



California State Board of Pharmacy

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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

Subject: Agenda Item 1: Discussion on Existing Requirements for Patient-Centered Prescription Drug Container Labels

The board's requirements for patient-centered prescription drug container labels took effect on January 1, 2011, as required by statute. Since June 2010, when the board finalized its work on the regulation, the board has been publicizing its requirements to the board's licensees. A full copy of the regulation's requirements follow this memorandum.

In addition to the actual text of the requirements, the regulation also contains several directives to the board. These directives are:

- (b) By October 2011, and updated as necessary, the board shall publish on its Web site translation of the directions for use listed in subdivision (a)(4) into at least five languages other than English, to facilitate the use thereof by California pharmacies.
- (c) Beginning in October 2011 the board shall collect and publish on its Web site examples of labels conforming to these requirements, to aid pharmacies in label design and compliance.
- (e) The board shall re-evaluate the requirements of this section by December 2013 to ensure optimal conformance with Business and Professions Code section 4076.5.

At this meeting the committee will have an opportunity to discuss and begin work on these items.

- Re: subdivision (b): translations are available for addition to the Web site and will be discussed as agenda item 3.
- Re: subdivision (c): The board already has examples of labels available on its Web site and has published these in its newsletter.
- Re: subdivision (e): The committee may want to begin discussions of the existing requirements to determine whether modifications to the requirements are needed.

Lastly, California law (section 4076.5 of the Business and Professions Code) requires the board to prepare a report to the Legislature on the implementation of the patient-centered labels by January 1, 2013.

1707.5. Patient-Centered Labels for Prescription Drug Containers; Requirements

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

(1) Each of the following items shall be clustered into one area of the label that comprises at least 50 percent of the label. Each item shall be printed in at least a 10-point sans serif typeface or, if requested by the consumer, at least a 12-point typeface, and listed in the following order:

(A) Name of the patient

(B) Name of the drug and strength of the drug. For the purposes of this section, “name of the drug” means either the manufacturer’s trade name of the drug, or the generic name and the name of the manufacturer.

(C) The directions for the use of the drug.

(D) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(2) For added emphasis, the label shall also highlight in bold typeface or color, or use blank space to set off the items listed in subdivision (a)(1).

(3) The remaining required elements for the label specified in section 4076 of the Business and Professions Code, as well as any other items of information appearing on the label or the container, shall be printed so as not to interfere with the legibility or emphasis of the primary elements specified in paragraph (1) of subdivision (a). These additional elements may appear in any style, font, and size typeface.

(4) When applicable, directions for use shall use one of the following phrases:

(A) Take 1 [insert appropriate dosage form] at bedtime

(B) Take 2 [insert appropriate dosage form] at bedtime

(C) Take 3 [insert appropriate dosage form] at bedtime

(D) Take 1 [insert appropriate dosage form] in the morning

(E) Take 2 [insert appropriate dosage form] in the morning

(F) Take 3 [insert appropriate dosage form] in the morning

(G) Take 1 [insert appropriate dosage form] in the morning, and Take 1 [insert appropriate dosage form] at bedtime

(H) Take 2 [insert appropriate dosage form] in the morning, and Take 2 [insert appropriate dosage form] at bedtime

(I) Take 3 [insert appropriate dosage form] in the morning, and Take 3 [insert appropriate dosage form] at bedtime

(J) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, and 1 [insert appropriate dosage form] in the evening

(K) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, and 2 [insert appropriate dosage form] in the evening

(L) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, and 3 [insert appropriate dosage form] in the evening

(M) Take 1 [insert appropriate dosage form] in the morning, 1 [insert appropriate dosage form] at noon, 1 [insert appropriate dosage form] in the evening, and 1 [insert appropriate dosage form] at bedtime

(N) Take 2 [insert appropriate dosage form] in the morning, 2 [insert appropriate dosage form] at noon, 2 [insert appropriate dosage form] in the evening, and 2 [insert appropriate dosage form] at bedtime

(O) Take 3 [insert appropriate dosage form] in the morning, 3 [insert appropriate dosage form] at noon, 3 [insert appropriate dosage form] in the evening, and 3 [insert appropriate dosage form] at bedtime

(P) If you have pain, take ___ [insert appropriate dosage form] at a time. Wait at least ___ hours before taking again. Do not take more than ___ [appropriate dosage form] in one day

(b) By October 2011, and updated as necessary, the board shall publish on its Web site translation of the directions for use listed in subdivision (a)(4) into at least five languages other than English, to facilitate the use thereof by California pharmacies.

