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

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| In the Matter of the Accusation and First Amended Accusation Against:<br><br>**THE MEDICINE SHOPPE, SANJIV BHALLA, OWNER, PHARMACY;**<br>**Pharmacy Permit No. PHY 49809**<br><br>and<br><br>**SANJIV BHALLA,**<br>**Pharmacist License No. RPH 46064**<br><br>Respondents. | Case No. 5251<br><br>OAH No. 2016031074 |

## DECISION AND ORDER

The attached Proposed Decision of the Administrative Law Judge 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 February 21, 2018.

It is so ORDERED on January 22, 2018.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Amy Gutierrez, Pharm.D.
Board President

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**PROPOSED DECISION**

Joseph D. Montoya, Administrative Law Judge (ALJ) conducted the hearing in this matter on February 13, 2017, April 3 through 5, 2017, telephonically on May 19, 2017, with additional telephonic hearing on October 13, 2017.

Complainant Virginia Herold, Executive Officer of the Board of Pharmacy (Board), was represented by Antonio Lopez, Jr., Deputy Attorney General. Respondents The Medicine Shoppe, and its owner and pharmacist-in-charge (PIC), Sanjiv Bhalla, were represented by Armond Marcarian.

The record was held open after testimony concluded on April 5, 2017, so that the parties could obtain transcripts, and prepare written closing arguments. The time to file closing argument was twice extended at Complainant's request, to September 8, 2017. Each party submitted a post hearing brief. Complainant's brief is identified as exhibit 6, and Respondents as exhibit M.[1] The transcripts will be identified as exhibits 8 (April 3), 9 (April 4), and exhibit 10 (April 5, 2017.)

[1] Respondent's written request to take official notice of the minutes of Board meetings was identified as exhibit I. It his hereby re-designated as exhibit L for identification.

Thereafter, the record was reopened by the ALJ, and a telephonic proceeding held October 13, 2017. The ALJ requested letter briefs regarding when the CURES system allowed for on-line usage, and he asked Respondents' counsel to provide copies of Respondent's exhibits, which had been lost. Each party submitted a letter brief on October 20, 2017, and Respondents' counsel submitted copies of the missing exhibits. Complainant's is identified as exhibit 7, and Respondents' brief is identified as exhibit N.

The record was again closed on October 20, 2017.

Because the record contains a substantial amount of private medical information, primarily prescription records, a separate protective order will issue, placing those documents under seal.

The ALJ hereby makes his factual findings, legal conclusions, and orders.

## SUMMARY OF THE CASE

In the main, Complainant alleges that in the period January 1, 2011 to December 5, 2012,[2] while Respondent Bhalla owned and was operating The Medicine Shoppe pharmacy in Santa Barbara, Respondents filled prescriptions for controlled substances of the type subject to abuse, for 21 patients of a physician who was later arrested and charged for excessively prescribing those drugs. The doctor in question was Julio Diaz, M.D. (Diaz). Complainant alleges that Respondents failed to fulfill their corresponding responsibility when they continued to fill the prescriptions for controlled substances, because there were indications—"red flags"—that the prescriptions were excessive or otherwise improper. Complainant asserts that Bhalla should have inquired further into the prescriptions, and that he should have utilized the California Controlled Substances Utilization Review and Evaluation System, known as CURES, to discover the excessive prescribing, and the excessive use of controlled substances by the patients. He is also alleged to have failed to maintain some prescription records, and to have filled erroneous or uncertain prescriptions.

Respondent Bhalla adduced evidence that he had inquired into the diagnoses given to the patients, and had interviewed the prescribing physician regarding his practice. Respondents were able to discredit some of the allegations made against them. Respondents also argue that, until after the relevant time period, the Board did not provide adequate guidance regarding the ways that pharmacists should watch for signs of overprescribing and other improper prescribing practices.

Complainant has sustained her case that Respondents had reason to inquire further into the prescriptions, and that they failed to discharge their corresponding responsibility. She also proved that Respondents did not retain all of their records, and filled a few erroneous or uncertain prescriptions, though the number is not large.

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[2] This will sometimes be referred to as "the subject time period."

## FACTUAL FINDINGS

*The Parties and Jurisdiction*

1. Complainant filed the Accusation and First Amended Accusation, and maintained this proceeding, while acting in her official capacity.

2. From February 17, 2009, through February 14, 2014, The Medicine Shoppe, Sanjiv Bhalla, owner, was licensed as a pharmacy by the Board, holding license number PHY 49809. The pharmacy will sometimes be referred to by its full name, or as "respondent pharmacy." The respondent pharmacy went out of business in 2013. The license is expired, but the Board retains jurisdiction to proceed against it.

3. On March 15, 1993, the Board issued Pharmacist License number RPH 46046 to Respondent Sanjiv Bhalla (Bhalla). The license was set to expire on March 31, 2017, unless renewed.

4. After the Accusation was served, Respondents filed a Notice of Defense, contesting the allegations, and demanding a hearing. After the First Amended Accusation (FAA) was served, the allegations therein were deemed denied by operation of law.

5. Jurisdiction was established to proceed in this matter.

*Indicia of a Potentially Improper Prescription—Red Flags*

6. Complainant, through the investigation report and testimony of Board Inspector Sajal Desai, asserted that a pharmacist, when filling prescriptions for controlled substances, must look for and spot indicia that a prescription may not be for a legitimate purpose. These indicia are often referred to as "red flags." Complainant asserts that in the cases of the subject patients, there were many red flags, that Bhalla did not heed them, and that if he had, and had used the CURES system to obtain more information, he would have seen that the prescriptions were not for a legitimate purpose.

7. There are a number of red flags that may appear in a dispensing transaction or transactions which indicate an improper attempt to prescribe or obtain controlled substances. A well-known example is where the patient is filling the prescription many miles from his or her home, and where they live outside the usual radius of the pharmacy's customer base. Likewise, the prescribing doctor may practice well away from the area where the pharmacy is located. The demeanor of the patient might indicate a problem. Handwriting on the prescription may hint at forgery, the writing being either too neat, or too illegible, and not using the sort of abbreviations and acronyms common in the medical and prescribing arena. The prescription should be on proper (security) paper. Early refills, or excuses for them, may be a red flag. Further, high doses of a given medication might be a tip-off that the patient is abusing the drug, sometimes with the assistance of the prescribing physician. Paying cash, especially where insurance might be available, is a potential tip-off, when the payment is for

controlled substances. A patient's medical profile can indicate a problem and so should be reviewed. The pharmacy's records may indicate that a substantial number of prescriptions for controlled substances are coming from the same doctor or doctors, which can be a sign of impropriety. Where prescriptions are being dropped off or picked up by people other than the patient, this may be a sign of impropriety. Ms. Desai testified that in this case the combinations of drugs being prescribed, and the large doses often being prescribed, should have alerted Bhalla and the respondent pharmacy that something was amiss.

8. Plainly, not every "red flag" has to mean that the patient in question is attempting to obtain controlled substances improperly. For example, a patient may need to obtain an early refill because a vacation or long business trip will overlap the normal refill date. The customer who lives a significant distance from the pharmacy may work near the licensed premises, or the patient may be visiting the area for business or a vacation. However, basic questions put to the patient, along with a call to the prescriber, is often sufficient to ferret out the illegitimate prescription from the one that should be filled.

9. Respondent asserts that the Board has not adequately educated licensees as to how they may carry out their corresponding responsibility, noting that the Board did not publish a recitation of the "red flags" that might indicate an improper prescription until after the events relevant to this proceeding. That line of argument is not supported by the evidence or the law.

10. (A) Indicia of improper prescription of controlled substances have been recognized for some time, even if the indicia were not labeled as "red flags" until approximately 2014. This was established, in part, by the testimony of Respondent's expert, and by reference to the Board's publication, the Script. In February 2010, the Script reminded pharmacists of their corresponding duty, and made note of things for a pharmacist to look for in discharging that duty. Regarding corresponding duty, the publication stated:

> If a physician writes a controlled substance prescription that is not for a legitimate medical purpose, the pharmacist who fills the prescription shares a corresponding responsibility or liability with that physician if he or she fills that prescription while knowing or having objective reason to know that the prescription was not issued for a legitimate medical purpose.

(Ex. J, p. 4.)

The language pertaining to knowledge or having an objective reason to know that the prescription was not issued for a legitimate medical purpose is substantially similar to language contained in California Code of Regulations (CCR), title 16, section 1761, subdivision (b).[3] (See Legal Conclusion 3.) Respondent Bhalla must be charged with knowledge of CCR section 1761.

[3] All further citations to the CCR shall be to title 16 thereof.

(B) The February 2010 Script goes on to set out, as "guidelines," questions that a pharmacist might ask him or herself before filling a prescription for dangerous drugs. They include questions about the identity of the patient, whether the patient lives within the normal trade area of the pharmacy, the distance between the patient's home and the doctor's office. Pharmacists were encouraged to ask themselves about the patient's drug use history, and to examine the patient's demeanor. Licensees were advised to look to the prescribing physician, including the nature of the doctor's practice, and what has been the nature of the total prescriptions filled at the pharmacy, with an eye out for excessive percentages of controlled substance prescriptions. Finally, questions were set forth regarding the therapeutic appropriateness of the prescription. This would delve into matters such as whether the drugs in question were the type that were sometimes abused; unusual combinations of drug prescriptions; frequency of refills; and whether the prescription was appropriate for the diagnosis. (Ex. J, p. 4.)

11. (A) The weight of the evidence establishes that in the prescribing patterns for many, if not all, of the subject patients, revealed red flags that were reasonably visible to Respondents. Those red flags could be seen from the pharmacy's own patient profiles—the pharmacy records of the prescriptions filled by The Medicine Shoppe—as well as in the CURES system.

(B) In this regard, the testimony of the Board's inspector, who testified in this matter, is credited. Ms. Desai is a licensed pharmacist with retail experience, and she testified that many red flags were present. While Respondent was able to show that on some issues Desai had misapprehended the available data, and that in some instances, typical red flags were not obviously flying, there were still sufficient facts available to Respondents that would have indicated to Respondents that they should look further into the issue of whether the prescriptions, all written by Diaz, were appropriate.

(C) In this regard, the subject red flags that were missed can be summarized as including excessive doses of controlled substances and combinations of controlled substances that indicated improper prescribing. This is magnified by the information that Diaz was a general practitioner, and not clearly specializing in pain management. There were some early refills of prescriptions for controlled substances. Some of this information was available in the pharmacy's own records, such as in the case where pharmacy staff made a note to the effect that one patient, J.C., was persistent in trying to obtain early refills. (Ex. 3, p. AG 333.) A review of available CURES data would have shown that some of the subject patients had been, at one time or another, "pharmacy shopping," "doctor shopping," or both. The CURES data showed that some of subject patients were sometimes double dipping for controlled substances. However, there is no evidence that Bhalla or other pharmacists at The Medicine Shoppe reviewed CURES data.

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*The CURES system*

12. The CURES system is operated and controlled by the California Department of Justice. It amounts to a data base that shows the prescription and dispensing of controlled substances, schedules II through IV.

13. There was a dispute regarding the efficacy of the CURES system. According to Ms. Desai, the system was readily searchable from 2009 forward. Respondents' expert, Mr. Jeb Sydejko, testified that CURES was not readily searchable until more recent years. By that, he meant searchable on-line—he described it as "going live"—in that for some time a pharmacist or doctor desiring to obtain information could not go on-line and obtain it, but would have to FAX in a request for information. A response would not be immediately forthcoming.

14. However, Mr. Sydjeko could not state just when the system became accessible on-line, and he acknowledged that Ms. Desai would be a better source of information on that issue. Ms. Desai testified that CURES became searchable, on-line, in approximately 2008 or 2009. She was very sure that the system was searchable on-line in 2011 and 2012.

15. Bhalla acknowledged to Desai, when she inspected the pharmacy in January 2013, that he was registered with CURES and that he had access to it. This is corroborated by information—patient activity reports or PARs—generated from CURES, and received in evidence as exhibit 5. For example, the PAR for patient T.B. has, as its first entry, a January 6, 2009 prescription for APAP/Oxycodone, written by Diaz, and filled by The Medicine Shoppe. (Ex. 5A, p. 1.) Likewise, the PAR for patient K.B. has, as its first entry, a Diaz-prescription for APAP/Hydrocodone being filled at the respondent pharmacy on March 31, 2009. (Ex. 5C, p. 1.) Regardless of exactly when CURES "went live," Bhalla and the respondent pharmacy were providing data to CURES, and could have obtained data from the system as early as January 2009, and certainly during the period of 2011 and 2012. Even a faxed request for a patient profile could have provided significant information to Bhalla and his staff, and helped them ferret out Diaz's overprescribing of controlled substances.

*Discrepancies Between the Pharmacy Customer Profiles and the PARs*

16. The PARs provided one source of information regarding the activity of the patients, and pharmacies (respondent pharmacy and others), and doctors. Another source of information was the patient profiles generated by The Medicine Shoppe; these constitute summaries of activity for each of the subject patients at the pharmacy. They were produced by Respondents to the Board's investigators, and each is for the period January 1, 2010 through January 15, 2013.

17. During cross-examination, Desai testified that the profiles would be more accurate than the PARs. However, in reviewing the pharmacy profiles for the subject patients, which are found throughout Desai's investigation report, and the PARs, a pattern emerges: many prescriptions for controlled substances filled by The Medicine Shoppe are

not shown in the particular patient's PAR, but they are shown in the patient's profile. Not every subject patient's profile was compared to the relevant PAR, but a review of a sample establishes discrepancies.

18. For patient K.B., his PAR shows a gap between October 16, 2010, and June 24, 2011; that is, no prescriptions appear for that time period in the PAR. However, the patient profile shows that the patient obtained controlled substances from the respondent pharmacy, with Diaz prescriptions, in every month of 2011. (Ex. 3, p. AG 309.)

19. Patient A.B. also has discrepancies between his PAR and his patient profile. Numerous transactions during the period January 19, 2011 to June 1, 2011 appear in the profile, but not in the PAR. (Ex. 5D, p. 6; ex. 3, p. AG 323.) The Medicine Shoppe filled prescriptions for A.B. on June 1, 2011, but the sales do not appear in the PAR. The sale on June 1, 2011 appears to be an early refill and duplicate therapy, because A.B. had obtained a 30-day supply of the same drugs on May 11—20 days earlier—from Caldwell Pharmacy. (Ex. 5D, p. 6.) In turn, the purchases on May 11 were an early refill, because the patient profile shows that on April 22, 2011, Respondents had filled prescriptions for the same controlled substances—Opana, Oxycodone, and Methadone. (Ex. 3, p. AG 323.) While the April 22, 2011 sales appear in the patient profile, they do not appear in the PAR.

20. (A) Patient A.J.'s records show discrepancies. The PAR for A.J. shows that between May 22, 2010, and September 7, 2010, she only filled prescriptions at Goleta Valley Medical Pharmacy. Those prescriptions were all written by Diaz, and were primarily for Oxycontin, with some prescriptions for Methadone and Oxycodone HCL as well. During that time period the PAR shows no sales by The Medicine Shoppe, but according to the patient profile, 14 Diaz-generated prescriptions for controlled substances were filled there during that time period. This included prescriptions for Methadone, Oxycontin, and Oxycodone. (Ex. 3, p. AG 358; Ex. 5I, p. 4.)

(B) The PAR for A.J. shows no transactions by the Medicine Shoppe in the period between September 30, 2010, and June 28, 2011; the activity in that period is shown in the PAR as occurring at Goleta Valley Medical Pharmacy. However, the patient profile shows that during that time period The Medicine Shoppe filled some 34 prescriptions written by Diaz for A.J., all providing her with controlled substances. The prescriptions included Methadone, Oxycodone, and Oxycontin. (Ex. 3, p. AG 358; Ex. 5I, pp. 4-5.)

(C) Other prescriptions filled at The Medicine Shoppe do not appear in the PAR, including prescriptions filled on October 26, 2011 (2 rx's.); October 27, 2011, (1 rx.); November 9, 2011 (2 rx.), November 21, 2022, (2 rx.), and November 23, 2011 (1 rx.). (Ex. 3, p. AG 359; Ex. 5I, p. 7.)

21. It appears that between March 24, 2011, and June 15, 2011, M.M. filled five prescriptions for controlled substances at The Medicine Shoppe, all written by Diaz. However, those prescriptions do not appear in M.M.'s PAR. (Ex. 3, p. AG 396; Ex. 5K, p. 6.) Other prescriptions shown in the profile do not appear in the PAR, including: October 7,

2011 (3); October 28, 2011 (1); November 5 and 22, 2011, one prescription each day. (Ex. 3, p. AG 396; Ex 5K, p. 8.)

22. (A) According to his patient profile, patient S.M. first obtained controlled substances prescribed by Diaz at The Medicine Shoppe on February 10, 2011, the drugs being Oxycodone and Hydromorphone. He obtained the same drugs from the respondent pharmacy in March, April, May, June, July, August, and October 2011. (Ex. 3, p. AG 411.) It appears he paid cash for the drugs, as an insurance payment is indicated only one time on the profile, for a prescription of Fortesta on June 21, 2011. (*Id.*)

(B) The PAR for this patient does not show any activity at The Medicine Shoppe in the period from February 1 through June 15, 2011. (Ex. 5 M, p. 5.) The PAR does show the dispensing of Fortesta, Oxycodone HCL, and Hydromorphone on that date, matching the profile. However, the prescriptions from the patient profile that were filled in July and August do not appear on the PAR.

23. The fact that in many cases the patient profile shows activity at The Medicine Shoppe, but those transactions do not appear in the PARs, is troubling. It leads to the inference that the respondent pharmacy was not reporting all of its activity to the CURES data base. To be sure, there may have been some problem with the system not processing reports from The Medicine Shoppe, though the months-long gaps in the PAR are not readily explained by some processing problem with the CURES system. The fact that the PARs in some cases show activity for the pharmacy's customers all the way back to 2009, implicates reporting by The Medicine Shop.

*The Subject Patients*

24. During the relevant time period, 21 patients filled prescriptions for controlled substances at The Medicine Shoppe. The 21 patients—hereafter collectively referred to as the subject patients—all filled prescriptions written by Diaz. The patients filled the prescriptions written by Diaz at The Medicine Shoppe, and sometimes at other pharmacies. Bhalla, or sometimes another pharmacist employed by him, filled the prescriptions.

25. Many of the subject patients had filled such prescriptions before the relevant time period (January 1, 2011 through December 5, 2012), and according to Bhalla, some of the subject patients had been customers of the pharmacy before he had purchased it.

26. (A) The subject patients each received prescriptions for numerous controlled substances from Diaz, and they often filled more than one controlled substance prescription at the respondent pharmacy on the same day, or within a short time of another such prescription being filled.

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(B) For example, patient T.B., a woman who was approximately 42 years old during the subject time period, received the following controlled substances at various times from The Medicine Shoppe. All were prescribed by Diaz:

Opana ER, 40 mg.,
Morphine Sulfate, 100 mg.,
Clonazapem, 2 mg.
APAP/Oxycodone, 325 mg.-10 mg.
Hydromorphone Hydrocloride, 8 mg.
Amphetamine Salt Combo, 20 mg.
Fentanyl Transdermal System, 50 mcg/hr.
Buprenorphine Hydrocloride, 8 mg.
Dextroamphetamine Sulfate, 5 mg.
Promethazine VC with Codeine,

(C) Another example is Patient D.B., approximately 54 years old during the relevant time period, who received regular prescriptions for controlled substances from Diaz, which prescriptions he filled at The Medicine Shoppe. For example, in the period between July 13, 2011, and September 9, 2011, D.B. filled prescriptions for Hydromorphone Hydrocloride, 8. mg.; Morphine Sulfate, 100 mg.; and Alprazolam, 2 mg.

(D) In 2011 Diaz typically prescribed to Patient A.B. the following: Fentanyl Cittrate, in powder form; Alprazolam, 2 mg.; Oxycodone HCL, 30 m.g.; Amphetamine Salt Combo, 30 m.g.; Methadone Hydrocloride, 10 m.g. Opana ER, 40 m.g., and APAP/Hydrocodone Bitartrate. A.B. filled such prescriptions on numerous occasions at The Medicine Shoppe.

(E) Another example is Patient M.C., a woman who was approximately 30 years old during the subject period. She first filled Diaz-written prescriptions at The Medicine Shoppe on June 21, 2011, when she obtained Hydromorphone Hydrocloride, 8 m.g., and two prescriptions of Morphine Sulfate, one at 100 mg. strength, and one at 30 m.g. strength. At other times she obtained Diazepam, Oxycontin, Oxycodone HCL, Alprazolem, and APAP/Hydrocodone Bitartrate.

*Prescribing Patterns and History That Constituted Red Flags*

27. To avoid a prolix decision, not every patient or red flag will be discussed herein. However, sufficient examples are found in the record, and discussed below.

28, Desai understood that Diaz was not a pain specialist, but a general practitioner. In part she relied on the Medical Board's website when coming to that understanding, as it listed him as a general practitioner. Hence, in most cases she opined that to have large prescriptions for controlled substances coming from a general practitioner should have been taken into account by Respondents. Bhalla testified that when he met Diaz in 2009, the latter

told him he had been prescribing pain pills for 10 years, but that does not establish that Diaz was a specialist in pain management.

