensed early refills of prescriptions of OxyContin 80mg, Methadone 10mg and Dilaudid 8mg for Patient C.C. Based upon the patient's records, the consistent early filling of OxyContin 80mg, Methadone 10mg and Dilaudid 8mg would constitute an extreme departure from the standards of practice:

Date	Drug Name	Prescription Number	Days Early
05/23/02	O 80	249337	11
10/09/02	M10	256611	8
10/09/02	O 80	256612	7
11/01/01	DIL8	257744	9
11/01/02	O 80	257746	8

Patient D.D.

38. Respondents dispensed early refills of prescriptions of OxyContin 80mg and Methadone 10mg for Patient D.D. Based upon the patient's records, the consistent early filling of OxyContin 80mg and Methadone 10mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
8/24/02	Oxycontin 80mg	253953	8
8/26/02	Methadone 10mg	253952	7
9/17/02	Methadone 10mg	255448	9
9/17/02	Oxycontin 80mg	255447	7

Patient R.G.

39. Respondents dispensed early refills of prescriptions of OxyContin 80mg, Roxiocodone, and Methadone 10mg for Patient R.G. Based upon the patient's records, the consistent early filling of OxyContin 80mg, Actiq 1600mcg, Roxiocodone 30mg, and Methadone

10mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
5/14/02	OxyContin 80mg	248827	40
6/14/02	Roxicodone 30mg	250480	70
6/17/02	OxyContin 80mg	250573	21
8/19/02	OxyContin 80mg	253886	11
10/2/02	Methadone 10mg	256233	8
12/5/02	OxyContin 80mg	259638	12
2/4/03	Actiq 1600mcg	261146	20
2/17/03	OxyContin 80mg	263807	9
2/18/03	Methadone 10mg	263809	8

Patient R.K.

40. Respondents dispensed early refills of prescriptions of Actiq 1600mcg for Patient R.K. Based upon the patient's records, the consistent early filling of Actiq 1600mcg would constitute an extreme departure from the standards of practice

Date	Drug Name	Prescription Number	Days Early
7/9/02	Actiq 1600mcg	251686	5 Days early on a 6 day supply
7/20/02	Actiq 1600mcg	252249	3 Days early on a 7 day supply
7/22/02	Actiq 1600mcg	252427	5 Days early on a 7 day supply
8/5/02	Actiq 1600mcg	253090	16 Days early on a 26 day supply
8/13/02	Actiq 1600mcg	253504	9 Days early on a 17 day supply
8/22/02	Actiq 1600mcg	253920	15
8/31/02	Actiq 1600mcg	254338	4

Patient C.L.

41. Respondents dispensed early refills of prescriptions of OxyContin 80mg for Patient C.L. Based upon the patient's records, the consistent early filling of OxyContin 80mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
6/13/02	OxyContin 80mg	250368	21
9/30/02	OxyContin 80mg	255832	7

Patient W.O.

42. Respondents dispensed early refills of prescriptions of Actiq 1600mcg, OxyContin 80mg, and Methadone 10mg for Patient W.O. Based upon the patient's records, the consistent early filling of Actiq 1600mcg, OxyContin 80mg, and Methadone 10mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
10/9/01	OxyContin 80mg	236454	9
12/6/01	OxyContin 80mg	239667	7
12/6/02	Methadone 10mg	239668	7
12/19/02	Actiq 1600mcg	240385	8
2/6/02	Actiq 1600mcg	243288	7 Days early on at 12 day supply
2/12/02	Methadone 10mg	243634	33 Days early on a 67 day supply
3/11/02	Methadone 10mg	245191	11
4/2/02	Methadone 10mg	246516	29
4/6/02	Actiq 1600mcg	246734	4
4/17/02	Actiq 1600mcg	247275	4 Days early on a 15 day supply
5/8/02	Actiq 1600mcg	248492	5 Days early on a 12 day supply
6/25/02	Actiq 1600mcg	250992	22
7/3/02	Actiq 1600mcg	251461	7
8/1/02	Actiq 1600mcg	252851	9
8/1/02	Methadone 10mg	252954	34 Days early on a 50 day supply
8/9/02	Actiq 1600mcg	253380	10
9/3/02	Methadone 10mg	254617	20
9/7/02	Actiq 1600mcg	254944	22
10/1/02	Methadone 10mg	256136	22
10/16/02	Actiq 1600mcg	257008	40 Days early on a 51 day supply