(c) Beginning in October 2011 the board shall collect and publish on its Web site examples of labels conforming to these requirements, to aid pharmacies in label design and compliance.

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

(e) The board shall re-evaluate the requirements of this section by December 2013 to ensure optimal conformance with Business and Professions Code section 4076.5.

(f) As used in this section, "appropriate dosage form" includes pill, caplet, capsule or tablet.



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GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

Subject: Agenda Item 2: Review of USP’s Guidance for Prescription Container Labeling

Earlier this year, the United States Pharmacopeia completed its work on standards for prescription container labeling. This is the first committee meeting scheduled after the release of these, so this is the board’s first discussion.

Following this memorandum is the USP’s guidance. This guidance is a recommendation -- it does not carry the effect of law or regulation.

A comparison chart of the requirements has been developed which highlights the board’s regulation with the USP’s. It is not surprising how similar they are as USP considered the board’s initial draft requirements at an early state in the development of their standards.

	USP	Board Regulation
Organize label to emphasize patient info	X	X
• Patient’s Name	X	X
• Drug Name & Strength	X	X
• Instructions in Clear & Simple Language	X	X
• Standardize order	O	X
• Dedicate 50% of label	O	X
• Require Purpose if on Rx	O	X
• Require Mfg if generic drug	O	X
Place all other required elements elsewhere so not as to interfere with the above	X	X
Use standardized pat-centered translations of directions for use “when appropriate”	X	X
Separate dose from timing of dose	X	X (in stnd. directions)
Use numeric, not alphabetic characters	X	X
Purpose for use if desired by patient and use simple terms	X	O

Purpose for use if written on Rx	<input type="radio"/>	<input checked="" type="radio"/>
Limit Auxiliary information/labels	<input checked="" type="radio"/>	<input type="radio"/>
Standardize terms & placement	<input checked="" type="radio"/>	<input type="radio"/>
Validate use of icons	<input checked="" type="radio"/>	<input type="radio"/>
Labels should be in language of Patient	<input checked="" type="radio"/>	<input type="radio"/> Bd provided translations of directions In 5 additional lang.
or should have interpreter services available	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Labels should be easy to read	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Use high contrast ink	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Simple uncondensed fonts	<input checked="" type="radio"/>	
Large Font size	<input checked="" type="radio"/>	
e.g., (not specified one type)		
12-point Times New Roman	<input checked="" type="radio"/>	<input type="radio"/>
11-point Arial	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Use san serif (e.g, Arial) 10 point	<input type="radio"/>	<input checked="" type="radio"/>
Or 12 point if requested	<input type="radio"/>	<input checked="" type="radio"/>
No font smaller than 10 point	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Use sentence case (not all caps)	<input checked="" type="radio"/>	<input type="radio"/>
Use Adequate white space	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Use white space to separate directions from pharmacy info	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Use horizontal text only	<input checked="" type="radio"/>	<input type="radio"/>
Minimize need to turn container to read	<input checked="" type="radio"/>	<input type="radio"/>
Do not truncate information	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Use highlight, gold and typo cues to emphasize pt. centric or adherence (e.g., ordering)	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Limit number of highlight colors	<input checked="" type="radio"/>	<input type="radio"/>

The committee may want to consider the USP guidance when it evaluates changes needed to the board's regulation requirements.

BRIEFING

(17) Prescription Container Labeling. This proposed new general test chapter provides information on prescription container labeling. On May 18, 2007, the USP Safe Medication Use Expert Committee established an Advisory Panel to (1) determine optimal prescription label content and format to promote safe medication use by critically reviewing factors that promote or distract from patient understanding of prescription medication instructions and (2) create universal prescription label standards for format/appearance and content/language.

In November 2009, the Health Literacy and Prescription Container Labeling Advisory Panel presented its recommendations to the Safe Medication Use Expert Committee, which then requested that USP develop patient-centered label standards for the format, appearance, content, and language of prescription medication instructions to promote patient understanding. Those recommendations formed the basis of this general test chapter.

(NSL: S. Becker) RTS—C85490

Add the following:

▲(17) PRESCRIPTION CONTAINER LABELING

INTRODUCTION

Medication misuse has resulted in more than 1 million adverse drug events per year in the United States (1). Patients' best source (and often only source) of information regarding the medications they have been prescribed is on the prescription container label (2–6). Although other written information and oral counseling sometimes may be available (2–4,6–13), the prescription container label must fulfill the professional obligations of the prescriber and pharmacist. These obligations include giving the patient the most essential information needed to understand how to safely and appropriately use the medication and to adhere to the prescribed medication regimen (2,3,13–15).

