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

In the Matter of the Second Amended Accusation Against: **TWIN PHARMACY, INC. dba DABNEY PHARMACY,** 11115 S. Main Street Los Angeles, CA 90061 Pharmacy Permit No. PHY 46745 **AND** **ROBERT ROTHMAN** 16400 Saybrook Lane, No. 26 Huntington Beach, CA 92649 Pharmacist License No. RPH 30759 Respondents.	Case No. 4445 OAH No. 2014040886 **STIPULATED SURRENDER OF LICENSE AND ORDER** **[AS TO RESPONDENT ROBERT ROTHMAN ONLY]**

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 at 5:00 p.m. on December 5, 2016.

It is so ORDERED November 3, 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

KAMALA D. HARRIS
Attorney General of California
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BEFORE THE
BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Second Amended Accusation Against: **TWIN PHARMACY, INC. dba DABNEY PHARMACY,** 11115 S. Main Street Los Angeles, CA 90061 Pharmacy Permit No. PHY 46745 **AND** **ROBERT ROTHMAN** 16400 Saybrook Lane, No. 26 Huntington Beach, CA 92649 Pharmacist License No. RPH 30759 Respondent.	Case No. 4445 OAH No. 2014040886 **STIPULATED SURRENDER OF LICENSE AND ORDER** **[AS TO RESPONDENT ROBERT ROTHMAN ONLY]**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Susan Melton Wilson, Deputy Attorney General.

2. Respondent Robert Rothman ("Respondent") is represented in this proceeding by attorney Herbert L. Weinberg, Esquire, whose address is: Fenton Law Group LLP 1990 South Bundy Drive, Suite 777, Los Angeles, CA 90025.

3. On or about December 20, 1976, the Board of Pharmacy issued Pharmacist License No. RPH 30759 to Robert Rothman (Respondent). The Pharmacist License was in full force and effect at all times relevant to the charges brought in Second Amended Accusation No. 4445 and will expire on May 31, 2018, unless renewed.

JURISDICTION

4. The original Accusation in this matter was filed before the Board of Pharmacy (Board) on December 2, 2013, and duly served to Respondent, who filed his timely Notice of Defense contesting the Accusation. The First Amended Accusation was filed before the Board on July 24, 2015 and duly served to Respondent. The Second Amended Accusation was filed before the Board on May 16, 2016, duly served to Respondent , and is currently pending against him.

5. A copy of Second Amended Accusation No. 4445 is attached to this stipulation as **Exhibit A** and incorporated by this reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 4445. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his 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. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands that the charges and allegations in Accusation No. 4445, if proven at a hearing, constitute cause for imposing discipline upon his Pharmacist License.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

11. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Pharmacist License without further process.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board of Pharmacy. Respondent understands and agrees 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 Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his 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.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including Portable Document Format (PDF) and facsimile signatures thereto, shall have the same force and effect as the originals.

14. Parties agree that a clerical error appears in the numbering of causes in the Second Amended Accusation, and further agree that the Second Amended Accusation shall be amended by interlineation to correct and eliminate this error, so that the 16 causes for discipline are

numbered consecutively. No changes to the Second Amended Accusation, apart from re-numbering the causes as described, is authorized by this stipulation.

15. This Stipulated Surrender of License and Order is intended by the parties to be an integrated writing representing the complete, final, and exclusive embodiment of their agreement. It supersedes any and all prior or contemporaneous agreements, understandings, discussions, negotiations, and commitments (written or oral). This Stipulated Surrender of License and Order may not be altered, amended, modified, supplemented, or otherwise changed except by a writing executed by an authorized representative of each of the parties.

16. 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 Pharmacist License No. RPH 30759, issued to Respondent Robert Rothman, is surrendered and accepted by the Board of Pharmacy.

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

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

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. Respondent may not apply for any license, permit or registration from the Board for three (3) years from the effective date of this decision.

5. Respondent understands and agrees that if he ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a new application for licensure. Respondent may not apply for any license, permit, or registration from the board for three years from the effective date of this decision. Respondent stipulates that should he or she apply for any license from the board on or after the effective date of this decision, all allegations

set forth in the accusation shall be deemed to be true, correct and admitted by respondent when the board determines whether to grant or deny the application. Respondent shall satisfy all requirements applicable to that license as of the date the application is submitted to the board, including, but not limited to taking and passing the California Pharmacist Licensure Examination prior to the issuance of a new license. Respondent is required to report this surrender as disciplinary action.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of forty thousand dollars ($40,000.00) prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 4445 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

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

DATED: 8/3/2016

ROBERT ROTHMAN
Respondent

I have read and fully discussed with Respondent Robert Rothman the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 8/4/2016

HERBERT L. WEINBERG
Attorney for Respondent

ENDORSEMENT

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

Dated: August 5, 2016

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
THOMAS L. RINALDI
Supervising Deputy Attorney General

SUSAN MELTON WILSON
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 4445

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

In the Matter of the Accusation Against: **TWIN PHARMACY, INC. dba DABNEY PHARMACY,** **SHLOMO RECHNITZ, President, et al,** 11115 S. Main Street Los Angeles, CA 90061 Pharmacy Permit No. PHY 46745 **AND** **ROBERT ROTHMAN** 4682 Warner Avenue #C-115 Huntington Beach, CA 92649 Pharmacist License No. RPH 30759 Respondents.	Case No. 4445 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about December 20, 1976, the Board of Pharmacy issued Pharmacist License Number RPH 30759 to Robert Rothman (Respondent Rothman). The Pharmacist License was in full force and effect at all times relevant to the charges herein and will expire on May 31, 2016, unless renewed.

3. On or about June 14, 2004, the Board of Pharmacy issued Pharmacy Permit Number PHY 46745 to Twin Pharmacy, Inc. dba Dabney Pharmacy; Robert Rothman, Pharmacist-in-Charge; Shlomo Rechnitz, President; Denise Wilson-Ruane, Secretary (Respondent Pharmacy). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on June 1, 2016, unless renewed.

JURISDICTION

4. The original Accusation in this matter was filed on December 2, 2013, and duly served to Respondents, each of whom then filed a timely Notice of Defense. The First Amended Accusation was filed on July 24, 2015. This Second Amended Accusation is brought before the Board of Pharmacy (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section **118**, subdivision (b), provides in pertinent part that the suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

6. Section **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."

7. Business and Professions Code section **4301** states:

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

. . .

"(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 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."

. . .

8. Section **4306.5** states:

"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.

. . .

(d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and retain appropriate patient-specific information pertaining to the performance of any pharmacy function."

9. Section **4040** provides in pertinent part:

"(a) 'Prescription' means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either Section 4052.1 or 4052.2.

. . .

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail."

10. Section **4063** states:

"No prescription for any dangerous drug or dangerous device may be refilled except upon 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 **4059** subdivision (a) states:

"A person may not furnish any dangerous drug, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7."