29. Desai testified that patient D.B. was prescribed Buprenorphin by Diaz, and his patient profile shows that the respondent pharmacy provided it to him on October 28, 2010, and again on March 21, 2011. (Ex. 3, p. AG 308.) Neither of those prescriptions appear in the PAR. (Ex., 5B, p. 2.)[4] Desai credibly testified that Burprenorphin is commonly used to treat opioid addiction. That prescription, coupled with the large amounts of controlled substances, including opioids, being routinely prescribed by Diaz and filled by The Medicine Shoppe was a red flag, that should have led to a CURES review. Desai pointed out that it would have revealed that K.B. began to receive heavy doses of opioids after he left care of another doctor and began treating with Diaz.[5]

30. (A) Patient K.B. was receiving large doses of Acetaminophen. According to Desai, the recommended dose is 4000 mg. per day, but Diaz was prescribing 5200 to 5800 per day. Desai was of the opinion that this large dosage, coming from a general practitioner, was a red flag, that should have led to scrutiny by Bhalla and the respondent pharmacy.

(B) Desai described A.B. as pharmacy shopping. There is evidence in the documents to support that. To be sure, there are discrepancies between the PAR and the patient profile. (See Factual Finding 19.) The profile shows The Medicine Shoppe filled prescriptions for A.B. on June 1, 2011, for Methadone and Oxycodone, but the sales do not appear in the PAR. (Ex. 3, p. 323; ex. 5D, p. 6.) The sale on June 1, 2011 appears to be an early refill and duplicate therapy, because A.B. had obtained a 30-day supply of the same drugs on May 11—20 days earlier—from Caldwell Pharmacy. (Ex. 5D, p. 6.) In turn, the purchases on May 11 at Caldwell Pharmacy were an early refill, because the patient profile shows that just 19 days earlier, on April 22, 2011, Respondents had filled prescriptions for the same controlled substances—Oxycodone, and Methadone, in the same quantities. (Ex. 3, p. AG 323.)

31. For patient J.C., his profile shows his first transaction with The Medicine Shoppe occurring on February 22, 2011. His PAR shows the first transaction there as occurring on June 27 of that year. (Ex. 5E, p. 2; ex. 3, p. AG 329.) In any event, Desai deemed J.C. to be a doctor and pharmacy shopper, travelling significant distances to see

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[4] The profile and the PAR show that The Medicine Shoppe had also dispensed this drug to D.B. on May 6 and September 9, 2010. (Ex. 3, p. AG 308; Ex 5B, p. 2.) This provided further information to Respondents, that they could have taken notice of.

[5] The prior physician had prescribed Alprazolam, 2 mg. tablets, 90 quantity, and APAP/Hydrocodone 325-10, 90 quantity. Diaz started the patient with Hydromorphone and Morphine Sulfate, in addition to Alprazolam. (Ex. 5B, p. 1.)

Diaz, other doctors, and to fill prescriptions.[6] He was receiving high doses of drugs such as Methadone, Hydromorphone, and Oxycodone.

32. (A) On some occasions, patient T.B. filled prescriptions in close intervals. For example, on June 28, 2011, she received a 30-day supply of Opana ER and Fentanyl. On July 21, 2011—23 days later—she obtained another 30-day supply of Opana ER, and Fentanyl Transdermal, the latter listed as a 30 day supply. On August 15, 2011, she obtained another 30 day supply of Opana ER and of Fentanyl from The Medicine Shoppe.

(B) T.B. filled a prescription for Clonazepem at The Medicine Shoppe on July 7, 2011 (60 tablets, a 30-day supply), and she filled similar prescriptions on August 1, August 26, and September 17, 2011. Thus, in two and one-half months, she obtained four months worth of Clonazepem from Respondents, based on prescriptions from Diaz.

(C) T.B. filled prescriptions of APAP/Oxycodone, 120 tablets, shown as a 15-day supply in her PAR, on July 9, 2011, and four days later, on July 13, 2011. She next obtained that drug from Respondents on August 2—20 days later—when she obtained another 120 tablets. Seven days later (August 9, 2011) T.B. filled another Diaz prescription for APAP/Oxycodone, 120 tablets, bringing the total to a 60-day supply prescribed and filled in a 30-day period. Similar prescriptions were filled by Respondents on August 26, September 2, September 17, and September 29, 2011.[7] Hence, in the 70 days between July 9 and September 29, 2011, T.B. filled eight Diaz authored prescriptions for APAP/Oxycodone from Respondents, to provide her with what purported to be a 120 day supply of that controlled substance.

(D) The Medicine Shoppe filled T.B.'s prescriptions for morphine sulfate on August 9, 2011 and on September 2, 2011, or 24 days apart. Each prescription was purportedly for a 30-day quantity, and thus it appears that the September 2, 2011 prescription was six days early. During that same time period, Diaz had prescribed hydromorphone hydrochloride in 30-day quantities, *i.e.*, on July 9, August 2, August 26, and September 17, 2011.

(E) While Desai acknowledged that filling a prescription a few days ahead of time, once the insurer will pay for it, may not indicate early refills, the pattern with this patient, given the significant dosages, is deemed to constitute early refills of the type that indicates a red flag.

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[6] The patient lived in Buelton, saw Diaz in Santa Barbara, where The Medicine Shop is located, and he also saw physicians in Solvang and even Greenville, North Carolina. (Ex. 5E, p. 2.)

[7] The PAR for this patient lists the prescription of 120 tablets, 325 mg.-10 mg. as a 15-day supply, with one exception, when the same quantity is shown as a 30-day supply, that being the prescription filled on August 9, 2011.

(F) The PAR for patient T.B. shows that the APAP/Oxycodone prescriptions and the Amphetamine Salt Combo were paid for in cash in the period from July 9, 2011 to December 29, 2011, with two exceptions on September 29 and October 22.

33. Desai noted that in the case of one patient, J.C., the respondent pharmacy was on notice that he was trying to refill early. Hence, staff wrote, on a Diaz prescription, that the patient was "persistent" in trying to get early refills. (Ex. 3, p. AG 333.) That note was made on a prescription for Oxycodone written on July 28, 2011.

34 Desai opined that patient J.H. had a history of doctor and pharmacy shopping, and travelling significant distances for treatment and to fill prescriptions at the Medicine Shop. The PAR indicates that he lived in Santa Maria, but was seeing Diaz in Santa Barbara. (Ex. 5H.) According to Desai, he at one point obtained approximately 500 Hydrocodone tablets in a period of about 30 days. He was obtaining, at any one time, several controlled substances, as Diaz was prescribing him APAP/Hydrocodone, Diazapam, Hydromorphone, Methadone, Alprazolam, and Oxycodone. (Ex 5H, pp. 6-7.)

35. Regarding patient G.L., Desai opined that he was receiving higher than ordinary doses of various controlled substances from a general practitioner. His PAR indicates that he was pharmacy shopping. The PAR shows that on November 2, 2011, he obtained APAP/Hydrocodone (325-10 mg.), 300 tablets, from The Medicine Shop, and another 90 tablets on the same day from CVS. He obtained 300 more on November 28, and on December 17; both batches from respondent pharmacy. (Ex 5J, pp. 9-10.)

36. (A) Desai opined that if a CURES search had been performed by Respondents regarding patient M.M,, they would have readily perceived a history that showed doctor and pharmacy shopping, prescription by Diaz of excessive amounts of drugs, and travel all around the central coast of California for pharmacies. Desai's opinion must be credited in this matter. For example, the patient, who lived in Lompoc, filled prescriptions, over several years, in Santa Maria, Lompoc, Orcutt, Santa Barbara, and Santa Barbara. (Ex. 5K.)

(B) The patient profile for M.M. shows that The Medicine Shoppe first filled a prescription for M.M,, written by Diaz, in April 2010. It next shows prescriptions being filled in 2011, beginning on March 24, when a prescription for 240 Oxycodone tablets, 10 mg., was filled. Thereafter, the profile shows that the respondent pharmacy filled prescriptions, written by Diaz, for controlled substances including Oxycontin, Oxycodone, Hydromorphone, Fentanyl, Alprazolam, and Carisoprodol. It provided such drugs in May 2011, and on June 15, 2011. (Ex. 3, p. AG 396.)

(C) For some reason, the prescriptions filled on May 2011, and June 15, 2011, do not appear in the PAR for M.M. (Ex. 5K, p. 6 [first The Medicine Shoppe entry 6/21/11 for Fentanyl].)

(D) Desai correctly pointed out that on March 4, March 9, and March 10, 2011, M.M. filled Diaz-written prescriptions for Oxycontin at another pharmacy in Santa

Barbara. According to the PAR, this was a 90-day supply, dispensed in a six day period.[8] (Ex. 5K, p. 6.)

37. (A) Patient J.R. was receiving prescriptions from Diaz for significant amounts of controlled substances, including Oxycodone, APAP/Hydrocodone, Morphine Sulfate, Opana, Alprazolam, and Oxycontin. These drugs were being dispensed by The Medicince Shoppe, and other pharmacies in 2011.

(B) A CURES review by Bhalla or pharmacists in his employ would have revealed that J.R. not only obtained 240 Hydrocodone tablets from the Medicine Shoppe on July 28, 2011, and on August 23, 2011, but it would have revealed that he obtained another 240 Hydrocodone pills from another pharmacy on August 10, 2011. All three prescriptions were written by Diaz, and a review of CURES data would have revealed this excessive prescribing and pharmacy shopping.

38. Patient A.M. filled many Diaz-written prescriptions for drugs such as Hydromorphone, Alprazolam, APAP/Hydrocodone at The Medicine Shoppe. He bought such drugs at other pharmacies as well. He obtained Methadone at other pharmacies. (Ex. 5L.) Bhalla testified that he did eventually become suspicious of Patient A.M., because he understood that the patient was going to have surgery to ameliorate his condition, but did not do so. The patient profile and PAR show that A.M. last bought controlled substances at the Medicine Shoppe in September 2011. (Ex. 3, p. AG 406; ex. 5L, pp. 7-8.) Bhalla acknowledged on cross examination that the patient passed away some time later, but stated suicide had not been ruled out. The patient, who was obtaining a number of controlled substances from the respondent pharmacy, and other pharmacies, all prescribed by Diaz, always paid cash at The Medicine Shoppe, as indicated by the lack of insurance coding in the profile. (Ex. 3, p. AG 404-405.) And, he was driving from Solvang to Santa Barbara to see Diaz, and to fill his prescriptions..[9]

39. (A) The defense was able to show that Desai had made assertions in her report that were erroneous, such as the assertion that some patients were paying cash when they had insurance. Still, some patients, like A.M., were paying cash. Ultimately, her incorrect assertions did not discredit her entire analysis, and she was able to point to other facts that should have caused Bhalla or other pharmacists to refer to CURES. And, Respondents did not refute many of Desai's claims and opinions.

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[8] The patient's PAR also showed that on December 2 and December 6, 2010, M.M. filled Diaz-written prescriptions for Oxycontin, each being a 30-day supply. (Ex. 5K, p. 5.)

[9] This patient's profile and PAR show discrepancies as well. The profile shows sales in every month from January through May 2011, but those do not appear in the PAR; the first activity for The Medicine Shop in 2011 is shown as June 27. (Ex 3, p. AG405-406; ex 5L, 6.)

(B) The large doses of pain pills prescribed by Diaz should have prompted Bhalla, at some point, to review CURES data for his Diaz patients. The prescription of Burprenorphin to D.B. should have prompted an inquiry with CURES about that patient. There was evidence that at least nine patients were travelling greater than average distances to see Diaz or to fill prescriptions at The Medicine Shoppe. Despite the fact that Diaz provided diagnoses for the majority of patients, Bhalla did not have a diagnoses for eight of them, but they too were receiving large amounts of controlled substances from Diaz. Inquiry into one or two of the patients would have alerted Bhalla to some of the issues discussed above, and that should have led to a change in practice.

*Respondent Bhalla's Testimony*

40. Respondent has been a pharmacist for approximately 30 years. He was a pharmacist in England for approximately 10 years, and then he practiced here for about 20 years. He has no record of discipline

41. Respondent acknowledged that he told Desai and her inspector colleague, during their inspection of respondent pharmacy in January 2013, that if he was provided a diagnosis by the prescriber, he or his employees would fill the prescription. He would inspect the prescription itself, checking information such as the date, and the appearance of the document. He would look to the address, and if the patient was not a resident of Santa Barbara County, he would not fill the prescription. The patient's demeanor was considered as well.

42. Bhalla took steps to obtain a diagnosis from the prescriber, to justify the prescriptions of controlled substances. He had been advised by another pharmacist that Board representatives were of the opinion that if a pharmacist had a diagnosis to go with the prescription, such was sufficient to justify filling the prescriptions.

43. Bhalla's conversation with his colleague, regarding having a diagnosis to support prescription of pain medication, came in the context of his concerns about Diaz. The colleague in question was the prior owner of the Medicine Shoppe, and had filled a number of Diaz prescriptions. Bhalla had been working at the pharmacy before he bought it and he was aware that Diaz prescribed many pain killers. Bhalla decided he should meet Diaz, and in December 2009 went to Diaz's office. He did so to evaluate the practice. Further, knowing that Diaz prescribed a lot of pain pills, Bhalla was interested in doing compounding work for Diaz, by compounding pain medications. The meeting lasted five to ten minutes.

44. Diaz told Bhalla he had been practicing for about 10 years, and prescribing pain medication for about that many years. Bhalla questioned Diaz about his practice of prescribing short acting pain medications, such as Hydromorphone and Oxycodone, and Diaz had an explanation about the drugs working on different receptors.

45. (A) Bhalla inquired with others about Diaz, at other times. On one occasion he attended a presentation hosted by a manufacturer regarding drug diversion. A pharmacist who worked with the Drug Enforcement Administration made a presentation on what has come to be labeled red flags. After the presentation, Bhalla asked the manufacturer's representative about Diaz's practice, and she said, in the presence of the DEA representative, that she knew of no problems with his license.

(B) In May 2011, a sales representative from Cardinal Wholesale visited The Medicine Shoppe to conduct a supply integrity checkup. Bhalla discussed Diaz with the wholesaler's representative, who then looked up Diaz on various websites, but could find no bad information about him.

46. Bhalla acknowledges that in the back of his mind he thought he ought to look into Diaz, in part because he was "curious about his prescribing habits. He was always—you know, it's—we had seen the prescriptions come in. I was still the pharmacist in charge, so I wanted to stay on top of it, if you like." (Ex. 10, p. 118, lines 10-13.) This testimony validates Desai's testimony that the pattern and nature of the prescriptions generated by Diaz for the subject patients was alone enough to justify a search into the CURES records.

47. Bhalla admitted that he was "curious" about Diaz's prescribing habits from 2009 all the way until Diaz was arrested in January 2012, but in that time he never ran a check (through CURES) on Diaz. (Ex. 10, p. 160, lines 19-25. See also p. 161, line 25 through p. 162, line 2.)

48. Bhalla testified that he had trouble accessing CURES, though he believed it was a good idea to participate in the system. There was little or no evidence of a concerted effort on his part to obtain information from the system at any time after he bought the pharmacy.

*Failure to Produce Records*

49. It was established that Desai or her co-investigator requested prescription documents, original hard copy prescriptions. However, several were not produced. The prescriptions that were not produced were numbers 115234; 1136283; 1183085; 1185522; 1185523, and 1171890.

*Erroneous or Uncertain Prescriptions*

50. Complainant alleged in the Third Cause for Discipline that Respondents dispensed prescriptions that contained significant errors, omissions, irregularities, uncertainties, ambiguities, or alterations. There were three main clams: that four prescriptions had no date or suspicious dates; that 11 prescriptions were dispensed prior to the date on the prescription; and that three prescriptions were dispensed even though not signed by the doctor, in this case, Diaz.

51. It was established that three prescriptions were dispensed where the prescriptions had no date at all: numbers 1146852; 1146853, and 1146856. It was also established that these three prescriptions were dispensed even though not signed by Diaz.

52. It was established that one prescription was dispensed with an erroneous date (10/7/68), number 1182583.

53. The allegations of paragraph 41(a) though (d) of the FAA were established, showing prescriptions being dispensed before the date on the prescription. The balance of the allegations in paragraph 41, subparagraphs (e) through (k), were not proven.

*Costs*

54. The Board incurred costs of investigation and prosecution totaling $32,364. Respondents did establish that some of the allegations could not be substantiated, and Bhalla proceeded in a good faith manner to defend his license, and to potentially reduce any discipline that might be imposed. In those circumstances, the costs should be reduced to $20,000.

*Mitigation*

55. Bhalla has no disciplinary history during his many years in practice. Desai testified that he had been very cooperative during the investigation process, unlike other pharmacists she has dealt with. Bhalla credibly testified that because of his personal background, he has tended to look up to physicians, and that may have hindered his vision of Diaz, and made him susceptible to that prescriber's blandishments. Bhalla has consulted with his expert, Sydejko, who provides services to pharmacists designed to assist them in complying with applicable statutes and regulations. Bhalla now subscribes to Sydejko's service. Bhalla produced positive character reference letters. Finally, Bhalla obtained training and education after the Accusation was filed, which would assist him in avoiding future problems.

## LEGAL CONCLUSIONS

1. Jurisdiction was established to proceed in this matter pursuant to Business and Professions Code sections 118, subdivision (b), 4011, 4300, subdivision (a), and 4301, based on Factual Findings 1 through 5.[10]

2. Health and Safety Code section 11153, subdivision (a) states:

[10] All statutory references are to the Business and Professions Code unless otherwise noted.

> 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.

This "corresponding duty" requires the pharmacist to take steps to assure that controlled substances he or she is dispensing pursuant to a prescription is dispensed for a legitimate medical purpose.

3. CCR 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.

4. Respondent pharmacy and Bhalla violated Health and Safety Code section 11153, subdivision (a), and CCR section 1761, subdivision (b), by failing to discharge their corresponding responsibility to by dispensing controlled substances on numerous occasions when there was reason to believe that the prescriptions had not been issued for a legitimate medical purpose, and that the drugs dispensed were not going to be used for a legitimate medical purpose. This Conclusion is based on Factual Findings 6 through 39.

5. Respondents The Medicine Shoppe and Bhalla dispensed prescriptions of controlled substances in violation of CCR section 1761, subdivision (a), in that they filled prescriptions that had significant errors, omissions, or irregularities, based on Factual Findings 51 through 53.

6. (A) Section 4081, subdivision (a), requires that all records of sale, acquisition or disposition of dangerous drugs be maintained for at least three years, and available for review by authorized officers of the law.

(B) Section 4105, subdivision (a), provides that all records of the acquisition and disposition of dangerous drugs shall be retained by the licensee, at the licensed premises in a readily retrievable form. Subdivision (c) of the statute requires that the records be maintained for three years.

(C) It was established that Respondents violated sections 4081, subdivision (a), and 4105, subdivisions (a) and (c), by failing to account for and provide prescription documents, based on Factual Finding 49.

7. Cause has been established to discipline the pharmacy permit held by Respondent The Medicine Shoppe pursuant to section 4301, subdivision (j), for the violations of Health and Safety Code section 11153, subdivision (a), and CCR section 1761, based on Legal Conclusions 1 through 4, and their factual predicates.

8. Cause has been established to discipline the pharmacy permit held by Respondent The Medicine Shoppe pursuant to section 4301, subdivision (o), for the violations of Health and Safety Code section 11153, subdivision (a), and CCR section 1761, subdivision (b), based on Legal Conclusions 1 through 4, and their factual predicates.

9. Cause has been established to discipline the pharmacy permit held by Respondent The Medicine Shop, pursuant to section 4301, subdivision (d), for clearly excessive furnishing of controlled substances in violation of Health and Safety Code section 11153, subdivision (a), based on Legal Conclusions 1 through 4, and their factual predicates.

10. Cause has been established to discipline the pharmacy permit held by Respondent The Medicine Shoppe pursuant to section 4301, subdivision (o), for violating CCR section 1761, subdivision (a), based on Legal Conclusion 5 and Factual Findings 50 through 52.

11. Cause has been established to discipline the pharmacy permit held by Respondent The Medicine Shoppe pursuant to section 4301, subdivision (o), for violating sections 4081, subdivision (a), and 4105, subdivisions (a) and (c), based on Legal Conclusion 6(A) through (C) and Factual Finding 489.

12. Cause has been established to discipline the pharmacist license held by Respondent Bhalla pursuant to section 4301, subdivision (j), for the violations of Health and Safety Code section 11153, subdivision (a), and CCR section 1761, based on Legal Conclusions 1 through 4, and their factual predicates.

13. Cause has been established to discipline the pharmacist license held by Respondent Bhalla pursuant to section 4301, subdivision (o), for the violations of Health and

Safety Code section 11153, subdivision (a), and CCR section 1761, subdivision (b), based on Legal Conclusions 1 through 4, and their factual predicates.

14. Cause has been established to discipline the pharmacist license held by Respondent Bhalla pursuant to section 4301, subdivision (d), for clearly excessive furnishing of controlled substances in violation of Health and Safety Code section 11153, subdivision (a), based on Legal Conclusions 1 through 4, and their factual predicates.

15. Cause has been established to discipline the pharmacist license held by Respondent Bhalla pursuant to section 4301, subdivision (o), for violating CCR section 1761, subdivision (a), based on Legal Conclusion 5 and Factual Findings 51 through 53.

16. Cause has been established to discipline the pharmacy license held by Respondent Bhalla pursuant to section 4301, subdivision (o), for violating sections 4081, subdivision (a), and 4105, subdivisions (a) and (c), based on Legal Conclusion 6(A) through (C) and Factual Finding 49.