Inadequate understanding of prescription directions for use and auxiliary information on dispensed containers is widespread (2–12,14,16–18). Studies have found that 46% of patients misunderstood one or more dosage instructions (14), and 56% misunderstood one or more auxiliary warnings (17). The problem of misunderstanding is particularly troublesome in patients with low or marginal literacy (2,3,5,6,8,9,12,15,17). In one study, patients with low literacy were 34 times more likely to misinterpret prescription medication warning labels (17). However, even patients with adequate literacy often misunderstand common prescription directions and warnings (2,6,9,15,17). In addition, there is great variability in the actual auxiliary warning and supplemental instructional information applied by individual practitioners to the same prescription. The specific evidence to support a given auxiliary statement often is unclear, and patients often ignore such information (2,3,7,15,17,18). The essential need for, and benefit of, auxiliary label information (both text and icons) in improving patient understanding about safe and appropriate use of their medications versus explicit simplified language alone require further study (2–5,7,13–15,17–19).

Lack of universal standards for labeling on dispensed prescription containers is a root cause for patient misunderstanding, nonadherence, and medication errors (1–9,12,13,15,17,18,20).

PRESCRIPTION CONTAINER LABEL STANDARDS TO PROMOTE PATIENT UNDERSTANDING

Organize the prescription label in a patient-centered manner: Information shall be organized in a way that best reflects how most patients seek out and understand medication instructions. Prescription container

labeling should feature only the most important patient information needed for safe and effective understanding and use (2–5,7,6,11,13,14,16,18,20–23).

Emphasize instructions and other information important to patients: Prominently display information that is critical for patients' safe and effective use of the medicine. Place at the top of the label the patient's name, drug name and strength, and explicit clear directions for use in simple language.

Other less critical but important content (e.g., pharmacy name and phone number, prescriber name, fill date, refill information, expiration date, prescription number, drug quantity, product description, and evidence-based auxiliary information) should not supersede critical patient information. Such less critical information should be placed away from dosing instructions (e.g., at the bottom of the label or in another less prominent location) because it distracts patients, which can impair their recognition and understanding (2–6,11–16,18).

Simplify language: Language on the label should be clear, simplified, concise, and familiar, and should be used in a standardized manner. Only common terms and sentences should be used. Do not use unfamiliar words (including Latin terms) or unclarified medical jargon.

Whenever available and appropriate to the patient context, standardized patient-centered translations of common prescribing directions to patients (SIG) should be used. Use of readability formulas and software is not recommended to simplify short excerpts of text like those on prescription labels. The principles established by Doak, Doak, and Root for maintaining simple language can facilitate the simplification process (24). Consumer feedback also should be sought (2–6,9,12–15,17,18,25,26–28).

Give explicit instructions: Instructions for use shall clearly separate the dose itself from the timing of each dose in order to explicitly convey the number of dosage units to be taken and when (e.g., specific time periods each day such as morning and evening or at breakfast and dinner). Instructions should use numeric rather than alphabetic characters for numbers (e.g., write, "Take 2 tablets in the morning and 2 tablets in the evening" rather than "Take two tablets twice daily").

Whenever available, use standardized directions (e.g., write "Take 1 tablet in the morning and 1 tablet in the evening" or "Take 1 tablet at breakfast and 1 tablet at dinner" if the prescription reads b.i.d.). Vague instructions based on dosing intervals such as twice daily or 3 times daily, or hourly intervals such as every 12 hours, generally should be avoided because such instructions are implicit rather than explicit, they may involve numeracy skills, and patient interpretation may vary from prescriber intent. Although instructions that use specific hourly times (e.g., 8 a.m. and 10 p.m.) are more easily understood than implicit vague instructions, dosing by precise hours of the day is less readily understood and may present greater adherence issues than more general time frames such as in the morning, in the evening, after breakfast, with lunch, or at bedtime.

Ambiguous directions such as "take as directed" should be avoided unless clear and unambiguous supplemental instructions and counseling are provided (e.g., directions for use that will not fit on the prescription container label). A clear statement referring the patient to such supplemental materials should be included on the container label (2–4,6,12–15,29).

Include purpose for use: Determine what the patient prefers, and include the purpose of the medication on the label unless the patient prefers that it not appear. Confidentiality and FDA approval for intended use (e.g.,

labeled versus off-label use) may limit inclusion of the purpose on labels. Current evidence supports inclusion of purpose-for-use language in clear, simple terms (e.g., “for high blood pressure” rather than “for hypertension”) (2–4,13,14).