12. Section **4081** provides in pertinent part:

"(a) All 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 manufacturer, wholesaler, pharmacy ... or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

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(b) The owner, officer, and partner of a pharmacy … shall be jointly responsible, with the pharmacist-in-charge or designated representative-in-charge, for maintaining the records and inventory described in this section."

13. Section **4104** provides in pertinent part:

"(a) Every pharmacy shall have in place procedures for taking action to protect the public when a licensed individual employed by or with the pharmacy is discovered or known to be chemically, mentally, or physically impaired to the extent it affects his or her ability to practice the profession or occupation authorized by his or her license, or is discovered or known to have engaged in the theft, diversion, or self-use of dangerous drugs.

(b) Every pharmacy shall have written policies and procedures for addressing chemical, mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among licensed individuals employed by or with the pharmacy."

14. Section **4105** of the Code states:

"(a) All records or other documentation of the acquisition and disposition of dangerous drugs and dangerous devices by any entity licensed by the board shall be retained on the licensed premises in a readily retrievable form.

"(b) The licensee may remove the original records or documentation from the licensed premises on a temporary basis for license-related purposes. However, a duplicate set of those records or other documentation shall be retained on the licensed premises.

"(c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.

"(d) Any records that are maintained electronically shall be maintained so that the pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the case of a veterinary food-animal drug retailer or wholesaler, the designated representative on duty, shall, at all times during which the licensed premises are open for business, be able to produce a hard copy and electronic copy of all records of acquisition or disposition or other drug or dispensing-related records maintained electronically.

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"(e)(1) Notwithstanding subdivisions (a), (b), and (c), the board, may upon written request, grant to a licensee a waiver of the requirements that the records described in subdivisions (a), (b), and (c) be kept on the licensed premises.

(2) A waiver granted pursuant to this subdivision shall not affect the board's authority under this section or any other provision of this chapter."

15. Section **4110** of the Code states at subdivision (a):

"(a) No person shall conduct a pharmacy in the State of California unless he or she has obtained a license from the board. A license shall be required for each pharmacy owned or operated by a specific person. A separate license shall be required for each of the premises of any person operating a pharmacy in more than one location. The license shall be renewed annually. The board may, by regulation, determine the circumstances under which a license may be transferred."

16. Section **4115** provides in pertinent part:

"(a) A pharmacy technician may perform packaging, manipulative, repetitive, or other nondiscretionary tasks only while assisting, and under the direct supervision and control of a pharmacists. The pharmacist shall be responsible for the duties performed under his or her supervision by a technician.

. . .

(f)(1) A pharmacy with only one pharmacist shall have no more than one pharmacy technician performing the tasks specified in subdivision (a). The ratio of pharmacy technicians performing the tasks specified in subdivision (a) to any additional pharmacists shall not exceed 2:1, except that this ratio shall not apply to personnel performing clerical functions pursuant to Section 4116 or 4117."

17. Section **4342** provides at subdivision (a):

The board may institute any action or actions as may be provided by law and that, in its discretion, are necessary to prevent the sale of pharmaceutical preparations and drugs that do not conform to the standard and tests as to quality and strength, provided in the latest edition of the

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united States Pharmacopoeia or the Sherman, Drug and Cosmetic Law (Part 5 (commencing with Section 109875) of Division 104 of the Health and Safety Code).

18. Health and Safety Code section **11153** provides at subsection (a):

"(a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use."

19. Health and Safety Code section **11208** provides:

"In a prosecution under this division, proof that a defendant 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 defendant is a lesser amount than is accounted for by any record required by law is prima facie evidence of guilt."

20. Civil Code section **56.10** requires in pertinent part, that a provider of health case, health care service plan, or contractor shall not disclose medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization.

21. California Code of Regulations, Title 16, section **1718** states:

"Current Inventory" as used in Sections 4081 and 4332 of the Business and Professions Code shall be considered to include complete accountability for all dangerous drugs handled by every licensee enumerated in Sections 4081 and 4332.

The controlled substances inventories required by Title 21, CFR, Section 1304 shall be available for inspection upon request for at least 3 years after the date of the inventory."

22. California Code of Regulations, Title 16, section **1714** provides 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. Possession of a key to the pharmacy where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist."

. . .

23. California Code of Regulations, Title 16, section **1717** provides in pertinent part:

"(b) In addition to the requirements of Business and Professions Code section 4040, the following information shall be maintained for each prescription on file and shall be readily retrievable:

(1) The date dispensed, and the name or initials of the dispensing pharmacist. All prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising pharmacist before they are dispensed.

(2) The brand name of the drug or device; or if a generic drug or device is dispensed, the distributor's name which appears on the commercial package label; and

(3) If a prescription for a drug or device is refilled, a record of each refill, quantity dispensed, if different, and the initials or name of the dispensing pharmacist.

(4) A new prescription must be created if there is a change in the drug, strength, prescriber or directions for use, unless a complete record of all such changes is otherwise maintained.

(c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the prescription to identify him or herself. All orally transmitted prescriptions shall be received and transcribed by a pharmacist prior to compounding, filling, dispensing, or furnishing. Chart orders as defined in section 4019 of the Business and Professions Code are not subject to the provisions of this subsection."

24. 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.

25. California Code of Regulations, Title 16, section 1764 states:

"No pharmacist shall exhibit, discuss, or reveal the contents of any prescription, the therapeutic effect thereof, the nature, extent, or degree of illness suffered by any patient or any medical information furnished by the prescriber with any person other than the patient or his or her authorized representative, the prescriber or other licensed practitioner then caring for the patient, another licensed pharmacist serving the patient, or a person duly authorized by law to receive such information."

26. California Code of Regulations, Title 16, section 1793.7 states in pertinent part:

. . .

"(b) Pharmacy technicians must work under the direct supervision of a pharmacist and in such a relationship that the supervising pharmacist is fully aware of all activities involved in the preparation and dispensing of medications, including the maintenance of appropriate records.

. . .

(e) A pharmacist shall be responsible for all activities of pharmacy technicians to ensure that all such activities are performed completely, safely and without risk of harm to patients"

. . .

COST RECOVERY

27. Business and Professions Code section **125.3** 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.

DRUG DEFINITIONS

28. **Hydrocodone with acetaminophen ("apap"),** trade name Vicodin ES, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business and Professions Code Section 4022.

29. **Acetaminophen with codeine**, trade name **Tylenol #3**, is a Schedule III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business and Professions Code Section 4022.

30. **Promethazine with codeine**, trade name **Phenergan with Codeine**, is a Schedule V controlled substance pursuant to Health and Safety Code Section 11058 and a dangerous drug per Business and Professions Code Section 4022.

FACTS COMMON TO ALL CAUSES FOR DISCIPLINE

31. The following allegations are common to all causes for discipline in this matter:

32. At all times relevant herein, Respondent Robert Rothman was Pharmacist-in-Charge of Respondent Twin Pharmacy, Inc. dba Dabney Pharmacy (Respondent Pharmacy), a retail pharmacy located at 11115 S. Main Street, in the city of Los Angeles.