17. (A) The Board is entitled to recover its costs of investigation and prosecution pursuant to section 125.3, based on Legal Conclusions 1 through 16.

(B) Into the analysis must come the case of *Zuckerman v. State Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45, which pertained to a cost regulation with language similar to that found in section 125.3. In that case the Supreme Court held that an agency must exercise its discretion to reduce or eliminate cost awards in a manner which will ensure that the costs statute does not deter licensees with potentially meritorious claims or defenses from exercising their right to a hearing. The court stated: "Thus, the Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a chiropractor who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed." (29 Cal.4th at 45.)

(C) Under *Zuckerman*, the agency must also consider the licensee's subjective good faith belief in the merits of his or her position and whether the licensee has raised a colorable challenge to the proposed discipline. The Court further required that the agency must determine that the licensee will be financially able to make later payments. It concluded by stating that an agency "may not assess the full costs of investigation and prosecution when it has conducted a disproportionately large investigation to prove that a [licensee] engaged in relatively innocuous misconduct." (*Id.*, footnote omitted.)

(D) The foregoing analysis was applied to the cost claim in this case, and led to the reduction of costs to $20,000 (Factual Finding 54). Furthermore, the large amount still owing should be paid in installments.

18. (A) The purpose of proceedings of this type are to protect the public, and not to punish an errant licensee. (*Camacho v. Youde* (1979) 95 Cal.App.2d 79; *Hughes v. Board*

*of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.) Public protection is the Board's paramount obligation. (§ 4001.1.)

(B) Respondent Bhalla's failure to inquire further into Diaz's activities appears negligent, rather than as deliberate act to help others divert controlled substances. This is not a case where he and his pharmacy were selling controlled substances to van loads of "patients," or otherwise blatantly aiding in the diversion of controlled substances. (See *LDWPC INC, dba Garfield Prescription Pharmacy et. al*, case no. 5337, OAH No. 2016050584.) It appeared from Bhalla's attitude during this proceeding that he is respectful of the Board's role and obligations, and of his own, and it appears that he was somewhat naïve in his dealings with Diaz. He has been humbled by the entire experience, and it does not appear that outright revocation, requested by Complainant, is needed to protect the public. Instead, a period of probation should be sufficient for public protection.

(C) Under sections 4307 and 4308, Bhalla will be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee owning another pharmacy. This is a significant penalty. In these circumstances, a suspension of 90 days, called for in the Board's disciplinary guidelines appears harsh and punitive, and a suspension will not be ordered.

ORDER

1. The pharmacy permit, number PHY 49809, held by The Medicine Shoppe, Sanjiv Bhalla, owner, is hereby revoked.

2. Pharmacist License number RPH 46064, issued to Respondent Sanjiv Bhalla, is revoked; however, the revocation is stayed and respondent is placed on probation for four years upon the following terms and conditions:

1. Obey All Laws

Respondent shall obey all state and federal laws and regulations.

Respondent shall report any of the following occurrences to the board, in writing, within seventy-two (72) hours of such occurrence:

a. an arrest or issuance of a criminal complaint for violation of any provision of the Pharmacy Law, state and federal food and drug laws, or state and federal controlled substances laws

b. a plea of guilty or nolo contendere in any state or federal criminal proceeding to any criminal complaint, information or indictment

c. a conviction of any crime

d. discipline, citation, or other administrative action filed by any state or federal agency which involves respondent's pharmacist license or which is related to the practice of pharmacy or the manufacturing, obtaining, handling, distributing, billing, or charging for any drug, device or controlled substance.

Failure to timely report such occurrence shall be considered a violation of probation.

2. Report to the Board

Respondent shall report to the board quarterly, on a schedule as directed by the board or its designee. The report shall be made either in person or in writing, as directed. Among other requirements, Respondent shall state in each report under penalty of perjury whether there has been compliance with all the terms and conditions of probation. Failure to submit timely reports in a form as directed shall be considered a violation of probation. Any period(s) of delinquency in submission of reports as directed may be added to the total period of probation. Moreover, if the final probation report is not made as directed, probation shall be automatically extended until such time as the final report is made and accepted by the board.

3. Interview with the Board

Upon receipt of reasonable prior notice, Respondent shall appear in person for interviews with the board or its designee, at such intervals and locations as are determined by the board or its designee. Failure to appear for any scheduled interview without prior notification to board staff, or failure to appear for two (2) or more scheduled interviews with the board or its designee during the period of probation, shall be considered a violation of probation.

4. Cooperate with Board Staff

Respondent shall cooperate with the board's inspection program and with the board's monitoring and investigation of respondent's compliance with the terms and conditions of his probation. Failure to cooperate shall be considered a violation of probation.

5. Continuing Education

Respondent shall provide evidence of efforts to maintain skill and knowledge as a pharmacist as directed by the board or its designee.

6. Notice to Employers

During the period of probation, respondent shall notify all present and prospective employers of the decision in case number 5251 and the terms, conditions and restrictions imposed on respondent by the decision, as follows:

Within thirty (30) days of the effective date of this decision, and within fifteen (15) days of Respondent undertaking any new employment, Respondent shall cause his direct supervisor, pharmacist-in-charge (including each new pharmacist-in-charge employed during respondent's tenure of employment) and owner to report to the board in writing acknowledging that the listed individual(s) has/have read the decision in case number 5899 and terms and conditions imposed thereby. It shall be Respondent's responsibility to ensure that his employer(s) and/or supervisor(s) submit timely acknowledgment(s) to the board.

If Respondent works for or is employed by or through a pharmacy employment service, respondent must notify his direct supervisor, pharmacist-in-charge, and owner at every entity licensed by the board of the terms and conditions of the decision in case number 5899 in advance of the Respondent commencing work at each licensed entity. A record of this notification must be provided to the board upon request.

Furthermore, within thirty (30) days of the effective date of this decision, and within fifteen (15) days of respondent undertaking any new employment by or through a pharmacy employment service, Respondent shall cause his direct supervisor with the pharmacy employment service to report to the board in writing acknowledging that he or she has read the decision in case number 5251 and the terms and conditions imposed thereby. It shall be Respondent's responsibility to ensure that his employer(s) and/or supervisor(s) submit timely acknowledgment(s) to the board.

Failure to timely notify present or prospective employer(s) or to cause that/those employer(s) to submit timely acknowledgments to the board shall be considered a violation of probation.

"Employment" within the meaning of this provision shall include any full-time, part-time, temporary, relief or pharmacy management service as a pharmacist or any position for which a pharmacist license is a requirement or criterion for employment, whether the respondent is an employee, independent contractor or volunteer.

7. No Supervision of Interns, Serving as Pharmacist-in-Charge (PIC), Serving as Designated Representative-in-Charge, or Serving as a Consultant

During the period of probation, Respondent shall not supervise any intern pharmacist, be the pharmacist-in-charge or designated representative-in-charge of any entity licensed by the board nor serve as a consultant unless otherwise specified in this order. Assumption of any such unauthorized supervision responsibilities shall be considered a violation of probation.

8. Reimbursement of Board Costs

As a condition precedent to successful completion of probation, Respondent shall pay to the board its costs of investigation and prosecution in the amount of $20,000. Respondent shall make said payments on a schedule to be determined by the board.

There shall be no deviation from this schedule absent prior written approval by the board or its designee. Failure to pay costs by the deadline(s) as directed shall be considered a violation of probation.

9. Probation Monitoring Costs

Respondent shall pay any costs associated with probation monitoring as determined by the board each and every year of probation. Such costs shall be payable to the board on a schedule as directed by the board or its designee. Failure to pay such costs by the deadline(s) as directed shall be considered a violation of probation.

10. Status of License

Respondent shall, at all times while on probation, maintain an active, current license with the board, including any period during which suspension or probation is tolled. Failure to maintain an active, current license shall be considered a violation of probation.

If respondent's license expires or is cancelled by operation of law or otherwise at any time during the period of probation, including any extensions thereof due to tolling or otherwise, upon renewal or reapplication respondent's license shall be subject to all terms and conditions of this probation not previously satisfied.

11. License Surrender While on Probation/Suspension

Following the effective date of this decision, should Respondent cease practice due to retirement or health, or be otherwise unable to satisfy the terms and conditions of probation, Respondent may tender his license to the board for surrender. The board or its designee shall have the discretion whether to grant the request for surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance of the surrender of the license, Respondent will no longer be subject to the terms and conditions of probation. This surrender constitutes a record of discipline and shall become a part of the Respondent's license history with the board.

Upon acceptance of the surrender, Respondent shall relinquish his pocket and wall license to the board within ten (10) days of notification by the board that the surrender is accepted. Respondent may not reapply for any license from the board for three (3) years from the effective date of the surrender. Respondent shall meet all requirements applicable to the license sought as of the date the application for that license is submitted to the board, including any outstanding costs.

12. Notification of a Change in Name, Residence Address, Mailing Address or Employment

Respondent shall notify the board in writing within ten (10) days of any change of employment. Said notification shall include the reasons for leaving, the address of the new employer, the name of the supervisor and owner, and the work schedule if known. Respondent shall further notify the board in writing within ten (10) days of a change in name, residence address, mailing address, or phone number.

Failure to timely notify the board of any change in employer(s), name(s), address(es), or phone number(s) shall be considered a violation of probation.

13. Tolling of Probation

Except during periods of suspension, Respondent shall, at all times while on probation, be employed as a pharmacist in California for a minimum of 30 hours per calendar month. Any month during which this minimum is not met shall toll the period of probation, i.e., the period of probation shall be extended by one month for each month during which this minimum is not met. During any such period of tolling of probation, Respondent must nonetheless comply with all terms and conditions of probation.

Should Respondent, regardless of residency, for any reason (including vacation) cease practicing as a pharmacist for a minimum of 30 hours per calendar month in California, Respondent must notify the board in writing within ten (10) days of the cessation of practice, and must further notify the board in writing within ten (10) days of the resumption of practice. Any failure to provide such notification(s) shall be considered a violation of probation.

It is a violation of probation for Respondent's probation to remain tolled pursuant to the provisions of this condition for a total period, counting consecutive and non-consecutive months, exceeding thirty-six (36) months.

"Cessation of practice" means any calendar month during which respondent is not practicing as a pharmacist for at least 30 hours, as defined by Business and Professions Code section 4000 et seq. "Resumption of practice" means any calendar month during which respondent is practicing as a pharmacist for at least 30 hours as a pharmacist as defined by Business and Professions Code section 4000 et seq.

14. Violation of Probation

If Respondent has not complied with any term or condition of probation, the board shall have continuing jurisdiction over respondent, and probation shall automatically be extended, until all terms and conditions have been satisfied or the board has taken other action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed.

If Respondent violates probation in any respect, the board, after giving Respondent notice and an opportunity to be heard, may revoke probation and carry out the disciplinary

order that was stayed. Notice and opportunity to be heard are not required for those provisions stating that a violation thereof may lead to automatic termination of the stay and/or revocation of the license. If a petition to revoke probation or an accusation is filed against Respondent during probation, the board shall have continuing jurisdiction and the period of probation shall be automatically extended until the petition to revoke probation or accusation is heard and decided.

15. Completion of Probation

Upon written notice by the board or its designee indicating successful completion of probation, Respondent's license will be fully restored.

3. Pursuant to Business and Professions Code section 4307, Respondent Bhalla is prohibited from serving as a manager, administrator, owner, member, officer, director, associate, partner, or in any other position with management or control of a licensee.

November 20, 2017

DocuSigned by:
Joseph D. Montoya
[illegible]

Joseph D. Montoya
Administrative Law Judge
Office of Administrative Hearings

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**THE MEDICINE SHOPPE; SANJIV BHALLA, OWNER**<br>**1435 State Street**<br>**Santa Barbara, CA 93101**<br><br>**Pharmacy Permit No. PHY 49809,**<br><br>**and**<br><br>**SANJIV BHALLA**<br>**1250 La Venta Dr. #114**<br>**Westlake Village, CA 91361**<br><br>**Pharmacist License No. RPH 46064**<br><br>Respondent. | Case No. 5251<br><br>**FIRST AMENDED ACCUSATION** |

Complainant alleges:

**PARTIES**

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

2. On or about February 17, 2009, the Board of Pharmacy issued Pharmacy Permit Number PHY 49809 to The Medicine Shoppe with Sanjiv Bhalla as Pharmacist-In-Charge ("Respondent Pharmacy"). The Pharmacy Permit is cancelled, expired on February 1, 2014, and has not been renewed.

3. On or about March 15, 1993, the Board of Pharmacy issued Pharmacist License Number RPH 46064 to Sanjiv Bhalla ("Respondent Bhalla"). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, unless renewed.

## JURISDICTION

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

5. Section 4300 of the Code states, in pertinent part:

"(a) Every license issued may be suspended or revoked.

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding one year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper."

6. Section 4300.1 of the Code states:

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

## STATUTES AND REGULATIONS

7. Section 4301 of the Code states, in pertinent part:

"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:

. . . .

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

. . . .

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

. . . .

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

8. Section 4081, subdivision (a) of the Code states:

"(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, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, 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."

9. Section 4105, of the Code states, in pertinent part:

"(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.

. . . .

(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."

10. Section 4307(a) of the Code states that:

Any person who has been denied a license or whose license has been revoked or is under suspension, or who has failed to renew his or her license while it was under suspension, or who has been a manager, administrator, owner member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or revoked, is under suspension or has been placed on probation, and while acting as the manager, administrator, owner, member, officer, director, associate, or partner had knowledge or knowingly participated in any conduct for which the license was denied as a manager, administrator, owner, member, officer, associate, or partner of a licensee as follows:

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

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

. . . .

11. Health and Safety Code section 11153, subdivision (a), states:

"(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."

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

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

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

**COST RECOVERY**

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

**CONTROLLED SUBSTANCES[1]**

14. Alprazolam, the generic name for Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1). Alprazolam is a depressant used to treat anxiety and is a popular member of a class of drugs called "benzodiazepines," which is a general name for any group of psychotropic agents used as anti-anxiety agents, muscle relaxants, sedatives, and hypnotics.

15. Clonazepam, the generic name for Klonopin, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7). Clonazepam treats seizures, panic disorder, and anxiety and belongs to the class of drugs called "benzodiazepines."

[1] All of the controlled substances listed are also dangerous drugs pursuant to Code section 4022.

16. Diazepam, a generic name for Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9). Diazepam treats anxiety, muscle spasms, seizures, and belongs to the class of drugs called "benzodiazepines."

17. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8). Fentanyl is a narcotic opioid used to treat moderate to severe chronic pain.

18. The combination of Hydrocodone/Acetaminophen ("HC/AP") is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4). Hydrocodone is an opioid pain reliever that is subject to abuse because of the euphoric feeling it induces.

19. Lorazepam, the generic name for Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16). Lorazepam is used to treat anxiety, anxiety with depression, and insomnia and belongs to the class of drugs called "benzodiazepines."

20. Hydromorphone, the generic name for Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J). Hydromorphone is a narcotic opioid that is used to treat moderate to severe pain.

21. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14). Methadone treats moderate to severe pain and when used together with medical supervision and counseling is used for the treatment of narcotic drug addiction.

22. Opana ER, a brand name for Oxymorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N). Oxymorphone is a narcotic opioid that is used to treat moderate to severe pain.

23. Oxycodone, a generic name for Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxycodone is a narcotic opioid that is used to treat moderate to severe pain.

24. Percocet, a brand name for the combination of Oxycodone and Acetaminophen ("Oxy/Ap"), is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxy/Ap is a narcotic opioid that is used to treat moderate to moderately severe pain.

**BOARD INVESTIGATION**

25. Beginning in January 2013, the Board conducted an investigation into Respondent Pharmacy. The Board was alerted that Julio Diaz, M.D., a general practitioner with secondary practices in geriatrics and pathology, who had a medical practice in Santa Barbara, was arrested for trafficking narcotics. Respondent Pharmacy dispensed many controlled substances that Dr. Diaz prescribed.

26. On January 15, 2013, two Board Inspectors conducted an inspection of Respondent Pharmacy. When questioned about Dr. Diaz's prescriptions, Respondent Bhalla initially responded that he did not know if Dr. Diaz was a pain specialist but stated that he checked the prescriptions by calling the doctor's office and writing the diagnosis code on the prescriptions.

27. The Board Inspectors selected 21 patients to profile and asked Respondent Bhalla to complete questionnaires regarding the patients. Amongst the questions asked were the patients' diagnoses, the methods of payment, and the nature of prescriber's practice. All of the patients were Dr. Diaz's patients and Respondent Bhalla indicated that Dr. Diaz had a general practice.

28. The Board Inspectors requested CURES[2] data for Respondent Pharmacy from January 1, 2011 to December 5, 2012 and CURES Patient Activity Reports ("PARs") for the 21 selected patients from January 1, 2009 to January 28, 2013.

29. On October 4, 2012, the Medical Board of California revoked Dr. Diaz's license to practice medicine, in the case entitled *In the Matter of the Accusation Against Otero Julio*

[2] All prescription drug history information is maintained in the California Controlled Substance Utilization Review and Evaluation System, or CURES, a database. This CURES database includes information about the drug dispensed, drug quantity and strength, patient name, address, prescriber name, and authorization number including DEA number or prescription number.

*Gabriel Diaz, M.D.*, case no. 06-2010-209660. Dr. Diaz's license was revoked for gross negligence, incompetence, and excessive prescribing of narcotic medications to a patient.

**FIRST CAUSE FOR DISCIPLINE**

**(Corresponding Responsibility)**

30. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivisions (d), Code section 4301, subdivision (j) for violating Health and Safety Code section 11153, subdivision (a), and Code section 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1761, in that between January 1, 2011 and December 5, 2012, Respondents failed to assume their corresponding responsibility by failing to validate the legitimacy of prescriptions dispensed and/or by failing to review patients' drug therapy and thus dispensing prescriptions to physician shoppers or habitual users. The circumstances, which include by reference Paragraphs 24 through 28, are as follows:

31. For the 21 patients that the Board Inspectors selected to profile, there were many irregularities found with the prescriptions and dispensing methods, including: (1) no diagnosis for many patients; (2) a general practitioner that was prescribing an excessive amount of narcotics; (3) many patients that came to Respondent Pharmacy outside of the normal trading area, which is considered to be 5 miles from the patient's residence or adjacent to the prescriber's office; (4) consistent early fills of controlled substance prescriptions; (5) patients paying cash for expensive narcotics; (6) no verification in CURES Patient Activity Reports (PARs) for suspicious prescriptions; (7) evidence of doctor/pharmacy shopping; and (8) evidence of a pattern of prescribing controlled substances in large and redundant quantities and in questionable combinations.

32. A detailed review of the 21 patients reveals the following results:

a) Patient T.B. Patient T.B. was diagnosed with cervical myositis pain and Chronic Pain Syndrome. Between January 1, 2009 and January 1, 2013, Patient T.B. saw 4 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. On several occasions (January 5, 2010, January 25, 2010, February 19, 2010, April 7, 2010, August 27, 2010, September 17, 2011, and December 16, 2011) Patient T.B. received 2 hard copy

prescriptions from Dr. Diaz for Percocet with the same date. This should have been a red flag for the pharmacy. Respondent Pharmacy dispensed RX #1178784 for Fentanyl patches every 48 prescribed by Dr. Diaz. The recommended dosage is every 72 hours. Patient T.B. utilized insurance to pay for her medications but paid cash, including $1,298.90 for Opana and $732.90 for Fentanyl, when insurance did not cover her medications.

b) Patient D.B. Patient D.B. was diagnosed with degenerative chronic disease of the cervical spine. Between January 20, 2009 and January 3, 2013, Patient D.B. saw 5 different prescribers and went to 4 different pharmacies, including Respondent Pharmacy. Prior to seeing Dr. Diaz, Patient D.B. received HC/AP 10-325 monthly for approximately 1 year. Dr. Diaz prescribed hydromorphone 8 mg and morphine 60 mg. Dr. Diaz also prescribed buprenorphine 8 mg (which is commonly used to treat opiate addiction.) After Patient D.B. stopped seeing Dr. Diaz, Patient D.B. received morphine but the strength was much smaller. Patient D.B. utilized insurance to pay for his medications but paid cash, including $202.90 for Alprazolam, when insurance did not cover his medications.

c) Patient K.B. Patient K.B. was diagnosed with lumbar reticulopathy and spondylosis. Between March 31, 2009 and December 4, 2012, Patient K.B. saw 5 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and March 31, 2009, Patient K.B. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: HC/AP 10-325, Methadone 10 mg, and Alprazolam 2 mg. Patient K.B. also received numerous HC/AP 10-325 prescriptions from Dr. Diaz and had them dispensed at multiple pharmacies on or around the same time:

- On April 30, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply from Respondent Pharmacy and on May 8, 2009 he received 240 tablets (40 day supply from LM Caldwell Pharmacist.
- On May 28, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply) from Respondent Pharmacy and 240 tablets (40 day supply) from Walgreens. On June 4, 2009, he received 240 tablets (40 day supply) from LM Caldwell Pharmacist.

- On July 23, 2009, Patient K.B. received RX #1128237, 240 tablets (30 day supply) the Respondent Pharmacy and on July 28, 2009, he received 240 tablets (30 day supply) from Walgreens.
- On August 21, 2009, Patient K.B. received RX #1129966, 240 tablets (30 day supply) from Respondent Pharmacy and on August 28, 2009, he received 240 tablets (30 day supply) from Walgreens.