Limit auxiliary information: Auxiliary information on the prescription container label should be evidence-based on simple explicit language that is minimized to avoid distracting patients with nonessential information. Most patients, particularly those with low literacy, pay little attention to auxiliary information. The information should be presented in a standardized manner and should be critical for patient understanding and safe medication use (e.g., warnings and critical administration alerts). Icons are frequently misunderstood by patients. In addition, icons that provide abstract imagery for messages that are difficult to visually depict may be ineffective at improving understanding compared with simplified text alone. Use only icons for which there is evidence that they improve patient understanding about correct use. Because of the limited space on the container, use only those icons shown in consumer testing to improve understanding beyond simple explicit text alone. Evidence-based auxiliary information, both text and icons, should be standardized so that it is applied consistently and does not depend on individual practitioner choice (2–6,13–15,17–19).

Address limited English proficiency: Whenever possible, prescription container labeling should be provided in an individual’s preferred language. Otherwise there is a risk of misinterpretation of instructions by patients with limited English proficiency, that could lead to medication errors and adverse health outcomes.

Translations of prescription medication labels should be produced using a high-quality translation process. If a high-quality translation process cannot be provided, labels should be printed in English and translated by

trained interpreter services whenever possible to ensure patient comprehension. The use of computer-generated translations should be limited to programs with demonstrated quality because dosage instructions can be inconsistent and potentially hazardous. Standardized translated instructions and technology advances are needed to ensure the accuracy and safety of prescription container labeling for patients with low English proficiency (2,3,30,31).

Improve readability: Labels should be designed and formatted so they are easy to read. Currently no strong evidence supports the superiority in legibility of serif versus sans serif typefaces, so simple uncondensed fonts of either type can be used (2–4,20,22,2–37).

Optimize typography by using the following techniques:

- High-contrast print (e.g., black print on white background).
- Simple, uncondensed familiar fonts with sufficient space within letters and between letters (e.g., Times Roman or Arial).
- Sentence case (i.e., punctuated like a sentence in English: initial capital followed by lower-case words except proper nouns).
- Large font size (e.g., minimum 12-point Times Roman or 11-point Arial) for critical information. Note that point size is not the actual size of the letter, so two fonts with the same nominal point size can have different actual letter sizes. X-height, the height of the lower-case x in typeface, has been used as a more accurate indicator of apparent size than point size. For example, for a given point size, the x-height and apparent size of Arial are actually bigger than those for Times Roman. Do not use type smaller than 10-point Times Roman or equivalent size of another font. Older adults often experience declines in visual acuity.

- Adequate white space between lines of text (25%–30% of the point size).
- White space to distinguish sections on the label such as directions for use versus pharmacy information.
- Horizontal text only.

Other measures that can also improve readability include the following:

- If possible, minimize the need to turn the container in order to read lines of text.
- Never truncate critical information.
- Highlighting, bolding, and other typographical cues should preserve readability (e.g., high-contrast print and light color for highlighting) and should emphasize patient-centric information or information that facilitates adherence (e.g., refill ordering).
- Limit the number of colors used for highlighting (e.g., no more than one or two).

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**Recommendations to the Safe Medication Use Expert Committee
by the Health Literacy and
Prescription Container Labeling Advisory Panel
May and November 2009**

Posted April 2010

Background

Inadequate understanding of prescription medication directions for use and auxiliary information on dispensed containers is widespread among patients and is a major concern affecting safe and effective use. Lack of universal standards and formal oversight for dispensed prescription containers is a root cause for patient misunderstanding, nonadherence, and even medication errors. On May 18, 2007 the Safe Medication Use Expert Committee established the Health Literacy and Prescription Container Labeling Advisory Panel (HL AP) to examine ways to improve prescription drug container labeling and, if possible, to recommend ways to standardize this labeling. In December 2008 the HL AP held its first meeting. During 2009 the HL AP wrote a series of recommendations for standards development and requested that USP develop patient-centered label standards for the format, appearance content, and language of prescription medication instructions to promote patient understanding.

The following recommendations for patient-centered prescription label standards are for the format, appearance, content, and language of prescription medication containers to promote patient understanding. These recommendations are evidence-based and address optimal understanding, adherence, and safe and effective use of medications by patients. These recommendations emanated from the May 16, 2009 and November 4, 2009 meetings of the HL AP. Pursuant to these recommendations, the HL AP is developing a proposed General Chapter <17> *Prescription Container Labeling* that will be forwarded into the *Pharmacopeial Forum* public review and comment process. The General Chapter also will be pre-posted on the USP Web site to enable broad public comment.