11/1/02	OxyContin 80mg	257852	7
11/5/02	Methadone 10mg	257226	18
11/7/02	Methadone 10mg	258193	11
11/7/02	Methadone 10mg	258194	23
12/4/02	OxyContin 80mg	259560	7
12/14/02	OxyContin 80mg	260190	7
12/24/02	OxyContin 80mg	260761	7
12/24/02	Actiq 1600mcg	260762	15
1/17/02	OxyContin 80mg	262129	7
1/17/02	Actiq 1600mcg	262130	24
1/27/02	OxyContin 80mg	262653	6
1/27/02	Actiq 1600mcg	262652	7
2/8/02	Actiq 1600mcg	263412	6
2/8/02	OxyContin 80mg	263413	5
2/17/02	OxyContin 80mg	263810	4

Patient M.R.

43. Respondents dispensed early refills of prescriptions of Actiq 1600mcg for Patient M.R. Based upon the patient's records, the consistent early filling of Actiq 1600mcg would constitute an extreme departure from the standards of practice:

Date	Drug Name	Prescription Number	Days Early
4/25/02	Actiq 1600mcg	247705	11
5/6/02	Actiq 1600mcg	248339	15 Days early on a 26 day supply
5/17/02	Actiq 1600mcg	248985	21 Days early on a 34 day supply
5/28/02	Actiq 1600mcg	249473	23 Days early on a 34 day supply
6/7/02	Actiq 1600mcg	250131	7
6/14/02	Actiq 1600mcg	250456	10 Days early on a 17 day supply
6/17/02	Actiq 1600mcg	250563	9 Days early on a 12 day supply
8/5/02	Actiq 1600mcg	253150	7
8/14/02	Actiq 1600mcg	253596	8 Days early on a 17 day supply
9/6/02	Actiq 1600mcg	254889	17

1/2/03	Actiq 1600mcg	261103	7
1/10/03	Actiq 1600mcg	261761	9 Days early on a 17 day supply
1/21/03	Actiq 1600mcg	262297	6
1/28/03	Actiq 1600mcg	262706	10
2/6/03	Actiq 1600mcg	263268	8 Days early on a 17 day supply
2/14/03	Actiq 1600mcg	263734	9 Days early on a 17 day supply
2/25/03	Actiq 1600mcg	264317	6 Days early on a 17 day supply

Patient B.R.

44. Respondents dispensed early refills of prescriptions of OxyContin 80mg for Patient B.R. Based upon the patient's records, the consistent early filling of OxyContin 80mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
2/7/02	OxyContin 80mg	243377	20
4/5/02	OxyContin 80mg	246689	14
5/1/02	OxyContin 80mg	248102	12
5/22/02	OxyContin 80mg	249242	10
6/17/02	OxyContin 80mg	250554	18
6/26/02	OxyContin 80mg	251103	21
9/19/02	OxyContin 80mg	255582	30 Days early on a 38 day supply
9/26/02	OxyContin 80mg	255959	20 Days early on a 27 day supply
10/18/02	OxyContin 80mg	257081	21
11/11/02	OxyContin 80mg	258377	13
1/2/03	OxyContin 80mg	261112	10 Days early on a 30 day supply

Patient D.S.

45. Respondents dispensed early refills of prescriptions of OxyContin 80mg for Patient D.S. Based upon the patient's records, the consistent early filling of OxyContin 80mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
5/8/02	OxyContin 80mg	248494	28 Days early on a 35 day supply
7/1/02	OxyContin 80mg	251310	12

Patient S.W.

46. Respondents dispensed early refills of prescriptions of Roxicodone 30mg for Patient S.W. Based upon the patient's records, the consistent early filling of Roxicodone 30mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
1/14/03	Roxicodone 30mg	261887	8
2/4/03	Roxicodone 30mg	263153	21 Days early on a 41 day supply

Patient T.W.