Had Respondent Pharmacy utilized PARs, it would have discovered the excessive dispensing. Patient K.B. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

d) Patient A.B. Patient A.B.'s diagnosis was unknown. Between May 21, 2009 and January 24, 2012, Patient A.B. saw 3 prescribers and went to 7 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 21, 2009, Patient A.B. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Fentanyl patch and Alprazolam 2 mg. Respondent Pharmacy dispensed RX #1175222 on June 29, 2011, RX #1178791 on August 26, 2011, and RX #1180528 on September 27, 2009 all prescribed by Dr. Diaz for Opana ER three times a day when the recommended dose is two times a day. Patient A.B. utilized insurance to pay for his medications but paid cash, including $828.90 and $421.95 for Opana and over $250 for Oxycodone and Adderall XR, when insurance did not cover his medications.

e) Patient J.C. Patient J.C.'s diagnosis was unknown. Between May 15, 2009 and January 3, 2012, Patient J.C. saw 8 different prescribers and went to 9 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 15, 2009, Patient J.C. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg, Methadone 10 mg, and clonazepam 2 mg. Patient J.C. resided in Solvang and traveled approximately 36 miles to see Dr. Diaz. Patient J.C. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

f) Patient M.C. Patient M.C.'s diagnosis was unknown. Between April 7, 2009 and January 8, 2013, Patient J.C. saw 8 different prescribers and went to 6 different pharmacies,

including Respondent Pharmacy. Between January 1, 2009 and April 7, 2009, Patient A.B. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medication: Oxycodone 80 mg. Between January 1, 2009 and May 8, 2009, Patient A.B. received no anxiety medication. Then Dr. Diaz prescribed the following high dosage medication: Alprazolam 2 mg (and later Lorazepam 2 mg). Respondent Pharmacy dispensed RX #1184620 Oxycontin 60 mg (22 day supply) and RX #1184646 Oxycontin 80 mg (22 day supply) on November 25, 2011 prescribed by Dr. Diaz. The directions were to take the mediation 2-3 times daily when the recommended dosage is twice daily. Patient M.C. utilized insurance to pay for his medication but paid cash, including $312 for morphine, $415 for Oxycontin, and $259 for hydromorphone, when insurance did not cover his medications.

g) Patient C.D. Patient C.D.'s diagnosis was unknown. Between April 19, 2009 and January 14, 2013, Patient C.D. went to 8 different prescribers and 9 different pharmacies, including Respondent Pharmacy. Patient C.D. utilized insurance to pay for her medications but paid cash when insurance did not cover her medications.

h) Patient J.H. Patient J.H. was diagnosed with migraine headaches. Between February 13, 2009 and December 28, 2011, Patient J.H. went to 4 different prescribers and 13 different pharmacies, including Respondent Pharmacy. He went to 5 other pharmacies while going to Respondent Pharmacy. On August 3, 2011, Patient J.H. received RX #4487887, 240 tablets of HC/AP 10-325 (30 day supply) from Walmart #1989 and on August 18, 2011, he received RX #1178320, 240 tablets of HC/AP 10-325 (30 day supply) at Respondent Pharmacy. Both prescriptions were prescribed by Dr. Diaz. A review of PARs would have caught this excessive prescribing. Patient J.H. resided in Santa Maria and traveled approximately 62 miles to see Dr. Diaz. Patient J.H. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

i) Patient A.J. Patient A.J. was diagnosed with arthritis. Between January 19, 2009 and December 14, 2012, Patient A.J. saw 2 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Patient A.J. resided in Santa Ynez and travelled

approximately 34 miles to see Dr. Diaz. Patient A.J. received early fills for Methadone and Oxycodone all prescribed by Dr. Diaz:

- On March 31, 2010, Patient A.J. received Methadone 10 mg (30 day supply) from Goleta Valley Pharmacy, on April 21, 2010, she received Methadone 10 mg (30 day supply) from LM Caldwell Pharmacist, and on May 10, 2010, she received RX #1148455, Methadone 10 mg (30 day supply) from Respondent Pharmacy.
- On May 21, 2010, Patient A.J. received RX #1149465, 240 tablets of Oxycodone 30 mg (30 day supply) from Respondent Pharmacy and on June 7, 2010, she received 200 tablets of Oxycodone (25 day supply) from Goleta Valley Pharmacy.

Had Respondent Pharmacy checked PARs it would have caught this excessive prescribing. Patient A.J. utilized insurance to pay for her medications but paid cash, including up to $660 for Oxycontin, when insurance did not cover her medications.

j) Patient G.L. Patient G.J. was diagnosed with chronic pain, multiple disc degeneration, and a pinched nerve. Between February 4, 2009 and January 10, 2013, Patient G.L. saw 14 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. Patient G.L. engaged in both doctor and pharmacy shopping while he had his prescriptions filled at Respondent Pharmacy. In 2009 and 2010, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed, HC/AP 10-325 and HC/AP 10-500 around the same time. This excessive prescribing and dispensing caused Patient G.J. to receive an excessive amount of Acetaminophen. Also, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed Opana ER and Oxycodone at the same time. Both medications are long lasting and the normal practice is to dispense one or the other, but not both. Patient G.J. utilized insurance to pay for his medications but paid cash, including $2,305 for Fentanyl OT and $202 for Alprazolam (the cost to Respondent Pharmacy was $10.82), when insurance did not cover his medications.

k) Patient A.M. Patient A.M. was diagnosed with a cervical lumbar sprain, right foot pain, and pain post trauma. Between January 12, 2009 and November 15, 2011, Patient A.M. saw 4 different prescribers and went to 8 different pharmacies, including Respondent Pharmacy. Patient A.M. engaged in pharmacy shopping while he had his prescriptions filled at

Respondent Pharmacy. A check of PARs would have reveals that Patient A.M. was going to multiple pharmacies to obtain and excessive amount of controlled substances prescribed by Dr. Diaz. Patient A.M. resided in Lompoc and traveled approximately 56 miles to see Dr. Diaz. Patient A.M. paid for his medications with cash. Patient A.M. passed away from a drug overdose in November 2011.

l) Patient S.M. Patient S.M.'s diagnosis was unknown. Between April 1, 2009 and November 30, 2012, Patient S.M. saw 8 different prescribers and went to 10 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and April 1, 2009, Patient S.M. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 40 mg and oxy/apap. Between January 1, 2009 and May 26, 2009, Patient S.M.. received no anxiety medication. Then Dr. Diaz prescribed Alprazolam 2 mg. Patient S.M. paid for his medications with cash.

m) Patient W.M. Patient W.M. was an amputee with Chronic Pain Syndrome and Phantom Pain Syndrome. Between February 20, 2009 and January 4, 2013, Patient W.M. saw 11 different prescribers and when to 5 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs it would have noticed that Patient W.M. was a doctor shopper. Patient W.M. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

n) Patient B.P. Patient B.P. was diagnosed with a slipped disc, pinched sciatic nerve, muscle spasm, and anxiety. Between January 1, 2009 and April 16, 2009, Patient B.P. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg and Alprazolam 2 mg. Patient B.P. also received numerous prescriptions for Alprazolam 2 mg prescribed by Dr. Diaz around the same time, which Respondent Pharmacy dispensed:

- On September 4, 2009, Patient B.P. received RX #1129218, 120 tablets (30 supply) and on September 8, 2009, he received RX #1130929, 100 tablets (25 day supply);
- On September 30, 2009, Patient B.P. received RX #1130929, 120 tablets (30 day supply) and on October 5, 2009, he received RX #1132519, 120 tablets (30 day supply);

- On November 23, 2009, Patient B.P. received RX #1130929, 100 tablets (25 day supply), on November 24, 2009 he received RX #1129218, 120 tablets (30 day supply), and on December 1, 2009, he received RX #1136288, 180 tablets (30 day supply);
- On February 24, 2010, Patient B.P. received RX #1136288, 180 tablets (30 day supply) and RX #1142355, 180 tablets (30 day supply); and
- On September 17, 2011, Patient B.P. received RX #1173125, 180 tablets (30 day supply) and RX #1178161, 180 tablets (30 day supply), and on September 23, 2011, Patient B.P. received RX #1178161, 180 tablets (30 day supply).

Patient B.P. paid for his medications with cash.

o) Patient J.P. Patient J.P's diagnosis was unknown. Patient J.P. utilized insurance to pay for his medications but paid cash, including $620 for morphine when insurance did not cover his medications.

p) Patient J.R. Patient J.R.'s diagnosis was unknown. Between March 1, 2009 and December 27, 2012, Patient J.R. saw 12 different prescribers and went to 16 different pharmacies, including Respondent Pharmacy. Patient J.R. engaged in pharmacy shopping while getting his prescriptions filled at Respondent Pharmacy. Had Respondent Pharmacy checked PARs, it would have noticed this practice. Dr. Diaz prescribed Opana ER to Patient J.R. to take the mediation every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1177927 on August 15, 2011 and RX #1179557 on September 9, 2011. Patient J.R. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

q) Patient J.S. (DOB 9/2/86) Patient J.S was diagnosed with knee and back pain, retinacular capsular trauma, fibromyalgia, and spondylosis. Between October 21, 2009 and July 28, 2012, Patient J.S. saw 5 different prescribers and three different pharmacies. Between January 1, 2009 and October 23, 2009, Patient J.S. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: oxycodone 30 mg, Hydromorphone, and Alprazolam 2 mg. J.S. resided in Solvang and travelled approximately 34.5 miles to see Dr. Diaz. Patient J.S. utilized insurance to pay for his

medications but paid cash, including $391 for oxycodone when insurance did not cover his medications.

r) Patient J.S. (DOB 7/16/77) Patient J.S.'s diagnosis was unknown. Patient J.S. resided in Lompoc and traveled approximately 58 miles to see Dr. Diaz. Dr. Diaz began Patient J.S.'s treatment with oxycodone 30 mg, Opana ER 20 mg, Diazepam 10 mg, and Lorazepam 2 mg. The latter two drugs, Diazepam and Lorazepam, are both in the same class and are not to be prescribed together. This should have raised a red flag for Respondent Pharmacy. Dr. Diaz prescribed Opana ER to Patient J.S. and instructed her to take the medication every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1182433 on October 24, 2011 and RX #1186298 on December 19, 2011. Patient J.S. paid for her medications with insurance.

s) Patient R.S. Patient R.S. was diagnosed with multiple injuries and trauma. Between January 3, 2009 and June 22, 2012, Patient R.S. saw 12 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have noticed that Patient R.S. was a doctor and pharmacy shopper. Dr. Diaz prescribed Oxycontin 80 mg to Patient R.S. and instructed him to take the medication every 6 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1157030 on September 21, 2010 and RX #1158402 on October 14, 2010. Dr. Diaz also prescribed Opana ER 80 mg to Patient R.S. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Opana ER and Oxycontin are both long acting narcotic pain killers and are not commonly prescribed together. This should have been a red flag for Respondent Pharmacy. Respondent Pharmacy dispensed this prescription as RX #1158399 on October 14, 2010. R.S. resided in Lompoc at the same location as Patient J.S. (DOB 7/16/77) and travelled approximately 58 miles to see Dr. Diaz. Patient R.S. paid for his medications with insurance.

t) Patient E.T. Patient E.T. was a right leg amputee diagnosed with phantom pain, left leg radicular pain, and a left foot fracture. Between June 20, 2011 and December 11, 2012, Patient E.T. saw 10 different prescribers and went to 4 different pharmacies, including

Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have discovered that Patient E.T. was a doctor shopper. Between January 1, 2009 and June 20, 2011, Patient E.T. received no controlled substance pain killers or anxiety medication. Then, on July 6, 2011, Dr. Diaz prescribed the following high dosage medications at the same time: methadone 10 mg, oxycodone 30 mg, Hydromorphone 8 mg, Opana ER 40 mg, morphine 100 mg, and Diazepam 10 mg. Dr. Diaz prescribed Opana ER 80 mg to Patient E.T. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1175540 on July 6, 2011, RX #1177255 on August 3, 2011, and RX #1180758 on September 28, 2011. Patient E.T. utilized insurance to pay for his medications but paid cash, including $179 for HC/AP (the cost to Respondent Pharmacy was $39.22), when insurance did not cover his medications.

u) Patient C.W. Patient C.W was diagnosed with pain, anxiety, and Attention Deficit Disorder. Patient C.W. received numerous prescriptions for HC/AP from Dr. Diaz around the same time and had them dispensed at multiple pharmacies:

- Patient C.W. filled RX #1125098, 10-325 mg, 100 tablets (25 day supply) on May 30, 2009, she filled RX #1123636, 10-500 mg, 180 tablets (22 day supply) on June 2, 2009, and she filled RX #1125367, 7.5-750 mg, 120 tablets (30 supply) on June 3, 2009 all at Respondent Pharmacy.
- Patient C.W. filled a prescription for 7.5-750 mg, 180 tablets (30 day supply) at CVS on December 16, 2009 and then filled RX #1130383, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on December 29, 2009.
- Patient C.W. filled a prescription for 7.5-750 mg, 120 tablets (30 supply) at CVS on March 17, 2010 and then filled RX #1144415, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on March 23, 2010.
- Patient C.W. filled a prescription for 7.5-750 mg, 150 tablets (30 supply) at CVS on April 11, 2010, then filled RX #1145891, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on April 13, 2010.

- Patient C.W. filled RX #1176959, 120 tablets, 10-325 mg (30 day supply) and RX #1176962, 120 tablets, 7.5-750 mg (30 day supply) on August 13, 2011 at Respondent Pharmacy.

On February 11, 2010, Respondent Pharmacy dispensed both Clonazepam (RX #1141456) and Lorazepam (RX #1141458) – prescribed by Dr. Diaz – to Patient C.W. These medications are in the same classification and would not normally be prescribed together. On July 28, 2011, Dr. Diaz prescribed both HC/AP 10-325 and HC/AP 7.5-750 on the same prescription. Respondent Pharmacy dispensed both medications (RX #1176962 and RX #1176965) on August 13, 2011. Patient C.W. utilized insurance to pay for her medications but paid cash, including $54.90 HC/AP (the cost to Respondent Pharmacy was $4.40), when insurance did not cover her medications.

33. Patient M.M.[3] Between January 2, 2009 and January 23, 2013, Patient M.M. saw 18 different prescribers and went to 20 different pharmacies, including Respondent Pharmacy. Patient M.M. engaged in both doctor and pharmacy shopping while she had her prescriptions filled at Respondent Pharmacy. Prior to getting prescriptions filled at Respondent Pharmacy, Patient M.M. received numerous prescriptions for Oxycontin from Dr. Diaz and went to different pharmacies to get them dispensed. Had Respondent Pharmacy checked PARs, it would have noticed this obvious pharmacy shopping. Patient M.M. resided in Lompoc and travelled approximately 56 miles to see Dr. Diaz. Patient M.M. utilized insurance to pay for her medications but paid cash, including up to $1,806 and $2,703 for Oxycontin, when insurance did not cover her medications.

34. A detailed review of the 21 patients of Respondent selected for the profile revealed a pattern of early refills of prescriptions as to 11 patients for Dr. Diaz (Patients T.B., K.B., M.C., C.D., J.H., G.L., B.P., J.R., R.S., E.T. and C.W.), as described in the following table:

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|

[3] No patient questionnaire was sent to Patient M.M. but the Board Inspector did gather CURES data, mileage data, prescription hard copies, and other relevant data regarding this patient.

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TB | 01/07/10 | 1138630 | 120 | 30 | Diaz | 01/27/10 | 1140103 | 120 | 30 | Diaz | 6 |
| TB | 01/07/10 | 1138631 | 180 | 30 | Diaz | 01/30/10 | 1140471 | 180 | 30 | Diaz | 6 |
| TB | 01/30/10 | 1140471 | 180 | 30 | Diaz | 02/22/10 | 1142175 | 180 | 30 | Diaz | 7 |
| TB | 02/22/10 | 1142175 | 180 | 30 | Diaz | 03/18/10 | 1143889 | 180 | 30 | Diaz | 6 |
| TB | 04/15/10 | 1145415 | 180 | 30 | Diaz | 05/07/10 | 1147810 | 180 | 30 | Diaz | 8 |
| TB | 08/30/10 | 1155489 | 180 | 30 | Diaz | 09/22/10 | 1156903 | 180 | 30 | Diaz | 7 |
| TB | 06/28/11 | 1174094 | 10 | 30 | Diaz | 07/21/11 | 1175838 | 10 | 30 | Diaz | 7 |
| TB | 06/28/11 | 1174108 | 60 | 30 | Diaz | 07/21/11 | 1176076 | 60 | 30 | Diaz | 7 |
| TB | 07/21/11 | 1176076 | 60 | 30 | Diaz | 08/15/11 | 1177205 | 60 | 30 | Diaz | 5 |
| TB | 08/09/11 | 1177643 | 180 | 30 | Diaz | 09/02/11 | 1179184 | 180 | 30 | Diaz | 6 |
| KB | 04/29/10 | 1147574 | 240 | 30 | Diaz | 05/20/10 | 1149406 | 240 | 30 | Diaz | 9 |
| KB | 04/29/10 | 1145017 | 240 | 30 | Diaz | 05/24/10 | 1145017 | 240 | 30 | Diaz | 5 |
| KB | 08/30/10 | 1152434 | 240 | 30 | Diaz | 09/24/10 | 1152434 | 240 | 30 | Diaz | 5 |
| MC | 06/21/11 | 1174708 | 160 | 40 | Diaz | 07/08/11 | 1175758 | 90 | 30 | Diaz | 23 |
| MC | 06/21/11 | 1174707 | 180 | 30 | Diaz | 07/08/11 | 1175757 | 120 | 30 | Diaz | 13 |
| MC | 06/30/11 | 1174710 | 120 | 30 | Diaz | 07/21/11 | 1176496 | 120 | 30 | Diaz | 9 |
| CD | 06/23/11 | 1174893 | 120 | 30 | Diaz | 07/18/11 | 1174893 | 120 | 30 | Diaz | 5 |
| JH | 08/18/11 | 1178318 | 90 | 30 | Diaz | 09/02/11 | 1178318 | 90 | 30 | Diaz | 15 |
| GL | 02/15/10 | 1141621 | 240 | 30 | Diaz | 03/10/10 | 1143429 | 240 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141624 | 240 | 30 | Diaz | 03/10/10 | 1143422 | 240 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141623 | 360 | 30 | Diaz | 03/10/10 | 1143428 | 360 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141616 | 60 | 30 | Diaz | 03/10/10 | 1143425 | 60 | 30 | Diaz | 7 |
| GL | 04/06/10 | 1145332 | 120 | 30 | Diaz | 04/29/10 | 1143423 | 120 | 30 | Diaz | 7 |
| GL | 04/06/10 | 1145336 | 240 | 30 | Diaz | 04/29/10 | 1145336 | 240 | 30 | Diaz | 7 |
| GL | 04/16/10 | 1146454 | 240 | 30 | Diaz | 05/10/10 | 1148175 | 240 | 30 | Diaz | 6 |
| GL | 04/29/10 | 1143423 | 120 | 30 | Diaz | 05/24/10 | 1148172 | 120 | 30 | Diaz | 5 |
| GL | 04/29/10 | 1145336 | 240 | 30 | Diaz | 05/24/10 | 1145336 | 240 | 30 | Diaz | 5 |
| GL | 06/22/11 | 1174785 | 120 | 30 | Diaz | 07/15/11 | 1172951 | 120 | 30 | Diaz | 7 |
| GL | 11/28/11 | 1183585 | 300 | 25 | Diaz | 12/17/11 | 1185523 | 300 | 25 | Diaz | 6 |

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GL | 12/07/11 | 1185524 | 180 | 30 | Diaz | 12/30/11 | 1186912 | 180 | 30 | Diaz | 6 |
| MM | 07/22/11 | 1176580 | 240 | 30 | Diaz | 08/16/11 | 1178046 | 240 | 30 | Diaz | 5 |
| MM | 07/22/11 | 1176579 | 120 | 30 | Diaz | 08/16/11 | 1178047 | 120 | 30 | Diaz | 5 |
| MM | 08/18/11 | 1176387 | 240 | 30 | Diaz | 09/12/11 | 1176387 | 240 | 30 | Diaz | 5 |
| MM | 12/03/11 | 1185275 | 15 | 30 | Diaz | 12/28/11 | 1186952 | 15 | 30 | Diaz | 5 |
| MM | 12/03/11 | 1185274 | 120 | 30 | Diaz | 12/28/11 | 1186953 | 120 | 30 | Diaz | 5 |
| BP | 02/24/10 | 1136288 | 180 | 30 | Diaz | 02/24/10 | 1142325 | 180 | 30 | Diaz | 30 |
| BP | 02/24/10 | 1142325 | 180 | 30 | Diaz | 03/20/10 | 1136288 | 180 | 30 | Diaz | 6 |
| BP | 03/24/10 | 1144472 | 240 | 30 | Diaz | 04/02/10 | 1145097 | 140 | 17 | Diaz | 21 |
| BP | 03/20/10 | 1136288 | 180 | 30 | Diaz | 04/12/10 | 1142325 | 180 | 30 | Diaz | 7 |
| BP | 04/12/10 | 1142325 | 180 | 30 | Diaz | 04/29/10 | 1147582 | 180 | 30 | Diaz | 13 |
| BP | 04/29/10 | 1147582 | 180 | 30 | Diaz | 05/11/10 | 1142325 | 180 | 30 | Diaz | 18 |
| BP | 09/13/10 | 1154202 | 180 | 30 | Diaz | 10/08/10 | 1154202 | 180 | 30 | Diaz | 5 |
| BP | 09/17/11 | 1173125 | 180 | 30 | Diaz | 09/23/11 | 1178161 | 180 | 30 | Diaz | 24 |
| BP | 09/14/11 | 1179896 | 300 | 25 | Diaz | 09/23/11 | 1180520 | 270 | 30 | Diaz | 16 |
| BP | 09/14/11 | 1179895 | 360 | 30 | Diaz | 09/23/11 | 1180519 | 360 | 30 | Diaz | 21 |
| JR | 06/27/11 | 1175073 | 30 | 30 | Diaz | 07/18/11 | 1176291 | 30 | 30 | Diaz | 9 |
| JR | 08/15/11 | 1177927 | 90 | 30 | Diaz | 09/09/11 | 1179557 | 90 | 30 | Diaz | 5 |
| JS | 09/04/10 | 1156516 | 90 | 30 | Diaz | 10/07/10 | 1156516 | 90 | 30 | Diaz | 7 |
| JR | 07/19/11 | 1174816 | 90 | 30 | Diaz | 08/13/11 | 1174816 | 90 | 30 | Diaz | 5 |
| JR | 08/13/11 | 1174816 | 90 | 30 | Diaz | 09/07/11 | 1174816 | 90 | 30 | Diaz | 5 |
| RS | 06/28/11 | 1175121 | 300 | 30 | Diaz | 07/22/11 | 1176613 | 240 | 30 | Diaz | 6 |
| RS | 06/28/11 | 1175116 | 600 | 30 | Diaz | 07/22/11 | 1176610 | 600 | 30 | Diaz | 6 |
| RS | 06/28/11 | 1175113 | 120 | 30 | Diaz | 07/22/11 | 1176615 | 120 | 30 | Diaz | 6 |
| ET | 06/20/11 | 1173573 | 240 | 30 | Diaz | 07/13/11 | 1169455 | 240 | 30 | Diaz | 7 |
| ET | 12/27/11 | 1175542 | 240 | 30 | Diaz | 12/27/11 | 1175542 | 240 | 30 | Diaz | 6 |
| CW | 12/29/09 | 1130383 | 120 | 30 | Diaz | 01/20/10 | 1130383 | 120 | 30 | Diaz | 8 |
| CW | 01/19/10 | 1126967 | 60 | 30 | Diaz | 02/11/10 | 1141458 | 60 | 30 | Diaz | 7 |
| CW | 03/23/10 | 1144415 | 120 | 30 | Diaz | 04/13/10 | 1145891 | 120 | 30 | Diaz | 9 |

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CW | 04/13/10 | 1144415 | 120 | 30 | Diaz | 05/06/10 | 1144415 | 120 | 30 | Diaz | 7 |
| CW | 09/08/10 | 1154679 | 120 | 30 | Diaz | 10/01/10 | 1154679 | 120 | 30 | Diaz | 7 |

35. The table above compares the original prescription number on the left with the refilled prescription number on the right. The final column on the right shows the number of days early that the prescription was refilled, based on the number of days supply for the original prescription. This shows a consistent pattern of early refills of prescriptions for Dr. Diaz patients.