Background

33. In or prior to April of 2011 a San Diego pharmacist informant led law enforcement authorities to Milton Farmer, who was suspected of smuggling prescription drugs. A search of

Farmer's trashcan at his residence in Oceanside, CA revealed empty prescription bottles from Respondent Pharmacy. Investigators subsequently concluded that Dr. Tyron Reece wrote prescriptions for patients that he did not actually examine and that Anthony "Sam" Wright would have these prescriptions filled at Respondent Pharmacy. Mr. Wright would then transport the prescription medication from Los Angeles to San Diego and deliver them to couriers like Milton Farmer. Mr. Farmer and other couriers would cross the border with the prescription medication strapped to their body and sell the drugs to pharmacies in Mexico.

Board Investigation - 2011

34. On or about April 8, 2011, Board Inspectors reviewed the Controlled Substances Utilization Review and Evaluation System (CURES)[1] data for Respondent Pharmacy. The CURES data revealed that Respondents were 18 months late in filing CURES reporting.

35. On April 11, 2011, Board inspectors were present when a search warrant was served at Respondent Pharmacy, pursuant to investigation of the Anthony "Sam" Wright/Milton Farmer prescription drug smuggling operation by several cooperating law enforcement agencies, including the California Department of Justice, the Federal Bureau of Investigation, and the Drug Enforcement Administration.

36. On April 11, 2011, Board Inspectors interviewed Charles Dabney III, a pharmacy technician who had worked at Respondent Pharmacy for seven (7) years.[2] Dabney stated that "Sam" Wright had been a frequent customer at the pharmacy for 4-5 years, and that he brought in prescriptions written by **Dr. Carlos Estiandan** or **Dr. Tyron Reece**. Dabney additionally stated that during this time, at Sam's request, he routinely compiled special lists with patient

[1] The CURES program started in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances and was since amended in January 2005 to include mandatory weekly reporting of Schedule II-IV controlled substances. The data is sent to a data collection company, who sends the pharmacy confirmation that the data was received and informs the pharmacy if the data was rejected. The data is collected statewide and can be used by health care professionals to evaluate and determine whether their patients are utilizing controlled substances correctly.

[2] In a sworn statement dated April 25, 2011, submitted later to Board Inspectors, Mr. Dabney's position with the pharmacy was described as " Pharmacy Manager/Data Entry Typist/Compliance Officer." Mr. Dabney was licensed by the Board as a pharmacy technician (TCH 9600) from September 20,1993 to July 31, 2013.

prescription data, which he provided to Sam "every 2-3-weeks." Dabney stated that Respondent Rothman knew of and/or saw him creating these lists for Sam.

2011 Audit Shows Massive Quantity of "Missing" Drugs

37. On or about April 11, 2011, Board Inspectors requested that Respondent Rothman inventory the three most frequently dispensed controlled substances at Respondent Pharmacy: Vicodin ES, Tylenol #3 and Phenergan with Codeine. This "stock on hand" data was the basis for an audit of these three controlled substances, completed on or about June 15, 2011. Dates chosen for the audit were August 4, 2009 through April 11, 2011(approximately 20 months).

38. The audit revealed that massive quantities of each drug were "missing" from pharmacy inventory, and could not be located or accounted for. Audit results are summarized as follows:

	hydrocodone /apap (Vicodin ES)	acetaminophen with codeine (Tylenol #3)	promethazine with codeine (Phenergan with Codeine)
Staring Amount	2,800	1,100	10,560
Total Purchased	287,400	226,300	1,944,000
Total Dispensed	271,028	221,724	1,793,255
Amount in inventory (on hand)as of 4/11/11	613	1767	25,920
Total Unaccounted For/Missing	**18,559** tablets	**3,909** tablets	**135,385** ml (about 282 pints)

39. Failure to Produce Policy - On or around November 10, 2011, Board Inspectors requested that Respondents produce a copy of its office policy relating to employee impairment and theft in the workplace.

40. Verbal Orders –Respondent Rothman received a "large number of verbal orders" When asked to produce written records of telephone orders, Respondent failed to produce compliant documentation which requires name of patient, date of request, name, address, telephone number, license number and DEA number of the prescriber, drug name, quantity and directions for use.

41. Prescriptions for Patient SJ - Records of Respondent Pharmacy showed that Patient SJ had medications dispensed pursuant to at least 15 prescriptions purportedly written by Dr. Ayodele on dates between approximately November 27, 2000 and August 7, 2001. Pursuant to Board investigation, Dr. Ayodele reported that SJ was first seen as a patient in his office in May 2009 – and that he (Avodele) had not authorized any prescriptions for SJ prior to May, 2009.

Empty Prescription Bottles in an Oceanside Trashcan

42. Board Inspectors reviewed patient profiles for 40 patients of Respondent Pharmacy whose names were found on empty prescription bottles which had been discarded in the trashcan at the Oceanside residence of known drug smuggler, Milton Farmer (See paragraph 24, above). Analysis of the 40 patient profiles revealed the following:

a. **Dr. Carlos Estiandan** [3] and **Dr. Tyron Reece** wrote a combined **94.2%** of all prescriptions attributed to the 40 patient prescriptions found in the trashcan and identified as having received prescription drugs filled by Respondents Pharmacy and Rothman.

b. Respondents routinely refilled several duplicate prescriptions for the same patient on the same day.

c. Respondents refilled three prescriptions for one patient when there was no authorization from the prescriber.

d. Prescription records show treatment for the same medical conditions (cough, anxiety and pain) with no prescription treatment for any other diagnosis (i.e. blood pressure, diabetes, cholesterol, etc.).

e. Dr. Estiandan wrote prescriptions for 24 of the 40 patients (approximately 66.1% of the prescriptions; 866 total prescriptions).

(1) Of all prescriptions written by Dr. Carlos Estiandan (Dr. Estiandan), 283 prescriptions were for promethazine with codeine and 276 were for hydrocodone/apap.

[3] Dr. Carlos Estiandan, was arrested and found guilty on March 15, 2010 of 13 counts of unlawfully writing controlled substance prescriptions without a legitimate medical purpose and outside the usual scope of practice in *The People of the State of California v. Carlos Estiandan*, Los Angeles County Superior Court Case No. BA34703 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). On or around September 9, 2009, Dr. Estiandan surrendered his license to practice medicine the state of California.

(2) Prescriptions written by Dr. Estiandan were filled on 221 different days, many of which were filled by Respondents on the same day, in bulk.

(3) On or about February 10, 2009, the Medical Board of California, Department of Consumer Affairs filed an Accusation against Dr. Estiandan alleging among other things, repeated acts of negligence, violation of drug laws, prescribing without appropriate examination of medical condition and prescribing to an addict.4 Dr. Estiandan was subsequently arrested and eventually surrendered his license to practice medicine in September, 2009. In Fall, 2009, Dr. Tyron Reece began writing prescriptions for Dr. Estiandan's former "patients."

f. **Dr. Tyron Reece** wrote approximately 369 prescriptions for **38 of the 40** patients during the period between October 2, 2009 – April 11, 2011.