47. Respondents dispensed early refills of prescriptions of OxyContin 80mg and Roxicodone 30mg for Patient T.W. Based upon the patient's records, the consistent early filling of OxyContin 80mg and Roxicodone 30mg would constitute an extreme departure from the standards of practice.

Date	Drug Name	Prescription Number	Days Early
7/24/02	OxyContin 80mg	252485	13 Days early on 25 day supply
9/16/02	Roxicodone 30mg	255387	30 Days early on 40 day supply
10/1/03	OxyContin 80mg	256090	9 Days early on 20 day supply
12/13/02	OxyContin 80mg	260148	9 Days early on 20 day supply
12/13/02	Roxicodone 30mg	260149	9 Days early on 20 day supply
2/12/03	OxyContin 80mg	263565	9
2/12/03	Roxicodone 30mg	263556	9

SECOND CAUSE FOR DISCIPLINE

(Failure to Properly Dispense Prescriptions)

48. Respondent Ozar has subjected his license to discipline pursuant to section

4301 for unprofessional conduct as defined in section 4301(d) and in conjunction with Health and Safety Code section 11153 in that Respondents dispensed prescriptions for numerous patients that were for excessive quantities, excessive dosage and frequencies as set forth hereinabove at paragraphs 31 through 47. Respondents knew or had reason to know that the prescriptions were not for legitimate medical purposes.

THIRD CAUSE FOR DISCIPLINE

(Incompetence and Gross Negligence)

49. Respondent Ozar has subjected his license to discipline pursuant to section 4301 as defined in sections 4301(b) and (c) for incompetence and gross negligence in that Respondent, without proper documentation, made early refills of prescriptions for patients as set forth hereinabove at paragraphs 31 through 47 which directly endangered their health and safety.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Accurate Accountability)

50. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 for unprofessional conduct as defined in section 4301(o) and in violation of sections 4081(a) and (b) in conjunction with California Code of Regulations, title 16, section 1718 and Health and Safety Code section 11208 in that Respondents failed to maintain compliance and control over drug inventory and accurate records of acquisitions and disposition of controlled substances. An audit was conducted for the time period of May 19, 2001 through March 10, 2003. The audit revealed that Respondents did not maintain accurate records of acquisition and disposition of controlled substances as follows:

a. An overage of 50 units of Actiq 800.

b. A shortage of 1,737 units of Actiq 1600.

c. A shortage of 590 tablets of Dilaudid 8.

d. An overage of 4,419 tablets of Methadone 10.

e. A shortage of 3,889 tablets OxyContin SR 80.

f. A shortage of 5,884 tablets of Roxicodone 15.

g. A shortage of 1,898 tablets of Roxicodone 30.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Prescription Documents)

51. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 for unprofessional conduct as defined in section 4301(j) and in violation of sections 4081(a) and (b) in that Respondents failed to maintain prescriptions as required by law. Specifically, these prescriptions were missing prescription documents:

a. Prescriptions 260846 for patient R.W., 260411 for patient D.S., 255485 for patient R.M., 255296 for patient T.W., refill for prescription 253579 for patient C.B., and 254224 for patient N.M. Prescription 246224 was inaccurate for patient K.D. in that 246224 was indicated on Controlled substance log printed 5/1/2002 and on controlled substance log printed 6/4/2003 prescription 246224 was deleted.

b. Prescription Controlled Substance Log was inaccurate for patient R.R. in that the prescription document had two strip labels showing 261061 was filled twice on 12/31/2002, once for 100 pills and again for 240 pills, and the Controlled Substance Log and CURES report only show 261061 was filled once on 12/31/2002 for 100 pills. Prescription 259403 was inaccurate for patient C.G. in that the prescription document had two strip labels showing 259403 was filled separately, once for 40 tablets and again for 260 tablets, but the Controlled Substance Log only indicated 20 tablets were filled, the patient profile and CURES report both indicated only 260 tablets were filled. Prescription 253579 for patient C.B. filed on 8/28/2002 was inaccurate in that it was listed on the CURES and Controlled Substance Log, but not listed on the patient profile.