36. A review of the CURES data for Respondent Pharmacy shows that between January 1, 2011 and December 5, 2012, Respondent Pharmacy dispensed a total of 10,436 controlled substance prescriptions. Of these prescriptions, 12.99% of them, or 1,356, were controlled substance prescriptions from Dr. Diaz, despite not being one of the pharmacies adjacent to Dr. Diaz's medical office. When compared to three other pharmacies in the area (Federal Drugs PHY 37078 – 1.92 miles from Respondent Pharmacy, Rite Aid 5789 – 0.65 miles from Respondent Pharmacy, and CVS PHY 49473 – 0.41 miles from Respondent Pharmacy), Respondent Pharmacy dispensed an exponentially disproportionate number of Dr. Diaz's controlled substance prescriptions. In fact, of the neighboring pharmacies sampled, neither Federal Drugs nor Rite Aid dispensed any of Dr. Diaz's controlled substance prescriptions and CVS only dispensed 44 of his controlled substance prescriptions.

37. A review of CURES data for Respondent Pharmacy showed that between January 1, 2011 and December 5, 2012, Dr. Diaz had a clear pattern of prescribing controlled substances. His pattern was to prescribe Hydromorphone, HC/AP, Oxycontin, Oxycodone, Morphine, Opana ER, Fentanyl, Alprazolam, Methadone, Diazepam, Clonazepam, Lorazepam, and/or Oxy/Ap in large and redundant quantities and in questionable combinations. Nevertheless, Respondent Pharmacy filled prescriptions from Dr. Diaz's patients.

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## SECOND CAUSE FOR DISCIPLINE

**(Records of Acquisition and Disposition)**

38. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with Code section 4081 and Code section 4105, subdivision (a), on the grounds of unprofessional conduct in that Respondents were unable to account for the records of sale, acquisition, and/or disposition of dangerous drugs for at least three years from the date of making. Respondent Pharmacy could not account for prescription hard copies for the following prescriptions: RX #1152434, RX #1187257, RX #1184958, RX #1136283, RX #1183085, RX #1185522, RX #1185523, and RX #1171890.

## THIRD CAUSE FOR DISCIPLINE

**(Erroneous or Uncertain Prescriptions)**

39. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct in that between January 1, 2010 and January 15, 2013, Respondent dispensed prescriptions which contained significant errors, omissions, irregularities, uncertainties, ambiguities, or alterations. The facts and circumstances are as follows:

40. The following hard copy prescriptions had suspicious or no dates: (1) RX #1182583 was dated 10/7/68. The date was nonsensical. (2) RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have dates.

41. The following prescriptions were dispensed prior to the dates written on the prescriptions:

a) The hard copy of the prescription for RX #1176498 was dated July 22, 2011, but the prescription itself was dispensed on July 21, 2011.

b) The hardcopy of the prescription for RX #1156765 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

c) The hardcopy of the prescription for RX #1156766 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

d) The hardcopy of the prescription for RX #1156769 was dated September 18, 2011 but the prescription itself was dispensed on September 17, 2010.

e) The hardcopy of the prescription for RX #1175775 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

f) The hardcopy of the prescription for RX #1175776 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

g) The hardcopy of the prescription for RX #1175777 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

h) The hardcopy of the prescription for RX #1179567 was dated September 14, 2011 but the prescription itself was dispensed on September 9, 2011.

i) The hardcopy of the prescription for RX #1179202 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

j) The hardcopy of the prescription for RX #1179203 was dated October 1, 2011, but the prescription itself was dispensed on September 2, 2011.

k) The hardcopy of the prescription for RX # 1179204 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

42. The following prescriptions were dispensed without a signature from the prescriber: RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have Dr. Diaz's signature.

**OTHER MATTERS**

43. Pursuant to Code Section 4307, if discipline is imposed on Pharmacy Permit Number PHY 49809 issued to The Medicine Shoppe, The Medicine Shoppe shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 49809 is placed on probation or until Pharmacy Permit Number PHY 49809 is reinstated if it is revoked.

44. Pursuant to Code section 4307, if discipline is imposed on Pharmacy permit Number 49809 issued to The Medicine Shoppe while Sanjiv Bhalla has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined,

Sanjiv Bhalla shall be prohibited from serving as manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy permit Number PHY 49809 is placed on probation or until Pharmacy Permit Number PHY 49809 is reinstated if it is revoked.

**PRAYER**

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

1. Revoking or suspending Pharmacy Permit Number PHY 49809, issued to The Medicine Shoppe with Sanjiv Bhalla as the Pharmacist-In-Charge;

2. Revoking or suspending Pharmacist License Number RPH 46064, issued to Sanjiv Bhalla; and

3. Prohibiting The Medicine Shoppe from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 49809 is placed on probation or until Pharmacy permit Number PHY 49809 is reinstated if Pharmacy permit Number 49809 issued to The Medicine Shoppe is revoked;

4. Prohibiting Sanjiv Bhalla from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 49809 is placed on probation or until Pharmacy permit Number PHY 49809 is reinstated if Pharmacy Permit Number 49809 issued to The Medicine Shoppe is revoked;

5. Ordering The Medicine Shoppe and Sanjiv Bhalla 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;

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

DATED: 1/31/17 Virginia Herold

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

LA2014512773

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**THE MEDICINE SHOPPE; SANJIV BHALLA**<br>**1435 State Street**<br>**Santa Barbara, CA 93101**<br><br>**Pharmacy Permit No. PHY 49809,**<br><br>**and**<br><br>**SANJIV BHALLA**<br>**1250 La Venta Dr. #114**<br>**Westlake Village, CA 91361**<br><br>**Pharmacist License No. RPH 46064**<br><br>Respondent. | Case No. 5251<br><br>**A C C U S A T I O N** |

Complainant alleges:

## PARTIES

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

2. On or about February 17, 2009, the Board of Pharmacy issued Pharmacy Permit Number PHY 49809 to The Medicine Shoppe with Sanjiv Bhalla as Pharmacist-In-Charge ("Respondent Pharmacy"). The Pharmacy Permit is cancelled, expired on February 1, 2014, and has not been renewed.

3. On or about March 15, 1993, the Board of Pharmacy issued Pharmacist License Number RPH 46064 to Sanjiv Bhalla ("Respondent Bhalla"). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, unless renewed.

## JURISDICTION

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

5. Section 4300 of the Code states, in pertinent part:

"(a) Every license issued may be suspended or revoked.

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding one year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper."

6. Section 4300.1 of the Code states:

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

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## STATUTES AND REGULATIONS

7. Section 4301 of the Code states, in pertinent part:

"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:

. . . .

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

. . . .

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

. . . .

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

8. Section 4081, subdivision (a) of the Code states:

"(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, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, 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."

9. Section 4105, of the Code states, in pertinent part:

"(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.

. . . .

(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."

10. Health and Safety Code section 11153, subdivision (a), states:

"(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."

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

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

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

**COST RECOVERY**

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

## CONTROLLED SUBSTANCES[1]

13. Alprazolam, the generic name for Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1). Alprazolam is a depressant used to treat anxiety and is a popular member of a class of drugs called "benzodiazepines," which is a general name for any group of psychotropic agents used as anti-anxiety agents, muscle relaxants, sedatives, and hypnotics.

14. Clonazepam, the generic name for Klonopin, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7). Clonazepam treats seizures, panic disorder, and anxiety and belongs to the class of drugs called "benzodiazepines."

15. Diazepam, a generic name for Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9). Diazepam treats anxiety, muscle spasms, seizures, and belongs to the class of drugs called "benzodiazepines."

16. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8). Fentanyl is a narcotic opioid used to treat moderate to severe chronic pain.

17. The combination of Hydrocodone/Acetaminophen ("HC/AP") is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4). Hydrocodone is an opioid pain reliever that is subject to abuse because of the euphoric feeling it induces.

18. Lorazepam, the generic name for Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16). Lorazepam is used to

[1] All of the controlled substances listed are also dangerous drugs pursuant to Code section 4022.

treat anxiety, anxiety with depression, and insomnia and belongs to the class of drugs called "benzodiazepines."

19. Hydromorphone, the generic name for Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J). Hydromorphone is a narcotic opioid that is used to treat moderate to severe pain.

20. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14). Methadone treats moderate to severe pain and when used together with medical supervision and counseling is used for the treatment of narcotic drug addiction.

21. Opana ER, a brand name for Oxymorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N). Oxymorphone is a narcotic opioid that is used to treat moderate to severe pain.

22. Oxycodone, a generic name for Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxycodone is a narcotic opioid that is used to treat moderate to severe pain.

23. Percocet, a brand name for the combination of Oxycodone and Acetaminophen ("Oxy/Ap"), is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxy/Ap is a narcotic opioid that is used to treat moderate to moderately severe pain.

**BOARD INVESTIGATION**

24. Beginning in January 2013, the Board conducted an investigation into Respondent Pharmacy. The Board was alerted that Julio Diaz, M.D., a general practitioner with secondary practices in geriatrics and pathology, who had a medical practice in Santa Barbara, was arrested for trafficking narcotics. Respondent Pharmacy dispensed many controlled substances that Dr. Diaz prescribed.

25. On January 15, 2013, two Board Inspectors conducted an inspection of Respondent Pharmacy. When questioned about Dr. Diaz's prescriptions, Respondent Bhalla initially

responded that he did not know if Dr. Diaz was a pain specialist but stated that he checked the prescriptions by calling the doctor's office and writing the diagnosis code on the prescriptions.

26. The Board Inspectors selected 21 patients to profile and asked Respondent Bhalla to complete questionnaires regarding the patients. Amongst the questions asked were the patients' diagnoses, the methods of payment, and the nature of prescriber's practice. All of the patients were Dr. Diaz's patients and Respondent Bhalla indicated that Dr. Diaz had a general practice.

27. The Board Inspectors requested CURES[2] data for Respondent Pharmacy from January 1, 2011 to December 5, 2012 and CURES Patient Activity Reports ("PARs") for the 21 selected patients from January 1, 2009 to January 28, 2013.

28. On October 4, 2012, the Medical Board of California revoked Dr. Diaz's license to practice medicine, in the case entitled *In the Matter of the Accusation Against Otero Julio Gabriel Diaz, M.D.*, case no. 06-2010-209660. Dr. Diaz's license was revoked for gross negligence, incompetence, and excessive prescribing of narcotic medications to a patient.

## FIRST CAUSE FOR DISCIPLINE

**(Corresponding Responsibility)**

29. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivisions (d), Code section 4301, subdivision (j) for violating Health and Safety Code section 11153, subdivision (a), and Code section 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1761, in that between January 1, 2011 and December 5, 2012, Respondents failed to assume their corresponding responsibility by failing to validate the legitimacy of prescriptions dispensed and/or by failing to review patients' drug therapy and thus dispensing prescriptions to physician shoppers or habitual users. The circumstances, which include by reference Paragraphs 24 through 28, are as follows:

[2] All prescription drug history information is maintained in the California Controlled Substance Utilization Review and Evaluation System, or CURES, a database. This CURES database includes information about the drug dispensed, drug quantity and strength, patient name, address, prescriber name, and authorization number including DEA number or prescription number.

30. For the 21 patients that the Board Inspectors selected to profile, there were many irregularities found with the prescriptions and dispensing methods, including: (1) no diagnosis for many patients; (2) a general practitioner that was prescribing an excessive amount of narcotics; (3) many patients that came to Respondent Pharmacy outside of the normal trading area, which is considered to be 5 miles from the patient's residence or adjacent to the prescriber's office; (4) consistent early fills of controlled substance prescriptions; (5) patients paying cash for expensive narcotics; (6) no verification in CURES Patient Activity Reports (PARs) for suspicious prescriptions; (7) evidence of doctor/pharmacy shopping; and (8) evidence of a pattern of prescribing controlled substances in large and redundant quantities and in questionable combinations.

31. A detailed review of the 21 patients reveals the following results:

a) Patient T.B. Patient T.B. was diagnosed with cervical myositis pain and Chronic Pain Syndrome. Between January 1, 2009 and January 1, 2013, Patient T.B. saw 4 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. On several occasions (January 5, 2010, January 25, 2010, February 19, 2010, April 7, 2010, August 27, 2010, September 17, 2011, and December 16, 2011) Patient T.B. received 2 hard copy prescriptions from Dr. Diaz for Percocet with the same date. This should have been a red flag for the pharmacy. Respondent Pharmacy dispensed RX #1178784 for Fentanyl patches every 48 prescribed by Dr. Diaz. The recommended dosage is every 72 hours. Patient T.B. utilized insurance to pay for her medications but paid cash, including $1,298.90 for Opana and $732.90 for Fentanyl, when insurance did not cover her medications.

b) Patient D.B. Patient D.B. was diagnosed with degenerative chronic disease of the cervical spine. Between January 20, 2009 and January 3, 2013, Patient D.B. saw 5 different prescribers and went to 4 different pharmacies, including Respondent Pharmacy. Prior to seeing Dr. Diaz, Patient D.B. received HC/AP 10-325 monthly for approximately 1 year. Dr. Diaz prescribed hydromorphone 8 mg and morphine 60 mg. Dr. Diaz also prescribed buprenorphine 8 mg (which is commonly used to treat opiate addiction.) After Patient D.B. stopped seeing Dr. Diaz, Patient D.B. received morphine but the strength was much smaller. Patient D.B. utilized

insurance to pay for his medications but paid cash, including $202.90 for Alprazolam, when insurance did not cover his medications.

c) Patient K.B. Patient K.B. was diagnosed with lumbar reticulopathy and spondylosis. Between March 31, 2009 and December 4, 2012, Patient K.B. saw 5 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and March 31, 2009, Patient K.B. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: HC/AP 10-325, Methadone 10 mg, and Alprazolam 2 mg. Patient K.B. also received numerous HC/AP 10-325 prescriptions from Dr. Diaz and had them dispensed at multiple pharmacies on or around the same time:

- On April 30, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply from Respondent Pharmacy and on May 8, 2009 he received 240 tablets (40 day supply from LM Caldwell Pharmacist.
- On May 28, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply) from Respondent Pharmacy and 240 tablets (40 day supply) from Walgreens. On June 4, 2009, he received 240 tablets (40 day supply) from LM Caldwell Pharmacist.
- On July 23, 2009, Patient K.B. received RX #1128237, 240 tablets (30 day supply) the Respondent Pharmacy and on July 28, 2009, he received 240 tablets (30 day supply) from Walgreens.
- On August 21, 2009, Patient K.B. received RX #1129966, 240 tablets (30 day supply) from Respondent Pharmacy and on August 28, 2009, he received 240 tablets (30 day supply) from Walgreens.

Had Respondent Pharmacy utilized PARs, it would have discovered the excessive dispensing. Patient K.B. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

d) Patient A.B. Patient A.B.'s diagnosis was unknown. Between May 21, 2009 and January 24, 2012, Patient A.B. saw 3 prescribers and went to 7 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 21, 2009, Patient A.B. received no

controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Fentanyl patch and Alprazolam 2 mg. Respondent Pharmacy dispensed RX #1175222 on June 29, 2011, RX #1178791 on August 26, 2011, and RX #1180528 on September 27, 2009 all prescribed by Dr. Diaz for Opana ER three times a day when the recommended dose is two times a day. Patient A.B. utilized insurance to pay for his medications but paid cash, including $828.90 and $421.95 for Opana and over $250 for Oxycodone and Adderall XR, when insurance did not cover his medications.

e) Patient J.C. Patient J.C.'s diagnosis was unknown. Between May 15, 2009 and January 3, 2012, Patient J.C. saw 8 different prescribers and went to 9 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 15, 2009, Patient J.C. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg, Methadone 10 mg, and clonazepam 2 mg. Patient J.C. resided in Solvang and traveled approximately 36 miles to see Dr. Diaz. Patient J.C. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

f) Patient M.C. Patient M.C.'s diagnosis was unknown. Between April 7, 2009 and January 8, 2013, Patient J.C. saw 8 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and April 7, 2009, Patient A.B. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medication: Oxycodone 80 mg. Between January 1, 2009 and May 8, 2009, Patient A.B. received no anxiety medication. Then Dr. Diaz prescribed the following high dosage medication: Alprazolam 2 mg (and later Lorazepam 2 mg). Respondent Pharmacy dispensed RX #1184620 Oxycontin 60 mg (22 day supply) and RX #1184646 Oxycontin 80 mg (22 day supply) on November 25, 2011 prescribed by Dr. Diaz. The directions were to take the mediation 2-3 times daily when the recommended dosage is twice daily. Patient M.C. utilized insurance to pay for his medication but paid cash, including $312 for morphine, $415 for Oxycontin, and $259 for hydromorphone, when insurance did not cover his medications.

g) Patient C.D. Patient C.D.'s diagnosis was unknown. Between April 19, 2009 and January 14, 2013, Patient C.D. went to 8 different prescribers and 9 different pharmacies,

including Respondent Pharmacy. Patient C.D. utilized insurance to pay for her medications but paid cash when insurance did not cover her medications.

h) Patient J.H. Patient J.H. was diagnosed with migraine headaches. Between February 13, 2009 and December 28, 2011, Patient J.H. went to 4 different prescribers and 13 different pharmacies, including Respondent Pharmacy. He went to 5 other pharmacies while going to Respondent Pharmacy. On August 3, 2011, Patient J.H. received RX #4487887, 240 tablets of HC/AP 10-325 (30 day supply) from Walmart #1989 and on August 18, 2011, he received RX #1178320, 240 tablets of HC/AP 10-325 (30 day supply) at Respondent Pharmacy. Both prescriptions were prescribed by Dr. Diaz. A review of PARs would have caught this excessive prescribing. Patient J.H. resided in Santa Maria and traveled approximately 62 miles to see Dr. Diaz. Patient J.H. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

i) Patient A.J. Patient A.J. was diagnosed with arthritis. Between January 19, 2009 and December 14, 2012, Patient A.J. saw 2 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Patient A.J. resided in Santa Ynez and travelled approximately 34 miles to see Dr. Diaz. Patient A.J. received early fills for Methadone and Oxycodone all prescribed by Dr. Diaz:

- On March 31, 2010, Patient A.J. received Methadone 10 mg (30 day supply) from Goleta Valley Pharmacy, on April 21, 2010, she received Methadone 10 mg (30 day supply) from LM Caldwell Pharmacist, and on May 10, 2010, she received RX #1148455, Methadone 10 mg (30 day supply) from Respondent Pharmacy.
- On May 21, 2010, Patient A.J. received RX #1149465, 240 tablets of Oxycodone 30 mg (30 day supply) from Respondent Pharmacy and on June 7, 2010, she received 200 tablets of Oxycodone (25 day supply) from Goleta Valley Pharmacy.