(1) 100% of Dr. Reece's prescriptions were written for either promethazine with codeine, hydrocodone/apap or ahydrocodonelprazolam (Xanax).[5]

43. **Corresponding Responsibility Analysis** - Dr. Estiandan and Dr. Reece wrote a combined **94.2%** of all prescriptions attributed to the 40 patients whose prescriptions were found in the trashcan and identified as having received prescription drugs dispensed by Respondents. Prescriptions of Dr. Estiandan and Dr. Reece for the 40 patients were filled by Respondents *despite key objective factors* indicating the prescriptions were not legitimate, including but not limited to:

1. The patients all had similar diagnosis and saw the same two doctors;

2. The patients received the same drug combinations in the same quantities/amounts irrespective of age;

3. The drugs prescribed are highly abused and have high street value;

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[4] Administrative action was brought in The Matter of the Accusation Against Carlos Estiandan, M.D., Before the Medical Board of California Department of Consumer Affairs State of California, File No. 17-2004-162750, OAH No. 2009020501 (2009). The Court may take judicial notice of this matter pursuant to CA Evid. Code §452(h). Dr. Estiandan surrendered his license to practice medicine in the state of California on or around September 9, 2009.

[5] Dr. Reece surrendered his DEA registration on July 8, 2011 in lieu of disciplinary action.

4. In many instances, the patient did not reside in close proximity to Respondent Pharmacy or to either physician;

5. All patients were prescribed controlled substances for chronic conditions (cough/anxiety/pain) - but were not submitting prescriptions for medications to treat other common health issues (e.g. blood pressure, diabetes);

6. The patients purportedly all had the same medical condition (cough/anxiety/pain) although neither physician specialized in treatment of these conditions (e.g. pulmonologists (chronic bronchitis) or psychiatrist (anxiety));

7. The patients did not drop off their own prescriptions to be filled;

8. All prescriptions were paid for in cash, and not by insurance;

9. Dr. Estiandan was arrested and charged with crimes relating to unlawfully prescribing medication;

10. After Dr. Estiandan was arrested – all of his patients were transferred to Dr. Reece, although the physicians' respective offices are approximately 20 miles apart.

44. When interviewed in April and May of 2012 by Board Inspectors regarding the 40 patient profiles, Respondent Rothman admitted that he did not know anything about the patients and failed to provide any specific information.

45. Respondent Rothman admitted that he defers to the doctor's judgment exclusively in lieu of personally verifying patient prescriptions. Respondent Rothman also admitted that he permits his pharmacy staff to make conclusive determinations regarding the legitimacy of patient prescriptions.

46. Respondent Rothman admitted that he did not use CURES reports or his own professional judgment when filling patient prescriptions.

47. Respondent Rothman admitted that he did not know about or act according to his corresponding responsibility when filling patient prescriptions.

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Analysis of CURES Patient Records (2007-2009)

48. To investigate controlled substance dispensing practices of Respondents, Board Inspectors obtained a CURES report for controlled substances dispensed by Respondent Pharmacy between 2007 and 2009.

a. Refills Without Authorization – In reviewing a sample group of 13 patient profiles, Inspectors found that Respondents had refilled at least *119 prescriptions* on dates between approximately January 2007 and September, 2009, without authorization by a prescribing physician.

Corresponding Responsibility Analysis (2011)

49. In closely analyzing the controlled substance drug treatment and therapy regiment for a sample group of six (6) patients, using CURES data, Board Inspectors found that Respondents routinely filled prescriptions despite key objective factors indicating the prescriptions were not legitimate, or circumstances that should have caused Respondents to question and investigate the prescription's legitimacy:

a. **PATIENT #41 ZA**[6]

DRUG	AMOUNT	DATE OF FILL
hydrocodone/apap ES	60	3/13/09
hydrocodone/apap ES	60	4/6/09
hydrocodone/apap ES	60	4/23/09
hydrocodone/apap ES	60	5/8/09
hydrocodone/apap ES	60	6/3/09
hydrocodone/apap ES	60	6/22/09
hydrocodone/apap ES	100	12/10/10
hydrocodone/apap ES	100	1/10/11

[6] Patient initials are used to protect confidentiality throughout the Accusation.

hydrocodone/apap ES	100	2/10/11
hydrocodone/apap ES	100	3/14/11

Summary of Findings: Patient received a quantity of 60 hydrocodone/apap within quick succession during the time period between 4/6/09 and 5/8/09 for a total of 180 tablets in just over 30 days.

PATIENT #43 EA

DATE	DRUG	PRESCRIBING PHYSICIAN
4/2005	Tylenol #3	Habbestad[7]
6/2005	promethazine/codeine	Reece
7/2005	Tylenol #3	Habbestad
7/2005	promethazine/codeine	Apusen
7/2005	Vicodin ES	Ayodele
8/2005	Vicodin ES	Apusen
8/2005	Vicodin ES	Ayodele
9/2005	Vicodin ES	Apusen
9/2005	promethazine/codeine	Rojas
10/2005	promethazine/codeine	Habbestad
10/2005	Vicodin ES	Ayodele
11/2005	promethazine/codeine	Rojas
11/2005	Vicodin ES	Rojas
12/2005	promethazine/codeine	Rojas

[7] On or around October 10, 2008, Robert Habbestad received a Public Reprimand for failing to maintain adequate and accurate medical records and failing to record information relating to patient examinations in The Matter of the Accusation Against Robert Habbestad, M.D., OAH No. L2006120274.

12/2005	Vicodin ES	Rojas
1/2006	Vicodin ES	Christian
3/2006	Vicodin ES	Apusen
3/2006	promethazine/codeine	Rojas
4/2006	Vicodin ES	Ware
6/2006	promethazine/codeine	Estiandan
8/2006	Vicodin ES	Rojas
8/2006	promethazine/codeine	Rojas
8/2006	Vicodin ES	Estiandan
10/2007	Vicodin ES	Chickey[8]
10/2007	promethazine/codeine	Chickey
1/2008	Vicodin ES	Chickey
3/2008	Vicodin ES	Chickey
3/2008	promethazine/codeine	Chickey
5/2008	Vicodin ES	Ware
5/2008	promethazine/codeine	Chickey
6/2008	promethazine/codeine	Chickey
8/2008	promethazine/codeine	Reece
8/2008	Vicodin ES	Reece
9/2008	promethazine/codeine	Reece
9/2008	Vicodin ES	Habbestad
9/2008	Vicodin ES	Ayodele

[8] Anna Lourdes Armada Chickey, M.D. DEA Registration is currently under investigation by DEA, Los Angeles Region.