c. Prescription 251052 for patient Y.P.L. filled on 7/3/2002 was missing a strip label. Prescription 248190 for patient D.D. filled on 5/2/2002 was inaccurate in that the strip label and Controlled Substance Log indicate 2880 tablets of Methadone 10mg were distributed on 5/2/02, the Controlled Substance Log for 6/21/2002 indicates 1880 were refilled, but the CURES report indicates that 1000 were filled on 5/2/2002 and 1880 were filled on 6/21/2002. Prescription 236032 for patient M.R. was inaccurate in that the strip label indicates that 1200 tablets of Methadone 10mg were filled on 10/1/2001 and the 10/24/2001 controlled substance report

indicates that 200 more tablets were filled, but the CURES report indicates 1000 tablets were filled on 10/1/2001 and 200 on 10/24/2001.

d. Prescription 228121 for patient S.T. was inaccurate in that the strip label indicates 200 tablets of Oxycontin 80mg were filled on 5/3/2001, the Controlled Substance Log for 5/29/2001 indicates that 100 tablets were refilled, but the patient profile indicates that 100 were filled on 5/3/2001 and the CURES report indicates 100 tablets were filled on 5/3/2001 and 5/29/2001. Prescription 241549 for patient B.K. was inaccurate in that the strip label and control substance log for 1/9/2002 both indicate that 1000 tablets of Methadone 10mg were filled on 1/9/2002, but the patient profile and CURES report indicate that 100 tablets were given on this date.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Patient Profiles)

52. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 for unprofessional conduct as defined in section 4301(o) in violation of section 4113(b) and in conjunction with California Code of Regulations, title 16, section 1707.1 in that

a. Respondents failed to maintain patient profiles as required. Prescriptions 259403 for patient C.G., 257596 for patient S.R., 255296 for patient T.W., 253579 for patient C.B., 251878 for patient R.S., 251435 for patient M.M., 246224 for patient K.D., and 281121 for patient S.T. were not included in the respective patient profile.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Verify Controlled Substance Log)

53. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 for unprofessional conduct as defined in sections 4301(g) and (j) in that Respondents failed to verify the Controlled Substance Log as follows:

a. The original Controlled Substance Log for December 27, 2002 indicates prescription 261228, 900 Dilaudid 8mg was dispensed; prescription 260847, 500 Roxicodone 30mg and prescription 260848, 400 Methadone 10mg were dispensed. These did not have

prescription documents, were not on CURES and not on the patient profiles.

b. The original Controlled Substance Log for December 19, 2002 indicates prescription 260411, Oxycontin 80mg, 1000 tablets were dispensed. There were no prescription documents, not on CURES report, and not on patient profile.

c. The original Controlled Substance Log for November 27, 2002 indicates prescription 259299, 200 tablets of Methadone 10mg were dispensed. The strip label on the prescription document and CURES indicates that 600 tablets were dispensed.

d. The original Controlled Substance Log for November 8, 2002 indicates prescription 258250, 140 tablets of Oxycontin 80 mg were dispensed, and prescription 258251, 224 tablets of Methadone 10mg were dispensed. Strip labels, CURES, and patient profiles indicate prescriptions were filled with 280 and 448 tablets respectively.

e. The original Controlled Substance Log of September 18, 2002 indicates prescription 255485, 200 tablets of Dilaudid 8mg were dispensed. There was no prescription document and it was not on the CURES report.

f. The prescription document for prescription 256090 indicates 1000 tablets of Oxycontin 80mg was filled on October 1, 2002. It was not on the Controlled Substance Log or CURES. It did appear on the patient profile.

g. The original Controlled Substance Log of September 13, 2002 indicates prescription 255296, 400 tablets of Roxicodone 15mg were filled. There was no prescription documents, not on the CURES report or patient profile.

h. The Controlled Substance Log for August 26, 2002 indicates prescription 254224, 120 tablets of Actiq 1600 was dispensed. There was no prescription document and it was not on the CURES report.

i. The original Controlled Substance Log of May 1, 2002 indicated prescription 246224, 60 tablets of Oxycontin 80mg was dispensed, the prescription was deleted on the Controlled Substance Log printed June 4, 2003.

j. The original Controlled Substance Log of January 9, 2002 indicates prescription 241549, 1000 tablets of Methadone 10 mg were dispensed, the Controlled Substance Log printed

June 4, 2003 indicates 100 tablets were dispensed.