Had Respondent Pharmacy checked PARs it would have caught this excessive prescribing. Patient A.J. utilized insurance to pay for her medications but paid cash, including up to $660 for Oxycontin, when insurance did not cover her medications.

j) Patient G.L. Patient G.J. was diagnosed with chronic pain, multiple disc degeneration, and a pinched nerve. Between February 4, 2009 and January 10, 2013, Patient G.L. saw 14 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. Patient G.L. engaged in both doctor and pharmacy shopping while he had his prescriptions filled at Respondent Pharmacy. In 2009 and 2010, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed, HC/AP 10-325 and HC/AP 10-500 around the same time. This excessive prescribing and dispensing caused Patient G.J. to receive an excessive amount of Acetaminophen. Also, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed Opana ER and Oxycodone at the same time. Both medications are long lasting and the normal practice is to dispense one or the other, but not both. Patient G.J. utilized insurance to pay for his medications but paid cash, including $2,305 for Fentanyl OT and $202 for Alprazolam (the cost to Respondent Pharmacy was $10.82), when insurance did not cover his medications.

k) Patient A.M. Patient A.M. was diagnosed with a cervical lumbar sprain, right foot pain, and pain post trauma. Between January 12, 2009 and November 15, 2011, Patient A.M. saw 4 different prescribers and went to 8 different pharmacies, including Respondent Pharmacy. Patient A.M. engaged in pharmacy shopping while he had his prescriptions filled at Respondent Pharmacy. A check of PARs would have reveals that Patient A.M. was going to multiple pharmacies to obtain and excessive amount of controlled substances prescribed by Dr. Diaz. Patient A.M. resided in Lompoc and traveled approximately 56 miles to see Dr. Diaz. Patient A.M. paid for his medications with cash. Patient A.M. passed away from a drug overdose in November 2011.

l) Patient S.M. Patient S.M.'s diagnosis was unknown. Between April 1, 2009 and November 30, 2012, Patient S.M. saw 8 different prescribers and went to 10 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and April 1, 2009, Patient S.M. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 40 mg and oxy/apap. Between January 1, 2009 and May 26, 2009, Patient S.M.. received no anxiety medication. Then Dr. Diaz prescribed Alprazolam 2 mg. Patient S.M. paid for his medications with cash.

m) Patient W.M. Patient W.M. was an amputee with Chronic Pain Syndrome and Phantom Pain Syndrome. Between February 20, 2009 and January 4, 2013, Patient W.M. saw 11 different prescribers and when to 5 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs it would have noticed that Patient W.M. was a doctor shopper. Patient W.M. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

n) Patient B.P. Patient B.P. was diagnosed with a slipped disc, pinched sciatic nerve, muscle spasm, and anxiety. Between January 1, 2009 and April 16, 2009, Patient B.P. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg and Alprazolam 2 mg. Patient B.P. also received numerous prescriptions for Alprazolam 2 mg prescribed by Dr. Diaz around the same time, which Respondent Pharmacy dispensed:

- On September 4, 2009, Patient B.P. received RX #1129218, 120 tablets (30 supply) and on September 8, 2009, he received RX #1130929, 100 tablets (25 day supply);
- On September 30, 2009, Patient B.P. received RX #1130929, 120 tablets (30 day supply) and on October 5, 2009, he received RX #1132519, 120 tablets (30 day supply);
- On November 23, 2009, Patient B.P. received RX #1130929, 100 tablets (25 day supply), on November 24, 2009 he received RX #1129218, 120 tablets (30 day supply), and on December 1, 2009, he received RX #1136288, 180 tablets (30 day supply);
- On February 24, 2010, Patient B.P. received RX #1136288, 180 tablets (30 day supply) and RX #1142355, 180 tablets (30 day supply); and
- On September 17, 2011, Patient B.P. received RX #1173125, 180 tablets (30 day supply) and RX #1178161, 180 tablets (30 day supply), and on September 23, 2011, Patient B.P. received RX #1178161, 180 tablets (30 day supply).

Patient B.P. paid for his medications with cash.

o) Patient J.P. Patient J.P's diagnosis was unknown. Patient J.P. utilized insurance to pay for his medications but paid cash, including $620 for morphine when insurance did not cover his medications.

p) Patient J.R. Patient J.R.'s diagnosis was unknown. Between March 1, 2009 and December 27, 2012, Patient J.R. saw 12 different prescribers and went to 16 different pharmacies, including Respondent Pharmacy. Patient J.R. engaged in pharmacy shopping while getting his prescriptions filled at Respondent Pharmacy. Had Respondent Pharmacy checked PARs, it would have noticed this practice. Dr. Diaz prescribed Opana ER to Patient J.R. to take the mediation every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1177927 on August 15, 2011 and RX #1179557 on September 9, 2011. Patient J.R. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

q) Patient J.S. (DOB 9/2/86) Patient J.S was diagnosed with knee and back pain, retinacular capsular trauma, fibromyalgia, and spondylosis. Between October 21, 2009 and July 28, 2012, Patient J.S. saw 5 different prescribers and three different pharmacies. Between January 1, 2009 and October 23, 2009, Patient J.S. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: oxycodone 30 mg, Hydromorphone, and Alprazolam 2 mg. J.S. resided in Solvang and travelled approximately 34.5 miles to see Dr. Diaz. Patient J.S. utilized insurance to pay for his medications but paid cash, including $391 for oxycodone when insurance did not cover his medications.

r) Patient J.S. (DOB 7/16/77) Patient J.S.'s diagnosis was unknown. Patient J.S. resided in Lompoc and traveled approximately 58 miles to see Dr. Diaz. Dr. Diaz began Patient J.S.'s treatment with oxycodone 30 mg, Opana ER 20 mg, Diazepam 10 mg, and Lorazepam 2 mg. The latter two drugs, Diazepam and Lorazepam, are both in the same class and are not to be prescribed together. This should have raised a red flag for Respondent Pharmacy. Dr. Diaz prescribed Opana ER to Patient J.S. and instructed her to take the medication every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1182433 on October 24, 2011 and RX #1186298 on December 19, 2011. Patient J.S. paid for her medications with insurance.

s) Patient R.S. Patient R.S. was diagnosed with multiple injuries and trauma. Between January 3, 2009 and June 22, 2012, Patient R.S. saw 12 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have noticed that Patient R.S. was a doctor and pharmacy shopper. Dr. Diaz prescribed Oxycontin 80 mg to Patient R.S. and instructed him to take the medication every 6 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1157030 on September 21, 2010 and RX #1158402 on October 14, 2010. Dr. Diaz also prescribed Opana ER 80 mg to Patient R.S. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Opana ER and Oxycontin are both long acting narcotic pain killers and are not commonly prescribed together. This should have been a red flag for Respondent Pharmacy. Respondent Pharmacy dispensed this prescription as RX #1158399 on October 14, 2010. R.S. resided in Lompoc at the same location as Patient J.S. (DOB 7/16/77) and travelled approximately 58 miles to see Dr. Diaz. Patient R.S. paid for his medications with insurance.

t) Patient E.T. Patient E.T. was a right leg amputee diagnosed with phantom pain, left leg radicular pain, and a left foot fracture. Between June 20, 2011 and December 11, 2012, Patient E.T. saw 10 different prescribers and went to 4 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have discovered that Patient E.T. was a doctor shopper. Between January 1, 2009 and June 20, 2011, Patient E.T. received no controlled substance pain killers or anxiety medication. Then, on July 6, 2011, Dr. Diaz prescribed the following high dosage medications at the same time: methadone 10 mg, oxycodone 30 mg, Hydromorphone 8 mg, Opana ER 40 mg, morphine 100 mg, and Diazepam 10 mg. Dr. Diaz prescribed Opana ER 80 mg to Patient E.T. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1175540 on July 6, 2011, RX #1177255 on August 3, 2011, and RX #1180758 on September 28, 2011. Patient E.T. utilized insurance to pay for his medications but paid cash, including $179 for HC/AP (the cost to Respondent Pharmacy was $39.22), when insurance did not cover his medications.

u) Patient C.W. Patient C.W was diagnosed with pain, anxiety, and Attention Deficit Disorder. Patient C.W. received numerous prescriptions for HC/AP from Dr. Diaz around the same time and had them dispensed at multiple pharmacies:

- Patient C.W. filled RX #1125098, 10-325 mg, 100 tablets (25 day supply) on May 30, 2009, she filled RX #1123636, 10-500 mg, 180 tablets (22 day supply) on June 2, 2009, and she filled RX #1125367, 7.5-750 mg, 120 tablets (30 supply) on June 3, 2009 all at Respondent Pharmacy.
- Patient C.W. filled a prescription for 7.5-750 mg, 180 tablets (30 day supply) at CVS on December 16, 2009 and then filled RX #1130383, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on December 29, 2009.
- Patient C.W. filled a prescription for 7.5-750 mg, 120 tablets (30 supply) at CVS on March 17, 2010 and then filled RX #1144415, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on March 23, 2010.
- Patient C.W. filled a prescription for 7.5-750 mg, 150 tablets (30 supply) at CVS on April 11, 2010, then filled RX #1145891, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on April 13, 2010.
- Patient C.W. filled RX #1176959, 120 tablets, 10-325 mg (30 day supply) and RX #1176962, 120 tablets, 7.5-750 mg (30 day supply) on August 13, 2011 at Respondent Pharmacy.

On February 11, 2010, Respondent Pharmacy dispensed both Clonazepam (RX #1141456) and Lorazepam (RX #1141458) – prescribed by Dr. Diaz – to Patient C.W. These medications are in the same classification and would not normally be prescribed together. On July 28, 2011, Dr. Diaz prescribed both HC/AP 10-325 and HC/AP 7.5-750 on the same prescription. Respondent Pharmacy dispensed both medications (RX #1176962 and RX #1176965) on August 13, 2011. Patient C.W. utilized insurance to pay for her medications but paid cash, including $54.90 HC/AP (the cost to Respondent Pharmacy was $4.40), when insurance did not cover her medications.

32. Patient M.M.[3] Between January 2, 2009 and January 23, 2013, Patient M.M. saw 18 different prescribers and went to 20 different pharmacies, including Respondent Pharmacy. Patient M.M. engaged in both doctor and pharmacy shopping while she had her prescriptions filled at Respondent Pharmacy. Prior to getting prescriptions filled at Respondent Pharmacy, Patient M.M. received numerous prescriptions for Oxycontin from Dr. Diaz and went to different pharmacies to get them dispensed. Had Respondent Pharmacy checked PARs, it would have noticed this obvious pharmacy shopping. Patient M.M. resided in Lompoc and travelled approximately 56 miles to see Dr. Diaz. Patient M.M. utilized insurance to pay for her medications but paid cash, including up to $1,806 and $2,703 for Oxycontin, when insurance did not cover her medications.

33. A detailed review of the 21 patients of Respondent selected for the profile revealed a pattern of early refills of prescriptions as to 11 patients for Dr. Diaz (Patients T.B., K.B., M.C., C.D., J.H., G.L., B.P., J.R., R.S., E.T. and C.W.), as described in the following table:

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TB | 01/07/10 | 1138630 | 120 | 30 | Diaz | 01/27/10 | 1140103 | 120 | 30 | Diaz | 6 |
| TB | 01/07/10 | 1138631 | 180 | 30 | Diaz | 01/30/10 | 1140471 | 180 | 30 | Diaz | 6 |
| TB | 01/30/10 | 1140471 | 180 | 30 | Diaz | 02/22/10 | 1142175 | 180 | 30 | Diaz | 7 |
| TB | 02/22/10 | 1142175 | 180 | 30 | Diaz | 03/18/10 | 1143889 | 180 | 30 | Diaz | 6 |
| TB | 04/15/10 | 1145415 | 180 | 30 | Diaz | 05/07/10 | 1147810 | 180 | 30 | Diaz | 8 |
| TB | 08/30/10 | 1155489 | 180 | 30 | Diaz | 09/22/10 | 1156903 | 180 | 30 | Diaz | 7 |
| TB | 06/28/11 | 1174094 | 10 | 30 | Diaz | 07/21/11 | 1175838 | 10 | 30 | Diaz | 7 |
| TB | 06/28/11 | 1174108 | 60 | 30 | Diaz | 07/21/11 | 1176076 | 60 | 30 | Diaz | 7 |
| TB | 07/21/11 | 1176076 | 60 | 30 | Diaz | 08/15/11 | 1177205 | 60 | 30 | Diaz | 5 |
| TB | 08/09/11 | 1177643 | 180 | 30 | Diaz | 09/02/11 | 1179184 | 180 | 30 | Diaz | 6 |
| KB | 04/29/10 | 1147574 | 240 | 30 | Diaz | 05/20/10 | 1149406 | 240 | 30 | Diaz | 9 |
| KB | 04/29/10 | 1145017 | 240 | 30 | Diaz | 05/24/10 | 1145017 | 240 | 30 | Diaz | 5 |

[3] No patient questionnaire was sent to Patient M.M. but the Board Inspector did gather CURES data, mileage data, prescription hard copies, and other relevant data regarding this patient.

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| KB | 08/30/10 | 1152434 | 240 | 30 | Diaz | 09/24/10 | 1152434 | 240 | 30 | Diaz | 5 |
| MC | 06/21/11 | 1174708 | 160 | 40 | Diaz | 07/08/11 | 1175758 | 90 | 30 | Diaz | 23 |
| MC | 06/21/11 | 1174707 | 180 | 30 | Diaz | 07/08/11 | 1175757 | 120 | 30 | Diaz | 13 |
| MC | 06/30/11 | 1174710 | 120 | 30 | Diaz | 07/21/11 | 1176496 | 120 | 30 | Diaz | 9 |
| CD | 06/23/11 | 1174893 | 120 | 30 | Diaz | 07/18/11 | 1174893 | 120 | 30 | Diaz | 5 |
| JH | 08/18/11 | 1178318 | 90 | 30 | Diaz | 09/02/11 | 1178318 | 90 | 30 | Diaz | 15 |
| GL | 02/15/10 | 1141621 | 240 | 30 | Diaz | 03/10/10 | 1143429 | 240 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141624 | 240 | 30 | Diaz | 03/10/10 | 1143422 | 240 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141623 | 360 | 30 | Diaz | 03/10/10 | 1143428 | 360 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141616 | 60 | 30 | Diaz | 03/10/10 | 1143425 | 60 | 30 | Diaz | 7 |
| GL | 04/06/10 | 1145332 | 120 | 30 | Diaz | 04/29/10 | 1143423 | 120 | 30 | Diaz | 7 |
| GL | 04/06/10 | 1145336 | 240 | 30 | Diaz | 04/29/10 | 1145336 | 240 | 30 | Diaz | 7 |
| GL | 04/16/10 | 1146454 | 240 | 30 | Diaz | 05/10/10 | 1148175 | 240 | 30 | Diaz | 6 |
| GL | 04/29/10 | 1143423 | 120 | 30 | Diaz | 05/24/10 | 1148172 | 120 | 30 | Diaz | 5 |
| GL | 04/29/10 | 1145336 | 240 | 30 | Diaz | 05/24/10 | 1145336 | 240 | 30 | Diaz | 5 |
| GL | 06/22/11 | 1174785 | 120 | 30 | Diaz | 07/15/11 | 1172951 | 120 | 30 | Diaz | 7 |
| GL | 11/28/11 | 1183585 | 300 | 25 | Diaz | 12/17/11 | 1185523 | 300 | 25 | Diaz | 6 |
| GL | 12/07/11 | 1185524 | 180 | 30 | Diaz | 12/30/11 | 1186912 | 180 | 30 | Diaz | 6 |
| MM | 07/22/11 | 1176580 | 240 | 30 | Diaz | 08/16/11 | 1178046 | 240 | 30 | Diaz | 5 |
| MM | 07/22/11 | 1176579 | 120 | 30 | Diaz | 08/16/11 | 1178047 | 120 | 30 | Diaz | 5 |
| MM | 08/18/11 | 1176387 | 240 | 30 | Diaz | 09/12/11 | 1176387 | 240 | 30 | Diaz | 5 |
| MM | 12/03/11 | 1185275 | 15 | 30 | Diaz | 12/28/11 | 1186952 | 15 | 30 | Diaz | 5 |
| MM | 12/03/11 | 1185274 | 120 | 30 | Diaz | 12/28/11 | 1186953 | 120 | 30 | Diaz | 5 |
| BP | 02/24/10 | 1136288 | 180 | 30 | Diaz | 02/24/10 | 1142325 | 180 | 30 | Diaz | 30 |
| BP | 02/24/10 | 1142325 | 180 | 30 | Diaz | 03/20/10 | 1136288 | 180 | 30 | Diaz | 6 |
| BP | 03/24/10 | 1144472 | 240 | 30 | Diaz | 04/02/10 | 1145097 | 140 | 17 | Diaz | 21 |
| BP | 03/20/10 | 1136288 | 180 | 30 | Diaz | 04/12/10 | 1142325 | 180 | 30 | Diaz | 7 |
| BP | 04/12/10 | 1142325 | 180 | 30 | Diaz | 04/29/10 | 1147582 | 180 | 30 | Diaz | 13 |
| BP | 04/29/10 | 1147582 | 180 | 30 | Diaz | 05/11/10 | 1142325 | 180 | 30 | Diaz | 18 |

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| BP | 09/13/10 | 1154202 | 180 | 30 | Diaz | 10/08/10 | 1154202 | 180 | 30 | Diaz | 5 |
| BP | 09/17/11 | 1173125 | 180 | 30 | Diaz | 09/23/11 | 1178161 | 180 | 30 | Diaz | 24 |
| BP | 09/14/11 | 1179896 | 300 | 25 | Diaz | 09/23/11 | 1180520 | 270 | 30 | Diaz | 16 |
| BP | 09/14/11 | 1179895 | 360 | 30 | Diaz | 09/23/11 | 1180519 | 360 | 30 | Diaz | 21 |
| JR | 06/27/11 | 1175073 | 30 | 30 | Diaz | 07/18/11 | 1176291 | 30 | 30 | Diaz | 9 |
| JR | 08/15/11 | 1177927 | 90 | 30 | Diaz | 09/09/11 | 1179557 | 90 | 30 | Diaz | 5 |
| JS | 09/04/10 | 1156516 | 90 | 30 | Diaz | 10/07/10 | 1156516 | 90 | 30 | Diaz | 7 |
| JR | 07/19/11 | 1174816 | 90 | 30 | Diaz | 08/13/11 | 1174816 | 90 | 30 | Diaz | 5 |
| JR | 08/13/11 | 1174816 | 90 | 30 | Diaz | 09/07/11 | 1174816 | 90 | 30 | Diaz | 5 |
| RS | 06/28/11 | 1175121 | 300 | 30 | Diaz | 07/22/11 | 1176613 | 240 | 30 | Diaz | 6 |
| RS | 06/28/11 | 1175116 | 600 | 30 | Diaz | 07/22/11 | 1176610 | 600 | 30 | Diaz | 6 |
| RS | 06/28/11 | 1175113 | 120 | 30 | Diaz | 07/22/11 | 1176615 | 120 | 30 | Diaz | 6 |
| ET | 06/20/11 | 1173573 | 240 | 30 | Diaz | 07/13/11 | 1169455 | 240 | 30 | Diaz | 7 |
| ET | 12/27/11 | 1175542 | 240 | 30 | Diaz | 12/27/11 | 1175542 | 240 | 30 | Diaz | 6 |
| CW | 12/29/09 | 1130383 | 120 | 30 | Diaz | 01/20/10 | 1130383 | 120 | 30 | Diaz | 8 |
| CW | 01/19/10 | 1126967 | 60 | 30 | Diaz | 02/11/10 | 1141458 | 60 | 30 | Diaz | 7 |
| CW | 03/23/10 | 1144415 | 120 | 30 | Diaz | 04/13/10 | 1145891 | 120 | 30 | Diaz | 9 |
| CW | 04/13/10 | 1144415 | 120 | 30 | Diaz | 05/06/10 | 1144415 | 120 | 30 | Diaz | 7 |
| CW | 09/08/10 | 1154679 | 120 | 30 | Diaz | 10/01/10 | 1154679 | 120 | 30 | Diaz | 7 |

34. The table above compares the original prescription number on the left with the refilled prescription number on the right. The final column on the right shows the number of days early that the prescription was refilled, based on the number of days supply for the original prescription. This shows a consistent pattern of early refills of prescriptions for Dr. Diaz patients.

35. A review of the CURES data for Respondent Pharmacy shows that between January 1, 2011 and December 5, 2012, Respondent Pharmacy dispensed a total of 10,436 controlled substance prescriptions. Of these prescriptions, 12.99% of them, or 1,356, were controlled substance prescriptions from Dr. Diaz, despite not being one of the pharmacies adjacent to Dr. Diaz's medical office. When compared to three other pharmacies in the area (Federal Drugs PHY

37078 – 1.92 miles from Respondent Pharmacy, Rite Aid 5789 – 0.65 miles from Respondent Pharmacy, and CVS PHY 49473 – 0.41 miles from Respondent Pharmacy), Respondent Pharmacy dispensed an exponentially disproportionate number of Dr. Diaz's controlled substance prescriptions. In fact, of the neighboring pharmacies sampled, neither Federal Drugs nor Rite Aid dispensed any of Dr. Diaz's controlled substance prescriptions and CVS only dispensed 44 of his controlled substance prescriptions.