10/2008	promethazine/codeine	Reece
10/2008	Vicodin ES	Reece
11/2008	Vicodin ES	Reece
1/2009	promethazine/codeine	Chickey
1/2009	Vicodin ES	Chickey
2/2009	promethazine/codeine	Chickey
7/2009	Vicodin ES	Chickey
7/2009	promethazine/codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	promethazine/codeine	Chickey
9/2009	Vicodin ES	Chickey
9/2009	promethazine/codeine	Chickey
11/2009	promethazine/codeine	Reece
11/2009	Vicodin ES	Chickey

Summary of Findings: Patient doctor shopped by using several different prescribers to obtain the same medications. In 2005, the patient used 6 different doctors to obtain Vicodin ES and promethazine/codeine. In 2006, the patient used 4 different doctors to obtain Vicodin ES and promethazine/codeine. In 2008, the patient used 5 different doctors to obtain Vicodin ES and promethazine/codeine. Respondents failed to document why the patient was seeing multiple prescribers for the same drugs.

c. **PATIENT #44 JB**

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/2008	Tylenol #3	Habbestad

3/2008	Tylenol #3	Habbestad
5/2008	Tylenol #3	Habbestad
5/2008	Vicodin ES	Ayodele
7/2008	Tylenol #3	Habbestad
8/2008	Vicodin ES	Ayodele
9/2008	Tylenol #3	Ayodele
11/2008	Tylenol #3	Mays[9]
12/2008	Tylenol #3	Habbestad

Summary of Findings :Patient received both Vicodin ES and Tylenol #3, both for pain. There is no documentation showing that the pharmacist consulted with the prescribing physicians to determine if both medications were appropriate or correctly prescribed for pain. In addition, the patient used multiple prescribers to receive the same medications in the same month.

d. **PATIENT #46 YD**

Summary of Findings: During the time period between December 2004 and 2012, approximately 123 of a total of 151 prescriptions written for the patient were for controlled substances. The patient received promethazine/codeine, Vicodin ES, Soma, Xanax, Tylenol #3, Valium, ampicillin, Keflex, ibuprofen, Pepcid and methocarbamol. In 2009 and 2010, the patient received controlled substances prescriptions from Drs. Estiandan, Al-Bussam, and Chickey – all of whom have had actions taken against their medical licenses or are currently under investigation. Respondents Pharmacy and Rothman failed to inquire about why the patient has had a cough and pain for 8 years and why so many different doctors were sought for these prescriptions.

e. **PATIENT #50 YG**

Summary of Findings: On or around April 13, 2009, Respondents Pharmacy and

[9] On or around July 23, 2006, James Arthur Mays received a Public Reprimand for failing to maintain adequate and accurate medical records and in The Matter of the Public Letter of Reprimand Issued to James Arthur Mays, M.D., Case No. 06-2003-147182.

Rothman filled a prescription for 240ml of promethazine/codeine for this patient. On or around April 20, 2009, Respondents Pharmacy and Rothman filled a second prescription for 240ml of promethazine/codeine for his patient. The patient would not have been able to complete one prescription within seven days. There is no documentation indicating that Respondents contacted the prescribing physician or the patient regarding the patient's usage of the medication.

f. **PATIENT #53 TH**

A review of the patient's CURES records revealed the following:

DATE	DRUG	PRESCRIBING PHYSICIAN
1/8/07	promethazine/codeine	Fishman
1/17/07	promethazine/codeine	Ayodele
3/8/07	promethazine/codeine	Lin

Summary of Findings: Within two months, the patient received 3 prescriptions for promethazine/codeine from 3 different prescribing physicians, the second arriving merely 9 days after the first. The maximum recommended dose is 30ml/day. There is no documentation that Respondents Pharmacy and Rothman contacted the prescribing physicians regarding deviation from the recommended dosage or contacted the patient regarding use of the medication.

Board Inspection – December 2013

50. **Board Inspection** - On or about December 23, 2013, a Board Inspector visited Respondent Pharmacy to investigate allegations made in an anonymous complaint. While at the pharmacy, the Inspector noticed outdated prescription medicines and diabetic supplies on pharmacy shelves, a violation of Business and Professions Code section 4342. Respondents were given notice of the violation and ordered to remove and inventory outdated product – and provide a disposal receipt to the Inspector, within thirty (30) days.

Board Inspection – January 2014

51. **Board Inspection**-On or about January 22, 2014, a Board Inspector returned to Respondent Pharmacy to conduct a follow-up inspection. He observed that Respondent was the

only pharmacist present in the pharmacy – along with four pharmacy technicians. During that inspection, the Inspector noted the following :

a. In random checks of pharmacy shelves, the Inspector found outdated medicines, which he then quarantined.

b. He also observed dust and dirt on pharmacy shelves.

c. Although only one pharmacist was present, one technician (LL) was labeling diabetic supplies while - simultaneously - a second technician (RY) was filling prescriptions.

d. The Inspector observed that there was a locked storage area of the facility – and was told that confidential patient prescription records were stored in that area. A key to the locked area was stored in a drawer in the pharmacy.

52. At the conclusion of the inspection, Respondents were issued an Inspection Report citing multiple violations of pharmacy law, and ordered to correct violations, including removal of outdated drugs from pharmacy shelves. Pursuant to this order, Respondents removed hundreds of different types of expired medications from their shelves - with expiration dates as far back as June 30, 2011.

Board Inspection – February 2016

53. During a Board inspection on November 10, 2015, Inspectors identified two separate areas of pharmacy operations at Respondent's pharmacy premises. The front section of the pharmacy was open to the public as a retail business for prescriptions, and a back section of the pharmacy was dedicated to the processing, packaging and shipping of diabetic testing supplies to long term care facilities.

54. A significant portion of Respondent Pharmacy's business is derived from providing "Assure" brand blood glucose testing machines and supplies needed to use the machines (diabetic strips and lancets) to diabetic inpatients of state licensed skilled nursing facilities, many of whom are insured by the state's Medi-CAL program.

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55. **Medi-CAL Reimbursement Guidelines** - At all times relevant herein, published Medi-CAL program requirement guidelines for reimbursement of the cost of medical supplies for inpatient residents of a nursing facility included the following:

a. "Program coverage"

...

"Medical supplies provided to inpatients receiving Nursing Facility (services), whether or not rendered in a hospital setting, are reimbursable only for the medical supplies listed below and only when required by a specific patient **for that patient's exclusive use.**

- **Diabetic test strips and lancets**

..."

b. "Medi-CAL Covered Services"

" Medi-CAL covers some medical supplies. When Medi-CAL covers an item and the recipient is eligible for Medicare, providers bill Medicare before billing Medi-CAL.

The products and product categories listed below must be billed to Medicare before being billed to Medi-CAL:

- **Diabetic testing supplies (lancets, test strips and reagent tablets)**

..."

c. "Authorization"

An **approved Treatment Authorization request (TAR)** is required for claims using certain supplies billing codes.