EIGHTH CAUSE FOR DISCIPLINE

(Unlawful Refilling of Controlled Substance Prescriptions)

54. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 as defined in sections 4301(e) and (f) for unprofessional conduct in violation of sections 4059 and 4063 in conjunction with Health and Safety Code sections 11158 and 11200(c) by refilling prescriptions 261228, 260223, 260225, 253579, 254294, 251878, 251878, 251435, 248190, 246224, 241787, 236032, and 228121 without authorization by the prescriber.

NINTH CAUSE FOR DISCIPLINE

(Filling of Triplicate Prescription Past Time Limit)

55. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 as defined in section 4301(j) for unprofessional conduct in violation of section 4113(b) in that Respondents filled triplicate prescriptions 756865, 253579, 251052, 248190, 241787, 236032 and 228121, fourteen or more days after the date written on the prescription by the prescriber in violation of Health and Safety Code section 11166.

TENTH CAUSE FOR DISCIPLINE

(Failure to Submit Schedule II Prescriptions)

56. Respondents Pharmacy and Ozar have subjected their licenses to discipline pursuant to section 4301 for unprofessional conduct as defined in sections 4301(j) and (o) in violation of section 4113(b) and in conjunction with California Code of Regulations, title 16, section 1715.5 and Health and Safety Code section 11165 in that Respondents submitted inaccurate prescription information to the Controlled Substance Utilization Review and Evaluation System (CURES) as required by law.

a. Specifically, prescription 261228 for patient R.S. was not listed on the CURES report. Prescription 257596 for patient S.R. was not listed on the CURES report. Prescriptions 257319, 257320 and 257321 for patient C.L. were also not listed on the CURES report.

Prescription 256865 for patient T.W. was not listed on the CURES report. Prescription 255485 for patient R.M. was not listed on the CURES report. Prescriptions 256090 and 255296 for patient T.W. were not listed on the CURES report. Prescription 254224 for patient N.M. was not listed on the CURES report. Prescription 246224 for patient K.D. was not listed on the CURES report.

b. Prescription 261061 for patient R.R. was inaccurate in that the prescription document had two strip labels showing 261061 was filled twice on 12/31/2002, once for 100 pills and again for 240 pills, and the Controlled Substance Log and CURES report only show 261061 was filled once on 12/31/2002 for 100 pills. Prescription 259403 for patient C.G. was inaccurate in that the prescription document had two strip labels showing 259403 was filled separately, once for 40 tablets and again for 260 tablets, but the Controlled Substance Log only indicated 20 tablets were filled, the patient profile and CURES report both indicated only 260 tablets were filled. Prescription 252878 for patient R.S. was inaccurate in that the prescription was filled for 1000 tablets on July 12, 2002 and refilled for 500 tablets on July 16, 2002; there was no CURES report for the 500 tablets refilled on July 16, 2002. Prescription 251435 for patient M.M. was inaccurate in that it was filled for 1000 tablets on July 7, 2002, refilled for 1000 tablets on July 22, 2002; the CURES report did not list the July 7, 2002 distribution, but did list the refill of July 22, 2002. Prescription 248190 for patient D.D. was inaccurate in that the strip label and Controlled Substance Log indicate 2880 tablets of Methadone 10mg were distributed on 5/2/02, the Controlled Substance Log for 6/21/2002 indicates 1880 were refilled, but the CURES report indicates that 1000 were filled on 5/2/2002 and 1880 were filled on 6/21/2002. Prescription 241787 for patient M.S. was inaccurate in that it was listed on the CURES report as filled for 6 tablets on January 14, 2002,and the Controlled Substance Log shows it was refilled for 42 tablets on February 5, 2002 but this was not listed on the CURES report. Prescription 228121 for patient S.T. was inaccurate in that the strip label indicates 200 tablets of Oxycontin 80mg were filled on 5/3/2001, the Controlled Substance Log for 5/29/2001 indicates that 100 tablets were refilled, but the patient profile indicates that 100 were filled on 5/3/2001 and the CURES report indicates 100 tablets were filled on 5/3/2001 and 5/29/2001.

Finally, prescription 241549 for patient B.K. was inaccurate in that the strip label and control substance log for 1/9/2002 both indicate that 1000 tablets of Methadone 10mg were filled on 1/9/2002, but the patient profile and CURES report indicate that 100 tablets were given on this date.