36. A review of CURES data for Respondent Pharmacy showed that between January 1, 2011 and December 5, 2012, Dr. Diaz had a clear pattern of prescribing controlled substances. His pattern was to prescribe Hydromorphone, HC/AP, Oxycontin, Oxycodone, Morphine, Opana ER, Fentanyl, Alprazolam, Methadone, Diazepam, Clonazepam, Lorazepam, and/or Oxy/Ap in large and redundant quantities and in questionable combinations. Nevertheless, Respondent Pharmacy filled prescriptions from Dr. Diaz's patients.

**SECOND CAUSE FOR DISCIPLINE**

**(Records of Acquisition and Disposition)**

37. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with Code section 4081 and Code section 4105, subdivision (a), on the grounds of unprofessional conduct in that Respondents were unable to account for the records of sale, acquisition, and/or disposition of dangerous drugs for at least three years from the date of making. Respondent Pharmacy could not account for prescription hard copies for the following prescriptions: RX #1152434, RX #1187257, RX #1184958, RX #1136283, RX #1183085, RX #1185522, RX #1185523, and RX #1171890.

**THIRD CAUSE FOR DISCIPLINE**

**(Erroneous or Uncertain Prescriptions)**

38. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct in that between January 1, 2010 and January 15, 2013, Respondent dispensed prescriptions which contained significant errors,

omissions, irregularities, uncertainties, ambiguities, or alterations. The facts and circumstances are as follows:

39. The following hard copy prescriptions had suspicious or no dates: (1) RX #1182583 was dated 10/7/68. The date was nonsensical. (2) RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have dates.

40. The following prescriptions were dispensed prior to the dates written on the prescriptions:

a) The hard copy of the prescription for RX #1176498 was dated July 22, 2011, but the prescription itself was dispensed on July 21, 2011.

b) The hardcopy of the prescription for RX #1156765 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

c) The hardcopy of the prescription for RX #1156766 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

d) The hardcopy of the prescription for RX #1156769 was dated September 18, 2011 but the prescription itself was dispensed on September 17, 2010.

e) The hardcopy of the prescription for RX #1175775 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

f) The hardcopy of the prescription for RX #1175776 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

g) The hardcopy of the prescription for RX #1175777 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

h) The hardcopy of the prescription for RX #1179567 was dated September 14, 2011 but the prescription itself was dispensed on September 9, 2011.

i) The hardcopy of the prescription for RX #1179202 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

j) The hardcopy of the prescription for RX #1179203 was dated October 1, 2011, but the prescription itself was dispensed on September 2, 2011.

k) The hardcopy of the prescription for RX # 1179204 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

41. The following prescriptions were dispensed without a signature from the prescriber: RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have Dr. Diaz's signature.

**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 49809, issued to The Medicine Shoppe with Sanjiv Bhalla as the Pharmacist-In-Charge;

2. Revoking or suspending Pharmacist License Number RPH 46064, issued to Sanjiv Bhalla; and

3. Ordering The Medicine Shoppe and Sanjiv Bhalla 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: 12/21/15

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

LA2014512773

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

| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>**THE MEDICINE SHOPPE; SANJIV BHALLA**<br>**1435 State Street**<br>**Santa Barbara, CA 93101**<br><br>**Pharmacy Permit No. PHY 49809,**<br><br>**and**<br><br>**SANJIV BHALLA**<br>**1250 La Venta Dr. #114**<br>**Westlake Village, CA 91361**<br><br>**Pharmacist License No. RPH 46064**<br><br>Respondent. | Case No. 5251<br><br>**A C C U S A T I O N** |

Complainant alleges:

## PARTIES

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

2. On or about February 17, 2009, the Board of Pharmacy issued Pharmacy Permit Number PHY 49809 to The Medicine Shoppe with Sanjiv Bhalla as Pharmacist-In-Charge ("Respondent Pharmacy"). The Pharmacy Permit is cancelled, expired on February 1, 2014, and has not been renewed.

3. On or about March 15, 1993, the Board of Pharmacy issued Pharmacist License Number RPH 46064 to Sanjiv Bhalla ("Respondent Bhalla"). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2017, unless renewed.

## JURISDICTION

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

5. Section 4300 of the Code states, in pertinent part:

"(a) Every license issued may be suspended or revoked.

(b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:

(1) Suspending judgment.

(2) Placing him or her upon probation.

(3) Suspending his or her right to practice for a period not exceeding one year.

(4) Revoking his or her license.

(5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper."

6. Section 4300.1 of the Code states:

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

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## STATUTES AND REGULATIONS

7. Section 4301 of the Code states, in pertinent part:

"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:

. . . .

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

. . . .

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

. . . .

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

8. Section 4081, subdivision (a) of the Code states:

"(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, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, 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."

9. Section 4105, of the Code states, in pertinent part:

"(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.

. . . .

(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."

10. Health and Safety Code section 11153, subdivision (a), states:

"(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."

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

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

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

**COST RECOVERY**

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of

the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

## CONTROLLED SUBSTANCES[1]

13. Alprazolam, the generic name for Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1). Alprazolam is a depressant used to treat anxiety and is a popular member of a class of drugs called "benzodiazepines," which is a general name for any group of psychotropic agents used as anti-anxiety agents, muscle relaxants, sedatives, and hypnotics.

14. Clonazepam, the generic name for Klonopin, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7). Clonazepam treats seizures, panic disorder, and anxiety and belongs to the class of drugs called "benzodiazepines."

15. Diazepam, a generic name for Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(9). Diazepam treats anxiety, muscle spasms, seizures, and belongs to the class of drugs called "benzodiazepines."

16. Fentanyl is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8). Fentanyl is a narcotic opioid used to treat moderate to severe chronic pain.

17. The combination of Hydrocodone/Acetaminophen ("HC/AP") is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4). Hydrocodone is an opioid pain reliever that is subject to abuse because of the euphoric feeling it induces.

18. Lorazepam, the generic name for Ativan, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16). Lorazepam is used to

[1] All of the controlled substances listed are also dangerous drugs pursuant to Code section 4022.

treat anxiety, anxiety with depression, and insomnia and belongs to the class of drugs called "benzodiazepines."

19. Hydromorphone, the generic name for Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J). Hydromorphone is a narcotic opioid that is used to treat moderate to severe pain.

20. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(14). Methadone treats moderate to severe pain and when used together with medical supervision and counseling is used for the treatment of narcotic drug addiction.

21. Opana ER, a brand name for Oxymorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N). Oxymorphone is a narcotic opioid that is used to treat moderate to severe pain.

22. Oxycodone, a generic name for Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxycodone is a narcotic opioid that is used to treat moderate to severe pain.

23. Percocet, a brand name for the combination of Oxycodone and Acetaminophen ("Oxy/Ap"), is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M). Oxy/Ap is a narcotic opioid that is used to treat moderate to moderately severe pain.

**BOARD INVESTIGATION**

24. Beginning in January 2013, the Board conducted an investigation into Respondent Pharmacy. The Board was alerted that Julio Diaz, M.D., a general practitioner with secondary practices in geriatrics and pathology, who had a medical practice in Santa Barbara, was arrested for trafficking narcotics. Respondent Pharmacy dispensed many controlled substances that Dr. Diaz prescribed.

25. On January 15, 2013, two Board Inspectors conducted an inspection of Respondent Pharmacy. When questioned about Dr. Diaz's prescriptions, Respondent Bhalla initially

responded that he did not know if Dr. Diaz was a pain specialist but stated that he checked the prescriptions by calling the doctor's office and writing the diagnosis code on the prescriptions.

26. The Board Inspectors selected 21 patients to profile and asked Respondent Bhalla to complete questionnaires regarding the patients. Amongst the questions asked were the patients' diagnoses, the methods of payment, and the nature of prescriber's practice. All of the patients were Dr. Diaz's patients and Respondent Bhalla indicated that Dr. Diaz had a general practice.

27. The Board Inspectors requested CURES[2] data for Respondent Pharmacy from January 1, 2011 to December 5, 2012 and CURES Patient Activity Reports ("PARs") for the 21 selected patients from January 1, 2009 to January 28, 2013.

28. On October 4, 2012, the Medical Board of California revoked Dr. Diaz's license to practice medicine, in the case entitled *In the Matter of the Accusation Against Otero Julio Gabriel Diaz, M.D.*, case no. 06-2010-209660. Dr. Diaz's license was revoked for gross negligence, incompetence, and excessive prescribing of narcotic medications to a patient.

## FIRST CAUSE FOR DISCIPLINE

**(Corresponding Responsibility)**

29. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivisions (d), Code section 4301, subdivision (j) for violating Health and Safety Code section 11153, subdivision (a), and Code section 4301, subdivision (o), for violating California Code of Regulations, title 16, section 1761, in that between January 1, 2011 and December 5, 2012, Respondents failed to assume their corresponding responsibility by failing to validate the legitimacy of prescriptions dispensed and/or by failing to review patients' drug therapy and thus dispensing prescriptions to physician shoppers or habitual users. The circumstances, which include by reference Paragraphs 24 through 28, are as follows:

[2] All prescription drug history information is maintained in the California Controlled Substance Utilization Review and Evaluation System, or CURES, a database. This CURES database includes information about the drug dispensed, drug quantity and strength, patient name, address, prescriber name, and authorization number including DEA number or prescription number.

30. For the 21 patients that the Board Inspectors selected to profile, there were many irregularities found with the prescriptions and dispensing methods, including: (1) no diagnosis for many patients; (2) a general practitioner that was prescribing an excessive amount of narcotics; (3) many patients that came to Respondent Pharmacy outside of the normal trading area, which is considered to be 5 miles from the patient's residence or adjacent to the prescriber's office; (4) consistent early fills of controlled substance prescriptions; (5) patients paying cash for expensive narcotics; (6) no verification in CURES Patient Activity Reports (PARs) for suspicious prescriptions; (7) evidence of doctor/pharmacy shopping; and (8) evidence of a pattern of prescribing controlled substances in large and redundant quantities and in questionable combinations.

31. A detailed review of the 21 patients reveals the following results:

a) Patient T.B. Patient T.B. was diagnosed with cervical myositis pain and Chronic Pain Syndrome. Between January 1, 2009 and January 1, 2013, Patient T.B. saw 4 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. On several occasions (January 5, 2010, January 25, 2010, February 19, 2010, April 7, 2010, August 27, 2010, September 17, 2011, and December 16, 2011) Patient T.B. received 2 hard copy prescriptions from Dr. Diaz for Percocet with the same date. This should have been a red flag for the pharmacy. Respondent Pharmacy dispensed RX #1178784 for Fentanyl patches every 48 prescribed by Dr. Diaz. The recommended dosage is every 72 hours. Patient T.B. utilized insurance to pay for her medications but paid cash, including $1,298.90 for Opana and $732.90 for Fentanyl, when insurance did not cover her medications.

b) Patient D.B. Patient D.B. was diagnosed with degenerative chronic disease of the cervical spine. Between January 20, 2009 and January 3, 2013, Patient D.B. saw 5 different prescribers and went to 4 different pharmacies, including Respondent Pharmacy. Prior to seeing Dr. Diaz, Patient D.B. received HC/AP 10-325 monthly for approximately 1 year. Dr. Diaz prescribed hydromorphone 8 mg and morphine 60 mg. Dr. Diaz also prescribed buprenorphine 8 mg (which is commonly used to treat opiate addiction.) After Patient D.B. stopped seeing Dr. Diaz, Patient D.B. received morphine but the strength was much smaller. Patient D.B. utilized

insurance to pay for his medications but paid cash, including $202.90 for Alprazolam, when insurance did not cover his medications.

c) Patient K.B. Patient K.B. was diagnosed with lumbar reticulopathy and spondylosis. Between March 31, 2009 and December 4, 2012, Patient K.B. saw 5 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and March 31, 2009, Patient K.B. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: HC/AP 10-325, Methadone 10 mg, and Alprazolam 2 mg. Patient K.B. also received numerous HC/AP 10-325 prescriptions from Dr. Diaz and had them dispensed at multiple pharmacies on or around the same time:

- On April 30, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply from Respondent Pharmacy and on May 8, 2009 he received 240 tablets (40 day supply from LM Caldwell Pharmacist.
- On May 28, 2009, Patient K.B. received RX #1121643, 200 tablets (30 day supply) from Respondent Pharmacy and 240 tablets (40 day supply) from Walgreens. On June 4, 2009, he received 240 tablets (40 day supply) from LM Caldwell Pharmacist.
- On July 23, 2009, Patient K.B. received RX #1128237, 240 tablets (30 day supply) the Respondent Pharmacy and on July 28, 2009, he received 240 tablets (30 day supply) from Walgreens.
- On August 21, 2009, Patient K.B. received RX #1129966, 240 tablets (30 day supply) from Respondent Pharmacy and on August 28, 2009, he received 240 tablets (30 day supply) from Walgreens.

Had Respondent Pharmacy utilized PARs, it would have discovered the excessive dispensing. Patient K.B. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

d) Patient A.B. Patient A.B.'s diagnosis was unknown. Between May 21, 2009 and January 24, 2012, Patient A.B. saw 3 prescribers and went to 7 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 21, 2009, Patient A.B. received no

controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Fentanyl patch and Alprazolam 2 mg. Respondent Pharmacy dispensed RX #1175222 on June 29, 2011, RX #1178791 on August 26, 2011, and RX #1180528 on September 27, 2009 all prescribed by Dr. Diaz for Opana ER three times a day when the recommended dose is two times a day. Patient A.B. utilized insurance to pay for his medications but paid cash, including $828.90 and $421.95 for Opana and over $250 for Oxycodone and Adderall XR, when insurance did not cover his medications.

e) Patient J.C. Patient J.C.'s diagnosis was unknown. Between May 15, 2009 and January 3, 2012, Patient J.C. saw 8 different prescribers and went to 9 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and May 15, 2009, Patient J.C. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg, Methadone 10 mg, and clonazepam 2 mg. Patient J.C. resided in Solvang and traveled approximately 36 miles to see Dr. Diaz. Patient J.C. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

f) Patient M.C. Patient M.C.'s diagnosis was unknown. Between April 7, 2009 and January 8, 2013, Patient J.C. saw 8 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and April 7, 2009, Patient A.B. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medication: Oxycodone 80 mg. Between January 1, 2009 and May 8, 2009, Patient A.B. received no anxiety medication. Then Dr. Diaz prescribed the following high dosage medication: Alprazolam 2 mg (and later Lorazepam 2 mg). Respondent Pharmacy dispensed RX #1184620 Oxycontin 60 mg (22 day supply) and RX #1184646 Oxycontin 80 mg (22 day supply) on November 25, 2011 prescribed by Dr. Diaz. The directions were to take the mediation 2-3 times daily when the recommended dosage is twice daily. Patient M.C. utilized insurance to pay for his medication but paid cash, including $312 for morphine, $415 for Oxycontin, and $259 for hydromorphone, when insurance did not cover his medications.

g) Patient C.D. Patient C.D.'s diagnosis was unknown. Between April 19, 2009 and January 14, 2013, Patient C.D. went to 8 different prescribers and 9 different pharmacies,

including Respondent Pharmacy. Patient C.D. utilized insurance to pay for her medications but paid cash when insurance did not cover her medications.

h) Patient J.H. Patient J.H. was diagnosed with migraine headaches. Between February 13, 2009 and December 28, 2011, Patient J.H. went to 4 different prescribers and 13 different pharmacies, including Respondent Pharmacy. He went to 5 other pharmacies while going to Respondent Pharmacy. On August 3, 2011, Patient J.H. received RX #4487887, 240 tablets of HC/AP 10-325 (30 day supply) from Walmart #1989 and on August 18, 2011, he received RX #1178320, 240 tablets of HC/AP 10-325 (30 day supply) at Respondent Pharmacy. Both prescriptions were prescribed by Dr. Diaz. A review of PARs would have caught this excessive prescribing. Patient J.H. resided in Santa Maria and traveled approximately 62 miles to see Dr. Diaz. Patient J.H. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

i) Patient A.J. Patient A.J. was diagnosed with arthritis. Between January 19, 2009 and December 14, 2012, Patient A.J. saw 2 different prescribers and went to 6 different pharmacies, including Respondent Pharmacy. Patient A.J. resided in Santa Ynez and travelled approximately 34 miles to see Dr. Diaz. Patient A.J. received early fills for Methadone and Oxycodone all prescribed by Dr. Diaz:

- On March 31, 2010, Patient A.J. received Methadone 10 mg (30 day supply) from Goleta Valley Pharmacy, on April 21, 2010, she received Methadone 10 mg (30 day supply) from LM Caldwell Pharmacist, and on May 10, 2010, she received RX #1148455, Methadone 10 mg (30 day supply) from Respondent Pharmacy.
- On May 21, 2010, Patient A.J. received RX #1149465, 240 tablets of Oxycodone 30 mg (30 day supply) from Respondent Pharmacy and on June 7, 2010, she received 200 tablets of Oxycodone (25 day supply) from Goleta Valley Pharmacy.

Had Respondent Pharmacy checked PARs it would have caught this excessive prescribing. Patient A.J. utilized insurance to pay for her medications but paid cash, including up to $660 for Oxycontin, when insurance did not cover her medications.

j) Patient G.L. Patient G.J. was diagnosed with chronic pain, multiple disc degeneration, and a pinched nerve. Between February 4, 2009 and January 10, 2013, Patient G.L. saw 14 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. Patient G.L. engaged in both doctor and pharmacy shopping while he had his prescriptions filled at Respondent Pharmacy. In 2009 and 2010, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed, HC/AP 10-325 and HC/AP 10-500 around the same time. This excessive prescribing and dispensing caused Patient G.J. to receive an excessive amount of Acetaminophen. Also, Dr. Diaz wrote prescriptions for, and Respondent Pharmacy dispensed Opana ER and Oxycodone at the same time. Both medications are long lasting and the normal practice is to dispense one or the other, but not both. Patient G.J. utilized insurance to pay for his medications but paid cash, including $2,305 for Fentanyl OT and $202 for Alprazolam (the cost to Respondent Pharmacy was $10.82), when insurance did not cover his medications.

k) Patient A.M. Patient A.M. was diagnosed with a cervical lumbar sprain, right foot pain, and pain post trauma. Between January 12, 2009 and November 15, 2011, Patient A.M. saw 4 different prescribers and went to 8 different pharmacies, including Respondent Pharmacy. Patient A.M. engaged in pharmacy shopping while he had his prescriptions filled at Respondent Pharmacy. A check of PARs would have reveals that Patient A.M. was going to multiple pharmacies to obtain and excessive amount of controlled substances prescribed by Dr. Diaz. Patient A.M. resided in Lompoc and traveled approximately 56 miles to see Dr. Diaz. Patient A.M. paid for his medications with cash. Patient A.M. passed away from a drug overdose in November 2011.

l) Patient S.M. Patient S.M.'s diagnosis was unknown. Between April 1, 2009 and November 30, 2012, Patient S.M. saw 8 different prescribers and went to 10 different pharmacies, including Respondent Pharmacy. Between January 1, 2009 and April 1, 2009, Patient S.M. received no controlled substance pain killers. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 40 mg and oxy/apap. Between January 1, 2009 and May 26, 2009, Patient S.M.. received no anxiety medication. Then Dr. Diaz prescribed Alprazolam 2 mg. Patient S.M. paid for his medications with cash.

m) Patient W.M. Patient W.M. was an amputee with Chronic Pain Syndrome and Phantom Pain Syndrome. Between February 20, 2009 and January 4, 2013, Patient W.M. saw 11 different prescribers and when to 5 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs it would have noticed that Patient W.M. was a doctor shopper. Patient W.M. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

n) Patient B.P. Patient B.P. was diagnosed with a slipped disc, pinched sciatic nerve, muscle spasm, and anxiety. Between January 1, 2009 and April 16, 2009, Patient B.P. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: Oxycodone 30 mg and Alprazolam 2 mg. Patient B.P. also received numerous prescriptions for Alprazolam 2 mg prescribed by Dr. Diaz around the same time, which Respondent Pharmacy dispensed:

- On September 4, 2009, Patient B.P. received RX #1129218, 120 tablets (30 supply) and on September 8, 2009, he received RX #1130929, 100 tablets (25 day supply);
- On September 30, 2009, Patient B.P. received RX #1130929, 120 tablets (30 day supply) and on October 5, 2009, he received RX #1132519, 120 tablets (30 day supply);
- On November 23, 2009, Patient B.P. received RX #1130929, 100 tablets (25 day supply), on November 24, 2009 he received RX #1129218, 120 tablets (30 day supply), and on December 1, 2009, he received RX #1136288, 180 tablets (30 day supply);
- On February 24, 2010, Patient B.P. received RX #1136288, 180 tablets (30 day supply) and RX #1142355, 180 tablets (30 day supply); and
- On September 17, 2011, Patient B.P. received RX #1173125, 180 tablets (30 day supply) and RX #1178161, 180 tablets (30 day supply), and on September 23, 2011, Patient B.P. received RX #1178161, 180 tablets (30 day supply).