...

d. "Code I"

Code I items marked with a single asterisk (*) require authorization in accordance with CCR, Title 22, Section 51003[10] , unless used under the clinical conditions

[10] California Code of Regulations, title 22 §51003 describes the process for obtaining authorization for treatment in the Medi-CAL program; §51476 sets out record-keeping requirements for Medi-CAL service providers, with sub-section "c" requiring that records of service providers "shall document the meeting of Code I restrictions for medical supplies."

individually specified by the Code I message. Code I item are subject to the prescription documentation requirements of Title 22, Section 51476(c).

e. "Quantity Limitations"

The quantity limitations for medical supply products are in the List of Medical Supplies: Billing Codes, Units and Quantity Limits spreadsheet. **TARs are required for claims billing for quantities in excess of the quantity limitations.**

f. "Diabetic Lancets and Test Strips"

(1) Lancets and blood glucose test strips are Code I items, restricted to recipients being treated by a physician for a diabetes diagnosis documented in their medical records. As a Code I requirement, **when billing for lancets and blood glucose tests strips, the following must be documented on the physician's order:**

- A description of item prescribed
- The specific frequency of testing ("as needed" or "PRN" are not acceptable)
- For a recipient currently being treated with insulin injections, document the recipient is an insulin user.

(2) When billing for blood glucose test strips or lancets, claim quantities are limited as follows:

- For a diabetic recipient who is currently being treated with insulin injections, no more than 150 blood glucose test strips and no more than 200 lancets are allowed per claim, with no more than three (3) claims in a 90-day period
- For a diabetic recipient who is not currently being treated with insulin injections, no more than 100 blood glucose test strips and no more than 100 lancets in a 90-day period
- For a gestational diabetic recipient being treated with or without insulin injections, no more than 150 blood glucose test strips and no more than 200 lancets are allowed per claim, with no more than three (3) claims in a 90-day period

(3) A **TAR documenting the following is required** if the recipient requires a quantity of blood glucose test strips or lancets that **exceeds the quantity limits**:

- The recipient has nearly exhausted the supply of test strips and lancets
- A **specific narrative statement**, as documented in the recipient's medical record, which supports the need for testing frequency that exceeds the billing limitations
- The recipient was seen and evaluated by the treating physician for diabetes control **within six months** prior to ordering quantities that exceed the quantity limits.

(emphasis added)

57. Board Inspectors requested prescription orders for diabetic testing supplies for 24 inpatient residents of French Park Care Center (FPCC) a long term care facility located in Santa Ana, CA, and related pharmacy purchase records for the supplies on dates 11/10/12 through 11/09/15.

58. The FPCC prescription records were subsequently received from Respondents. On review, Inspectors noted that the test strips prescriptions included the **frequency of testing** based on the physician order instructions - but that the lancet prescription records all showed "UUD" (use as directed) as the "sig code"[11] and that the day supplies for the quantity dispensed didn't appear to match. This was difficult to decipher because the day supply information was cut off on the copies of the fill record tags provided for review.

59. Documents initially provided by Respondent's employees as evidence of purchase records showed both Respondent and a different company - **Ramat Medical Supplies** listed on records related to the test strips on lancets.

60. Owners of Respondent Pharmacy also own Ramat Medical Supplies, aka JI Medical (Ramat) , a permitted Home Medical Devise Retailer[12], with offices in Los Angeles, CA.

[11] The term "sig code" refers to abbreviations commonly used in pharmacy practice.
[12] Home Medical Devise Retailer permits are issued by the California Department of Public Health.

At the time of the subject inspection, Respondent Pharmacy officer Denise Wilson-Ruane was the "chief operating officer" of Ramat, and Respondent Pharmacy's book-keeper Alan Smith was also "controller" for Ramat.

Billing For Diabetic Medical Supplies

61. Respondent employees explained Respondents' "work flow" and routine practices for processing diabetic supplies prescriptions to Board Inspectors as follows:

a. "Assure" brand blood glucose testing machines are provided to the patients at no cost. However, the pharmacy bills for test strips and lancets used in the machines.

b. Respondent Pharmacy receives monthly physician chart orders from various facilities they service for diabetic testing supplies. A pharmacy technician enters the monthly orders, check insurance eligibility for the patient, requests authorizations for those requiring it and then generates a prescription label once approved.

c. Typed labels and chart orders are then provided to a second pharmacy technician, who fills/labels the orders, has the pharmacist check them, then packages them for shipping to the ordering facility.

62. In inquiring about the "work flow" for processing diabetic supplies prescriptions at Respondent Pharmacy, including billing and shipping of dispensed products - Board Inspectors discovered that employees of Respondent Pharmacy routinely performed some of the work of preparing prescription orders off site - including verifying patient eligibility and preparing "packing slips." These tasks were performed at **Ramat Medical Supplies,** an unlicensed facility. During a Board Inspection of Ramat on or about February 19, 2016, two pharmacy technicians employed by Respondent Pharmacy were observed preparing prescription orders without requisite supervision of a pharmacist - using paper and electronic records pertaining to personal health and billing information of patients, which was maintained and retained at Ramat.

Audit of Medi-CAL Billings (2/1/15 To 11/10/15)

63. Diabetic supplies dispensing records for 2015 were reviewed. From 2/1/2015 through 11/10/2015, Medi-CAL prescriptions accounted for over 40% of Respondent's prescription transactions:

Billings by Respondents from 2/1/2015-11/10/15 for diabetic testing supplies	Total Number of Prescriptions	Quantity of Testing Supplies Dispensed	Percentage of Total Number of Prescriptions
"Assure" lancets/low flow	**25,792**	**2,702,200**	**49.79%**
"Assure" lancets/low flow billed to CA Medi-CAL	10,607	1,172,750	20.48%
"Assure" platinum test strips	**25,008**	**2,638,450**	**48.28%**
"Assure" platinum test strips billed to CA Medi-CAL	10,538	1,165,550	20.34%
Total of all **CA Medi-CAL** testing supplies (lancets + strips) transaction billings	**21,210**	**2,344,400**	**40.95%**
Total of all testing supplies (lancets + strips) transaction billings	51,802	5,420,300	**100.00%**

64. Of the 10,607 "Assure Lance Lancets Low Flow" prescriptions submitted for payment to Medi-CAL during the audit period, nearly all of them (a total of 10,360 prescriptions) had the directions for use as : "UUD or UD. "

65. In auditing these prescriptions records, the Inspector saw a discrepancy between the directions for use indicated by the sig codes and the day supply for many prescriptions. Further evaluation showed the pharmacy was submitting incorrect day supplies for the prescriptions, resulting in excessive furnishing and billing for the diabetic testing supplies as detailed below.