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 License Number PHY 32497, issued to Victoria Village Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 26283, issued to Richard Ozar;

3. Ordering Victoria Village Pharmacy and Richard Ozar 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;

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

DATED: March 25, 2004

Michael W. Valentine for
PATRICIA F. HARRIS
Executive Officer
Board of Pharmacy
Department of Consumer Affairs
State of California
Complainant

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

In the Matter of the Accusation Against: VICTORIA VILLAGE PHARMACY 1413 Victoria Avenue Ventura, CA 93003 Pharmacy Permit No. PHY 32497 and Richard Ozar 6556 Zumarez Drive Malibu, CA 90265 Pharmacist License No. RPH 26283 Respondent.	Case No. 2684 OAH No. L-2003120196

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective on _____.

It is so ORDERED _____.

_____
FOR THE BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS

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of the State of California
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Attorneys for Complainant

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

In the Matter of the Accusation Against: Victoria Village Pharmacy 1413 Victoria Avenue Ventura, CA 93003 Pharmacy License No. 32497 and Richard Ozar 6556 Zumarez Drive Malibu, CA 90265 Pharmacist License No. 26283 Respondents	Case No. 2684 OAH No. L-2003120196 **FIRST SUPPLEMENTAL AND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

Virginia K. Herold (Complainant) brings this First Supplemental and Amended Accusation solely in her official capacity as the Acting Executive Officer of the Board of Pharmacy, Department of Consumer Affairs and supplements the First Amended Accusation filed on March 25, 2004, in this matter, and for the cause for discipline further alleges:

57. Paragraphs two (2) through fifty-six (56), inclusive, are incorporated herein by reference, as if fully set forth.

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58. Section 4301 of the Code states:

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

. . . .

"(l) The conviction of a crime substantially related to the qualifications, functions, and duties of a licensee under this chapter. The record of conviction of a violation of Chapter 13 (commencing with Section 801) of Title 21 of the United States Code regulating controlled substances or of a violation of the statutes of this state regulating controlled substances or dangerous drugs shall be conclusive evidence of unprofessional conduct. In all other cases, the record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime, in order to fix the degree of discipline or, in the case of a conviction not involving controlled substances or dangerous drugs, to determine if the conviction is of an offense substantially related to the qualifications, functions, and duties of a licensee under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this provision. The board may take action when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment."

59. Section 490 of the Code provides, in pertinent part, that the Board may suspend or revoke a license when it finds that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of that license.

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60. 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."

ELEVENTH CAUSE FOR DISCIPLINE

(Conviction of a Substantially Related Crime)

61. Respondent is subject to disciplinary action under sections 4300, 4301, subdivision (l) and 490 of the Code, in conjunction with California Code of Regulations, title 16, section 1770, in that Respondent was convicted of a crime substantially related to the qualifications, functions or duties of a pharmacist, as follows:

A. On or April 4, 2004, Respondent was convicted by the court on a plea of guilty for violating Title 21, United States Code, Section 843, subdivision (a)(1), a felony (unlawful distribution of a controlled substance), in the United States District Court, for the Central District of California, Case No. CR 03-1197-GAF, entitled *United States v. Richard Ozar.*

B. The circumstances underlying the conviction are that on or about May 23, 2001, Respondent, a registrant authorized to distribute controlled substances, knowingly and intentionally distributed a schedule II controlled substance, to wit: 72 Fetanyl 1600 mcg. doses, to Patient GM, outside of his legitimate business and without a proper written order or order form.

TWELFTH CAUSE FOR DISCIPLINE

(Acts Involving Moral Turpitude)

62. Respondent is subject to disciplinary action under sections 4300 and 4301, subdivision (f) of the Code, on the grounds of unprofessional conduct, in that Respondent committed acts involving moral turpitude, as more fully set forth above in paragraph 61.

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 License No. PHY 32497, issued to Victoria Village Pharmacy;

2. Revoking or suspending Pharmacist License No. RPH 26283, issued to Richard Ozar;

3. Ordering Victoria Village Pharmacy and Richard Ozar 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: 7/21/06

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

LA2003600650
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