Patient B.P. paid for his medications with cash.

o) Patient J.P. Patient J.P's diagnosis was unknown. Patient J.P. utilized insurance to pay for his medications but paid cash, including $620 for morphine when insurance did not cover his medications.

p) Patient J.R. Patient J.R.'s diagnosis was unknown. Between March 1, 2009 and December 27, 2012, Patient J.R. saw 12 different prescribers and went to 16 different pharmacies, including Respondent Pharmacy. Patient J.R. engaged in pharmacy shopping while getting his prescriptions filled at Respondent Pharmacy. Had Respondent Pharmacy checked PARs, it would have noticed this practice. Dr. Diaz prescribed Opana ER to Patient J.R. to take the mediation every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1177927 on August 15, 2011 and RX #1179557 on September 9, 2011. Patient J.R. utilized insurance to pay for his medications but paid cash when insurance did not cover his medications.

q) Patient J.S. (DOB 9/2/86) Patient J.S was diagnosed with knee and back pain, retinacular capsular trauma, fibromyalgia, and spondylosis. Between October 21, 2009 and July 28, 2012, Patient J.S. saw 5 different prescribers and three different pharmacies. Between January 1, 2009 and October 23, 2009, Patient J.S. received no controlled substance pain killers or anxiety medication. Then Dr. Diaz prescribed the following high dosage medications: oxycodone 30 mg, Hydromorphone, and Alprazolam 2 mg. J.S. resided in Solvang and travelled approximately 34.5 miles to see Dr. Diaz. Patient J.S. utilized insurance to pay for his medications but paid cash, including $391 for oxycodone when insurance did not cover his medications.

r) Patient J.S. (DOB 7/16/77) Patient J.S.'s diagnosis was unknown. Patient J.S. resided in Lompoc and traveled approximately 58 miles to see Dr. Diaz. Dr. Diaz began Patient J.S.'s treatment with oxycodone 30 mg, Opana ER 20 mg, Diazepam 10 mg, and Lorazepam 2 mg. The latter two drugs, Diazepam and Lorazepam, are both in the same class and are not to be prescribed together. This should have raised a red flag for Respondent Pharmacy. Dr. Diaz prescribed Opana ER to Patient J.S. and instructed her to take the medication every 8 hours, or 3 times a day. The normal dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1182433 on October 24, 2011 and RX #1186298 on December 19, 2011. Patient J.S. paid for her medications with insurance.

s) Patient R.S. Patient R.S. was diagnosed with multiple injuries and trauma. Between January 3, 2009 and June 22, 2012, Patient R.S. saw 12 different prescribers and went to 13 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have noticed that Patient R.S. was a doctor and pharmacy shopper. Dr. Diaz prescribed Oxycontin 80 mg to Patient R.S. and instructed him to take the medication every 6 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1157030 on September 21, 2010 and RX #1158402 on October 14, 2010. Dr. Diaz also prescribed Opana ER 80 mg to Patient R.S. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Opana ER and Oxycontin are both long acting narcotic pain killers and are not commonly prescribed together. This should have been a red flag for Respondent Pharmacy. Respondent Pharmacy dispensed this prescription as RX #1158399 on October 14, 2010. R.S. resided in Lompoc at the same location as Patient J.S. (DOB 7/16/77) and travelled approximately 58 miles to see Dr. Diaz. Patient R.S. paid for his medications with insurance.

t) Patient E.T. Patient E.T. was a right leg amputee diagnosed with phantom pain, left leg radicular pain, and a left foot fracture. Between June 20, 2011 and December 11, 2012, Patient E.T. saw 10 different prescribers and went to 4 different pharmacies, including Respondent Pharmacy. If Respondent Pharmacy had consulted PARs, it would have discovered that Patient E.T. was a doctor shopper. Between January 1, 2009 and June 20, 2011, Patient E.T. received no controlled substance pain killers or anxiety medication. Then, on July 6, 2011, Dr. Diaz prescribed the following high dosage medications at the same time: methadone 10 mg, oxycodone 30 mg, Hydromorphone 8 mg, Opana ER 40 mg, morphine 100 mg, and Diazepam 10 mg. Dr. Diaz prescribed Opana ER 80 mg to Patient E.T. and instructed him to take the medication every 8 hours as needed. The recommended dosage is 2 times a day. Respondent Pharmacy dispensed these prescriptions as RX #1175540 on July 6, 2011, RX #1177255 on August 3, 2011, and RX #1180758 on September 28, 2011. Patient E.T. utilized insurance to pay for his medications but paid cash, including $179 for HC/AP (the cost to Respondent Pharmacy was $39.22), when insurance did not cover his medications.

u) Patient C.W. Patient C.W was diagnosed with pain, anxiety, and Attention Deficit Disorder. Patient C.W. received numerous prescriptions for HC/AP from Dr. Diaz around the same time and had them dispensed at multiple pharmacies:

- Patient C.W. filled RX #1125098, 10-325 mg, 100 tablets (25 day supply) on May 30, 2009, she filled RX #1123636, 10-500 mg, 180 tablets (22 day supply) on June 2, 2009, and she filled RX #1125367, 7.5-750 mg, 120 tablets (30 supply) on June 3, 2009 all at Respondent Pharmacy.
- Patient C.W. filled a prescription for 7.5-750 mg, 180 tablets (30 day supply) at CVS on December 16, 2009 and then filled RX #1130383, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on December 29, 2009.
- Patient C.W. filled a prescription for 7.5-750 mg, 120 tablets (30 supply) at CVS on March 17, 2010 and then filled RX #1144415, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on March 23, 2010.
- Patient C.W. filled a prescription for 7.5-750 mg, 150 tablets (30 supply) at CVS on April 11, 2010, then filled RX #1145891, 10-325 mg, 120 tablets (30 day supply) at Respondent Pharmacy on April 13, 2010.
- Patient C.W. filled RX #1176959, 120 tablets, 10-325 mg (30 day supply) and RX #1176962, 120 tablets, 7.5-750 mg (30 day supply) on August 13, 2011 at Respondent Pharmacy.

On February 11, 2010, Respondent Pharmacy dispensed both Clonazepam (RX #1141456) and Lorazepam (RX #1141458) – prescribed by Dr. Diaz – to Patient C.W. These medications are in the same classification and would not normally be prescribed together. On July 28, 2011, Dr. Diaz prescribed both HC/AP 10-325 and HC/AP 7.5-750 on the same prescription. Respondent Pharmacy dispensed both medications (RX #1176962 and RX #1176965) on August 13, 2011. Patient C.W. utilized insurance to pay for her medications but paid cash, including $54.90 HC/AP (the cost to Respondent Pharmacy was $4.40), when insurance did not cover her medications.

32. Patient M.M.[3] Between January 2, 2009 and January 23, 2013, Patient M.M. saw 18 different prescribers and went to 20 different pharmacies, including Respondent Pharmacy. Patient M.M. engaged in both doctor and pharmacy shopping while she had her prescriptions filled at Respondent Pharmacy. Prior to getting prescriptions filled at Respondent Pharmacy, Patient M.M. received numerous prescriptions for Oxycontin from Dr. Diaz and went to different pharmacies to get them dispensed. Had Respondent Pharmacy checked PARs, it would have noticed this obvious pharmacy shopping. Patient M.M. resided in Lompoc and travelled approximately 56 miles to see Dr. Diaz. Patient M.M. utilized insurance to pay for her medications but paid cash, including up to $1,806 and $2,703 for Oxycontin, when insurance did not cover her medications.

33. A detailed review of the 21 patients of Respondent selected for the profile revealed a pattern of early refills of prescriptions as to 11 patients for Dr. Diaz (Patients T.B., K.B., M.C., C.D., J.H., G.L., B.P., J.R., R.S., E.T. and C.W.), as described in the following table:

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TB | 01/07/10 | 1138630 | 120 | 30 | Diaz | 01/27/10 | 1140103 | 120 | 30 | Diaz | 6 |
| TB | 01/07/10 | 1138631 | 180 | 30 | Diaz | 01/30/10 | 1140471 | 180 | 30 | Diaz | 6 |
| TB | 01/30/10 | 1140471 | 180 | 30 | Diaz | 02/22/10 | 1142175 | 180 | 30 | Diaz | 7 |
| TB | 02/22/10 | 1142175 | 180 | 30 | Diaz | 03/18/10 | 1143889 | 180 | 30 | Diaz | 6 |
| TB | 04/15/10 | 1145415 | 180 | 30 | Diaz | 05/07/10 | 1147810 | 180 | 30 | Diaz | 8 |
| TB | 08/30/10 | 1155489 | 180 | 30 | Diaz | 09/22/10 | 1156903 | 180 | 30 | Diaz | 7 |
| TB | 06/28/11 | 1174094 | 10 | 30 | Diaz | 07/21/11 | 1175838 | 10 | 30 | Diaz | 7 |
| TB | 06/28/11 | 1174108 | 60 | 30 | Diaz | 07/21/11 | 1176076 | 60 | 30 | Diaz | 7 |
| TB | 07/21/11 | 1176076 | 60 | 30 | Diaz | 08/15/11 | 1177205 | 60 | 30 | Diaz | 5 |
| TB | 08/09/11 | 1177643 | 180 | 30 | Diaz | 09/02/11 | 1179184 | 180 | 30 | Diaz | 6 |
| KB | 04/29/10 | 1147574 | 240 | 30 | Diaz | 05/20/10 | 1149406 | 240 | 30 | Diaz | 9 |
| KB | 04/29/10 | 1145017 | 240 | 30 | Diaz | 05/24/10 | 1145017 | 240 | 30 | Diaz | 5 |

[3] No patient questionnaire was sent to Patient M.M. but the Board Inspector did gather CURES data, mileage data, prescription hard copies, and other relevant data regarding this patient.

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| KB | 08/30/10 | 1152434 | 240 | 30 | Diaz | 09/24/10 | 1152434 | 240 | 30 | Diaz | 5 |
| MC | 06/21/11 | 1174708 | 160 | 40 | Diaz | 07/08/11 | 1175758 | 90 | 30 | Diaz | 23 |
| MC | 06/21/11 | 1174707 | 180 | 30 | Diaz | 07/08/11 | 1175757 | 120 | 30 | Diaz | 13 |
| MC | 06/30/11 | 1174710 | 120 | 30 | Diaz | 07/21/11 | 1176496 | 120 | 30 | Diaz | 9 |
| CD | 06/23/11 | 1174893 | 120 | 30 | Diaz | 07/18/11 | 1174893 | 120 | 30 | Diaz | 5 |
| JH | 08/18/11 | 1178318 | 90 | 30 | Diaz | 09/02/11 | 1178318 | 90 | 30 | Diaz | 15 |
| GL | 02/15/10 | 1141621 | 240 | 30 | Diaz | 03/10/10 | 1143429 | 240 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141624 | 240 | 30 | Diaz | 03/10/10 | 1143422 | 240 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141623 | 360 | 30 | Diaz | 03/10/10 | 1143428 | 360 | 30 | Diaz | 7 |
| GL | 02/15/10 | 1141616 | 60 | 30 | Diaz | 03/10/10 | 1143425 | 60 | 30 | Diaz | 7 |
| GL | 04/06/10 | 1145332 | 120 | 30 | Diaz | 04/29/10 | 1143423 | 120 | 30 | Diaz | 7 |
| GL | 04/06/10 | 1145336 | 240 | 30 | Diaz | 04/29/10 | 1145336 | 240 | 30 | Diaz | 7 |
| GL | 04/16/10 | 1146454 | 240 | 30 | Diaz | 05/10/10 | 1148175 | 240 | 30 | Diaz | 6 |
| GL | 04/29/10 | 1143423 | 120 | 30 | Diaz | 05/24/10 | 1148172 | 120 | 30 | Diaz | 5 |
| GL | 04/29/10 | 1145336 | 240 | 30 | Diaz | 05/24/10 | 1145336 | 240 | 30 | Diaz | 5 |
| GL | 06/22/11 | 1174785 | 120 | 30 | Diaz | 07/15/11 | 1172951 | 120 | 30 | Diaz | 7 |
| GL | 11/28/11 | 1183585 | 300 | 25 | Diaz | 12/17/11 | 1185523 | 300 | 25 | Diaz | 6 |
| GL | 12/07/11 | 1185524 | 180 | 30 | Diaz | 12/30/11 | 1186912 | 180 | 30 | Diaz | 6 |
| MM | 07/22/11 | 1176580 | 240 | 30 | Diaz | 08/16/11 | 1178046 | 240 | 30 | Diaz | 5 |
| MM | 07/22/11 | 1176579 | 120 | 30 | Diaz | 08/16/11 | 1178047 | 120 | 30 | Diaz | 5 |
| MM | 08/18/11 | 1176387 | 240 | 30 | Diaz | 09/12/11 | 1176387 | 240 | 30 | Diaz | 5 |
| MM | 12/03/11 | 1185275 | 15 | 30 | Diaz | 12/28/11 | 1186952 | 15 | 30 | Diaz | 5 |
| MM | 12/03/11 | 1185274 | 120 | 30 | Diaz | 12/28/11 | 1186953 | 120 | 30 | Diaz | 5 |
| BP | 02/24/10 | 1136288 | 180 | 30 | Diaz | 02/24/10 | 1142325 | 180 | 30 | Diaz | 30 |
| BP | 02/24/10 | 1142325 | 180 | 30 | Diaz | 03/20/10 | 1136288 | 180 | 30 | Diaz | 6 |
| BP | 03/24/10 | 1144472 | 240 | 30 | Diaz | 04/02/10 | 1145097 | 140 | 17 | Diaz | 21 |
| BP | 03/20/10 | 1136288 | 180 | 30 | Diaz | 04/12/10 | 1142325 | 180 | 30 | Diaz | 7 |
| BP | 04/12/10 | 1142325 | 180 | 30 | Diaz | 04/29/10 | 1147582 | 180 | 30 | Diaz | 13 |
| BP | 04/29/10 | 1147582 | 180 | 30 | Diaz | 05/11/10 | 1142325 | 180 | 30 | Diaz | 18 |

| Pt. | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Date Dispensed | Rx. No. | Qty | Day Supply | MD | Days Early |
|---|---|---|---|---|---|---|---|---|---|---|---|
| BP | 09/13/10 | 1154202 | 180 | 30 | Diaz | 10/08/10 | 1154202 | 180 | 30 | Diaz | 5 |
| BP | 09/17/11 | 1173125 | 180 | 30 | Diaz | 09/23/11 | 1178161 | 180 | 30 | Diaz | 24 |
| BP | 09/14/11 | 1179896 | 300 | 25 | Diaz | 09/23/11 | 1180520 | 270 | 30 | Diaz | 16 |
| BP | 09/14/11 | 1179895 | 360 | 30 | Diaz | 09/23/11 | 1180519 | 360 | 30 | Diaz | 21 |
| JR | 06/27/11 | 1175073 | 30 | 30 | Diaz | 07/18/11 | 1176291 | 30 | 30 | Diaz | 9 |
| JR | 08/15/11 | 1177927 | 90 | 30 | Diaz | 09/09/11 | 1179557 | 90 | 30 | Diaz | 5 |
| JS | 09/04/10 | 1156516 | 90 | 30 | Diaz | 10/07/10 | 1156516 | 90 | 30 | Diaz | 7 |
| JR | 07/19/11 | 1174816 | 90 | 30 | Diaz | 08/13/11 | 1174816 | 90 | 30 | Diaz | 5 |
| JR | 08/13/11 | 1174816 | 90 | 30 | Diaz | 09/07/11 | 1174816 | 90 | 30 | Diaz | 5 |
| RS | 06/28/11 | 1175121 | 300 | 30 | Diaz | 07/22/11 | 1176613 | 240 | 30 | Diaz | 6 |
| RS | 06/28/11 | 1175116 | 600 | 30 | Diaz | 07/22/11 | 1176610 | 600 | 30 | Diaz | 6 |
| RS | 06/28/11 | 1175113 | 120 | 30 | Diaz | 07/22/11 | 1176615 | 120 | 30 | Diaz | 6 |
| ET | 06/20/11 | 1173573 | 240 | 30 | Diaz | 07/13/11 | 1169455 | 240 | 30 | Diaz | 7 |
| ET | 12/27/11 | 1175542 | 240 | 30 | Diaz | 12/27/11 | 1175542 | 240 | 30 | Diaz | 6 |
| CW | 12/29/09 | 1130383 | 120 | 30 | Diaz | 01/20/10 | 1130383 | 120 | 30 | Diaz | 8 |
| CW | 01/19/10 | 1126967 | 60 | 30 | Diaz | 02/11/10 | 1141458 | 60 | 30 | Diaz | 7 |
| CW | 03/23/10 | 1144415 | 120 | 30 | Diaz | 04/13/10 | 1145891 | 120 | 30 | Diaz | 9 |
| CW | 04/13/10 | 1144415 | 120 | 30 | Diaz | 05/06/10 | 1144415 | 120 | 30 | Diaz | 7 |
| CW | 09/08/10 | 1154679 | 120 | 30 | Diaz | 10/01/10 | 1154679 | 120 | 30 | Diaz | 7 |

34. The table above compares the original prescription number on the left with the refilled prescription number on the right. The final column on the right shows the number of days early that the prescription was refilled, based on the number of days supply for the original prescription. This shows a consistent pattern of early refills of prescriptions for Dr. Diaz patients.

35. A review of the CURES data for Respondent Pharmacy shows that between January 1, 2011 and December 5, 2012, Respondent Pharmacy dispensed a total of 10,436 controlled substance prescriptions. Of these prescriptions, 12.99% of them, or 1,356, were controlled substance prescriptions from Dr. Diaz, despite not being one of the pharmacies adjacent to Dr. Diaz's medical office. When compared to three other pharmacies in the area (Federal Drugs PHY

37078 – 1.92 miles from Respondent Pharmacy, Rite Aid 5789 – 0.65 miles from Respondent Pharmacy, and CVS PHY 49473 – 0.41 miles from Respondent Pharmacy), Respondent Pharmacy dispensed an exponentially disproportionate number of Dr. Diaz's controlled substance prescriptions. In fact, of the neighboring pharmacies sampled, neither Federal Drugs nor Rite Aid dispensed any of Dr. Diaz's controlled substance prescriptions and CVS only dispensed 44 of his controlled substance prescriptions.

36. A review of CURES data for Respondent Pharmacy showed that between January 1, 2011 and December 5, 2012, Dr. Diaz had a clear pattern of prescribing controlled substances. His pattern was to prescribe Hydromorphone, HC/AP, Oxycontin, Oxycodone, Morphine, Opana ER, Fentanyl, Alprazolam, Methadone, Diazepam, Clonazepam, Lorazepam, and/or Oxy/Ap in large and redundant quantities and in questionable combinations. Nevertheless, Respondent Pharmacy filled prescriptions from Dr. Diaz's patients.

**SECOND CAUSE FOR DISCIPLINE**

**(Records of Acquisition and Disposition)**

37. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with Code section 4081 and Code section 4105, subdivision (a), on the grounds of unprofessional conduct in that Respondents were unable to account for the records of sale, acquisition, and/or disposition of dangerous drugs for at least three years from the date of making. Respondent Pharmacy could not account for prescription hard copies for the following prescriptions: RX #1152434, RX #1187257, RX #1184958, RX #1136283, RX #1183085, RX #1185522, RX #1185523, and RX #1171890.

**THIRD CAUSE FOR DISCIPLINE**

**(Erroneous or Uncertain Prescriptions)**

38. Respondent Pharmacy and Respondent Bhalla are subject to disciplinary action under Code section 4301, subdivision (o), in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct in that between January 1, 2010 and January 15, 2013, Respondent dispensed prescriptions which contained significant errors,

omissions, irregularities, uncertainties, ambiguities, or alterations. The facts and circumstances are as follows:

39. The following hard copy prescriptions had suspicious or no dates: (1) RX #1182583 was dated 10/7/68. The date was nonsensical. (2) RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have dates.

40. The following prescriptions were dispensed prior to the dates written on the prescriptions:

a) The hard copy of the prescription for RX #1176498 was dated July 22, 2011, but the prescription itself was dispensed on July 21, 2011.

b) The hardcopy of the prescription for RX #1156765 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

c) The hardcopy of the prescription for RX #1156766 was dated September 18, 2010 but the prescription itself was dispensed on September 17, 2010.

d) The hardcopy of the prescription for RX #1156769 was dated September 18, 2011 but the prescription itself was dispensed on September 17, 2010.

e) The hardcopy of the prescription for RX #1175775 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

f) The hardcopy of the prescription for RX #1175776 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

g) The hardcopy of the prescription for RX #1175777 was dated August 6, 2011 but the prescription itself was dispensed on July 8, 2011.

h) The hardcopy of the prescription for RX #1179567 was dated September 14, 2011 but the prescription itself was dispensed on September 9, 2011.

i) The hardcopy of the prescription for RX #1179202 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

j) The hardcopy of the prescription for RX #1179203 was dated October 1, 2011, but the prescription itself was dispensed on September 2, 2011.

k) The hardcopy of the prescription for RX # 1179204 was dated October 1, 2011 but the prescription itself was dispensed on September 2, 2011.

41. The following prescriptions were dispensed without a signature from the prescriber: RX #1146852, RX #1146853, RX #1146856 (all dispensed on April 20, 2010) did not have Dr. Diaz's signature.

**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 49809, issued to The Medicine Shoppe with Sanjiv Bhalla as the Pharmacist-In-Charge;

2. Revoking or suspending Pharmacist License Number RPH 46064, issued to Sanjiv Bhalla; and

3. Ordering The Medicine Shoppe and Sanjiv Bhalla 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: 12/21/15

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

LA2014512773