Medi-CAL Billing Practices - Excessive Furnishing and Billing

66. Board inspectors reviewed prescriptions dispensed for quantities of 50, 100, and 150 with a corresponding day supply of 30 days.

a. A total of **3,519** prescriptions were processed with a dispensed quantity of 50 test strips (1,755 prescriptions) and 50 lancets (1,764 prescriptions), but billed to Medi-CAL as a 30 day supply. The 1,755 prescriptions for test strips were in actuality a 50 day supply, according to the sig codes provided in the dispensing history – billed incorrectly to Medi-CAL as a 30 day supply, according to the sig code supplied for the testing strips with a testing frequency of less than once daily. Some were refilled 30 days

later. Only 42 of the 1,764 lancet prescription records included directions other than "UD" for the lancets[13] and were still incorrectly billed with a 30 day supply.

b. A total of **3,995** prescriptions were processed with a dispensed quantity of 100 test strips (1,976 prescriptions) and lancets (2,019 prescriptions) and billed to Medi-CAL as a 30 day supply. These prescriptions were actually a 50 day supply according to the sig code supplied for the test strips with a testing frequency of **twice daily** and billed as a 30 day supply. Only 48 prescriptions records included directions *other than* "UD" for the lancets and they were still incorrectly processed with a 30 day supply.

c. A total of **9,013** prescriptions were processed with a dispensed quantity of 150 test strips (4,496 prescriptions) and lancets (4,518 prescriptions) and billed to Medi-CAL as a 30 day supply. These prescriptions were actually a 37 day supply according to the sig code supplied for the test strips with a testing frequency of **four times daily** and billed as a 30 day supply Only 112 prescriptions records included directions *other than* "UD" for the lancets and they were still incorrectly processed with a 30 day supply.

d. During the timeframe of 2/1/15 to 11/10/15, a total of 21,210 (40.9%) of the 51,802 prescriptions were billed specifically to Medi-CAL. These prescriptions were billed incorrectly to Medi-CAL as a 30 day supply and some were refilled 30 days later resulting in excessive billing and furnishing of these diabetic test strips and corresponding lancet prescriptions.

67. Close to half of the prescriptions submitted by Respondents were for Medi-CAL patients, but Respondent also prepared and submitted incorrect billings to other insurers, including the state funded "Cal Optima Cal Wrap" program.

FPCC Patient Audit

68. 24 patient profiles were obtained for diabetic inpatients of French Park Care Center (FPCC), and Board Inspectors reviewed 48 prescriptions billed by Respondents for these

[13] A generalized 'use as directed' instruction does not comply with Medi-CAL reimbursement requirements, which requires that a specific frequency of testing/use be identified.

twenty four patients. Of the 48 prescriptions, **22 prescriptions** were incorrectly billed as a 30 day supply, as determined by frequency of use in the patient's chart, as summarized below:

Prescriptions processed with incorrect day supplies determined by frequency of use in the patient's chart							
	Prescription number	Drug Name/Form	Disp Qty.	SIG Codes	Day Supply **Billed**	Day Supply **Actual**	TP Name
1.	4202263	Assure Test Strips	50	UD @ 6.30	30	50	Health Net
2.	4202264	Assure Lancets	50	UD Q 6.30 AM	30	50	Health Net
3.	4202438	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
4.	4202439	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
5.	4203957	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
6.	4203958	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
7.	4208411	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
8.	4208412	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
9.	4211309	Assure Test Strips	50	UD QAM ISS	30	50	Cal Optima CalWrap
10.	4211311	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
11.	4211318	Assure Test Strips	100	UD BID ISS	30	50	Cal Optima CalWrap
12.	4211319	Assure Lancets	100	UUD	30	50	Cal Optima CalWrap
13.	4211320	Assure Test Strips	100	UD BID ISS	30	50	Cal Optima CalWrap
14.	4211321	Assure Lancets	100	UUD	30	50	Cal Optima CalWrap
15.	4211324	Assure Test Strips	100	UD BID look at chart	30	50	LA PHP Medi-CAL
16.	4211325	Assure Lancets	100	UUD	30	50	LA PHP Medi-CAL
17.	4212988	Assure Test Strips	50	UD QAM	30	50	CA Medi-CAL
18.	4212989	Assure Lancets	50	UUD	30	50	CA Medi-CAL
19.	4212994	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
20.	4212995	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
21.	4217225	Assure Test Strips	100	UD BID AC ISS	30	50	Cal Optima CalWrap
22.	4217226	Assure Lancets	100	UUD	30	50	Cal Optimal CalWrap

FIRST CAUSE FOR DISCIPLINE

(Failure to Assume Corresponding Responsibility to Assure Legitimacy of Prescriptions)

69. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with Health and Safety Code section 11153, subdivision (a) and Title 16 California Code of Regulations section 1761, in that, approximately between January 2007 and April 11, 2011, they failed to comply with their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose as follows:

a. Respondents furnished (and/or continued to furnish) prescriptions for controlled substances written by Dr. Carlos Estiandan and/or Dr. Tyron Reece to 40 patients despite key objective factors indicating prescriptions were not issued for a legitimate medical purpose.

b. Respondents furnished (and/or continued to furnish) prescriptions for controlled substances to patients #41 ZA, #43 EA, #44 JB,# 46 YD, #50 YG and #53 TH, despite key objective factors indicating prescriptions were not issued for a legitimate medical purpose.

SECOND CAUSE FOR DISCIPLINE

(Failure of Pharmacist to Exercise or Implement Best Professional Judgment or Corresponding Responsibility when Dispensing Controlled Substances)

70. Respondent Rothman *only* is subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with section 4306.5(a) and (b), in that he failed to exercise or implement his best professional judgment and/or corresponding responsibility when dispensing controlled substances.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Operational Standards and Security)

71. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with Title 16, California Code of Regulations section 1714 subdivision (b) and/or (d) and Health and Safety Code section 11208, in that pursuant to Board audit, between

approximately August 4, 2009 and April 11, 2011, Respondents failed to maintain pharmacy security or provide effective controls against theft or diversion, resulting in substantial inventory losses, and no ability to account for the whereabouts or disposition of missing drug stock as follows:

a. hydrocodone/apap - 18,559 tablets missing/unaccounted for
b. acetaminophen with codeine - 3,909 tablets missing/unaccounted for
c. promethazine with codeine – 135,385 ml (282 pints) missing/unaccounted for

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Records of Acquisition and Disposition)

72. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4081, subdivisions (a) and (b) and Health and Safety Code section 11208, in that, per Board audit for dates between August 4, 2009 and April 11, 2011, Respondents had substantial inventory losses, with no records to account for the whereabouts or disposition of the missing drug stock as follows:

a. hydrocodone/apap - 18,559 tablets missing/unaccounted for
b. acetaminophen with codeine - 3,909 tablets missing/unaccounted for
c. promethazine with codeine – 135,385 ml (282 pints) missing/unaccounted for

FIFTH CAUSE FOR DISCIPLINE

(Failure to Timely Submit CURES Data)

73. Respondents Twin Pharmacy and Rothman are subject to subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with Health and Safety Code section 11165, in that during the 18 month period between October 2009 and April 2011, Respondents failed to comply with state law requirements for submission of CURES data on a weekly basis.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Comply with Prescription Refill Requirements)

74. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in

conjunction with section 4063, in that in 119 instances between approximately January 2007 and September 2009, Respondents refilled prescriptions without requisite authorization of the prescriber.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Establish Policies and Procedures Regarding Employee Misconduct)

75. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4104, in that on or about November, 2011, Board Inspectors determined that Respondents had failed to comply with state law requirements to establish written policies and procedures addressing chemical, mental or physical impairment or diversion by licensed individuals employed by the pharmacy.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Comply with Requirements for Documenting Oral Prescriptions)

76. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4040, and California Code of Regulations, title 16, section 1717 (which requires that an orally transmitted prescription must be reduced to a writing initialed by a pharmacist, and that all prescriptions must document specified information) in that in or about April, 2011, Board Inspectors discovered that Respondents routinely filled oral prescriptions without compliant documentation.

NINTH CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs without a Prescription)

77. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with 4059, in that Respondents furnished controlled substances dangerous drugs to patient SJ pursuant to prescriptions purportedly issued by a Dr. A. In fact, SJ was not a patient of Dr. A prior to May 2009 – so that any prescriptions in his name prior to that date were unauthorized.

TENTH CAUSE FOR DISCIPLINE

(Drugs Lacking Quality of Strength – January 2014)

78. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with 4342, subdivision (a) in that during and following a Board Inspection on or about January 22, 2014, hundreds of different types of medication on the shelves of Respondent Pharmacy were identified as past the expiration date (thus failing to conform to the standard and tests as to quality and strength).

ELEVENTH CAUSE FOR DISCIPLINE

(Failure to Adequately Supervise Technicians – January 2014)

79. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with 4115, subdivisions (a) and (f), in that Respondents failed to provide adequate supervision to Pharmacy Technicians in the following instances:

a. **Board Inspection – January 2014**

During a Board Inspection on or about January 22, 2014, two pharmacy technicians were observed filling prescriptions, although only one pharmacist (Respondent Rothman) was present and working in Respondent Pharmacy.

b. **Board Inspection – February 2016**

During a Board Inspection on or about February 19, 2016, two pharmacy technicians employed by Respondent Pharmacy were observed to be engaged in the practice of pharmacy at an unlicensed location where they reviewed and retained personal health information and billing information of patients without the supervision of a pharmacist.

TWELFTH CAUSE FOR DISCIPLINE

(Misuse of Pharmacist Education - 2015)

80. Respondent Rothman *only* is subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with section 4306.5(a) ,in that on dates approximately February 1, 2015 to November 10, 2015, he

failed to exercise his education, training and experience as pharmacist , resulting in his verification of thousands of prescriptions for diabetic testing supplies, which were then transmitted to Medi-CAL for payment, and were later discovered to have an incorrect or excessive amount of supplies per patient, and/or incorrect or too early refill dates - resulting in incorrect and excessive billings to Medi-CAL.

THIRTEENTH CAUSE FOR DISCIPLINE

(Acts Involving Dishonesty, Fraud, or Deceit – 2015)

81. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4301, subdivision (f), in that on dates approximately February 1, 2015 to November 10, 2015, Respondents committed acts involving dishonesty, fraud, or deceit with the intent to substantially benefit themselves. Specifically, during a November 2015 inspection of Respondent Pharmacy, a Board Inspector identified 22 prescriptions for diabetic testing supplies transmitted to Medi-CAL with an incorrect 30 day supply when the pharmacy was actually dispensing a 50 day supply, resulting in excessive billing and excessive furnishing of these testing supplies. Furthermore, a review of the pharmacy's dispensing history from February 1, 2015 to November 10, 2015 showed thousands of prescriptions were billed to Medi-CAL and other insurers with incorrect day supplies for test strips and lancets.

FOURTEENTH CAUSE FOR DISCIPLINE

(Knowing Misrepresentation in Document - 2015)

82. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4301, subdivision (g), in that on dates approximately February 1, 2015 to November 10, 2015, Respondents knowingly made or signed a certificate or other document that falsely represents the existence or non-existence of a state of facts. Specifically, during a November 2015 inspection of Respondent Pharmacy, a Board Inspector identified 22 prescriptions for diabetic testing supplies transmitted to Medi-CAL and other insurers with an incorrect 30 day supply when the pharmacy was actually dispensing a 50 day supply, resulting in excessive billing and excessive furnishing of these testing supplies. Furthermore, a review of the pharmacy's

dispensing history from February 1, 2015 to November 10, 2015 showed thousands of prescriptions were billed with incorrect day supplies for test strips and lancets.

FIFTEENTH CAUSE FOR DISCIPLINE

(Unlicensed Pharmacy Activity- February 2016)

83. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4110, subdivision (a) and (b) in that, on or about February 19, 2016, during a Board inspection of Ramat Medical Supplies, an unlicensed location, two pharmacy technicians employed by Respondent Pharmacy were found engaged in the practice of pharmacy at that location and without requisite supervision of a pharmacist.

SIXTEENTH CAUSE FOR DISCIPLINE

(Retention of Pharmacy Records at Unlicensed Facility – February 2016)

84. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in conjunction with section 4105, subdivision (a) in that, on or about February 19, 2016, during a Board inspection of Ramat Medical Supplies, an unlicensed location, two pharmacy technicians employed by Respondent Pharmacy were found engaged in the practice of pharmacy at that location ,where they reviewed and retained paper and electronic records pertaining to personal health and billing information of patients without requisite supervision of a pharmacist.

DISCIPLINARY CONSIDERATIONS

85. To determine the degree of discipline, if any, to be imposed on Respondents in this matter, Complainant alleges as follows:

Prior Discipline - Respondent Rothman

a. On or about January 31, 1987, in a prior disciplinary action entitled *In the Matter of the Accusation Against Robert Rothman* before the Board of Pharmacy, Case Number 1217 Respondent's license was revoked and revocation was stayed and Respondent Rothman was placed on three (3) years probation with terms and conditions. In

addition, Respondent's Pharmacist License Number RPH 30759 was suspended for ninety (90) days.

b. Charges in that matter stemmed from Respondent's conviction on or about November 28, 1983, on his guilty plea, of violating Business and Professions Code section 4227 [furnishing or dispensing drugs without a prescription] and Penal Code sections 664/496 [attempted receipt of stolen property] in the matter *The People of the State of California v. Robert Bruce Rothman et al.*, Orange County Superior Court, Case No. C-1554 (1983).

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 46745, issued to Respondent Twin Pharmacy, Inc. dba Dabney Pharmacy; Shlomo Rechnitz, and Denise Wilson-Ruane;

2. Revoking or suspending Pharmacist License Number RPH 30759, issued to Respondent Robert Rothman;

3. Ordering Respondents Dabney Pharmacy and Robert Rothman 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: May 16, 2016

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

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