Recommendations

Organize the Prescription Label in a Patient-centered Manner

Patient-directed information must be organized in a way that best reflects how most patients seek out and understand medication instructions. Prescription container labeling should feature only the most critical patient information needed for safe and effective understanding and use.

Patient-directed instructional content will be at the top of the label, and other less critical content (e.g., pharmacy name and phone number, prescriber name, fill date, refill information, expiration date, prescription number, drug quantity, product description, and evidence-based auxiliary information) should not supersede critical patient information. Such less critical information can be placed e.g., at the bottom of the label or another less prominent location. Drug name and directions for use (e.g., specific dosage/usage/administration instructions) should be displayed with greatest prominence.

Simplify Language

To improve patient understanding and safe and effective prescription medication use, language on the label should be clear, simplified, concise, and standardized. Only common terms and sentences should be used. Use of unfamiliar words (including Latin terms; see below) and unclear medical jargon should be avoided.

Whenever available and appropriate to the patient context, standardized patient-centered translations of common prescribing directions to patients (SIG) should be used. Ambiguous directions such as "take as directed" should be avoided unless clear and unambiguous supplemental instructions and counseling are provided (e.g., directions for use that will not fit on the prescription container label). A clear statement referring the patient to such supplemental materials should be stated on the container label.

Readability formulas and software are not recommended for short excerpts of text like that on prescription labels. The principles established by Doak, Doak, and Root for maintaining simple language can facilitate the simplification process.¹ Consumer feedback should also be sought.

Use Explicit Text to Describe Dosage/Interval Instructions

Dosage/usage/administration instructions must clearly separate dose from interval and must provide the explicit frequency of drug administration (e.g., "Take 4 tablets each day. Take 2 tablets in the morning and 2 tablets in the evening" is better than "Take two tablets by mouth twice daily"). Use numeric rather than alphabetic characters for numbers.

Include Purpose for Use

Confidentiality and FDA approval for intended use (e.g., labeled vs off-label use) may limit inclusion of indications on drug product labels. Current evidence supports inclusion of purpose-for-use language in clear, simple terms. Therefore, the prescriber's intended purpose of use/indication should be included on the prescription medication label whenever possible and should be stated in clear, simple, patient-centered language. When such use conflicts with unit-of-use commercial packaging information, the patient should receive appropriate counseling to clarify the intended purpose of the medication vs. what is stated in commercial labeling.

Improve Readability

Critical information for patients must appear on the prescription label in an uncondensed, simple, familiar, minimum 12-point, sans serif font (e.g., Arial) that is in sentence case (i.e., punctuated like a normal sentence in English: initial capital followed by lower-case letters except for proper nouns, acronyms, etc.). Field size and font size may be increased in the best interest of patient care. Critical information should never be truncated.

The following several general rules can improve readability:

- Optimize typography
- Optimize white space (use adequate space between lines of text; use wide letter spacing; and use white space to distinguish sections on the label such as directions for use vs pharmacy information)
- Use numeric rather than alpha representation (e.g., for dose information)
- Use horizontal text only
- If possible, minimize need to turn the container in order to read lines of text.

Highlighting, bolding, and other typographical cues should preserve readability (e.g., contrast, light color for highlighting), and should emphasize patient-centric information or information that facilitates patient adherence.

Provide Labeling in Patient's Preferred Language Whenever possible, prescription container labeling should be provided in a patient's preferred language. Translations of prescription medication labels should be produced using a high-quality translation process. An example of a high-quality translation process includes the following four elements:

¹ by the Suitability Assessment of Materials by Doak, Doak, and Root

- Initial translation by a trained and competent translator (e.g., a translator with documented proficiency in both English and the other language and knowledge in both languages of terminology and concepts relevant to prescription medication)
- Review of the translation by another trained and competent translator and reconciliation of differences
- Review of the translation by a pharmacist or other medical professional who is a native speaker of the target language and reconciliation of differences
- Testing of comprehension with target audiences.

If a high-quality translation process cannot be provided, labels should be printed in English.

Include Supplemental Information

Auxiliary information on the prescription container should be minimized and should be limited to evidence-based critical information regarding safe. The information should be presented in a standardized manner and should be necessary for patient understanding. This is necessary because of the extensive variability in the content and application of supplemental information, the lack of scientific evidence for these labels, and potential ambiguity and failure to address specific patient needs.

Auxiliary information should be critical to the medicine's safe and appropriate use and should be evidence-based, should clarify instructions for use, and should enhance understanding. Use of icons should be limited to those for which evidence demonstrates enhancement of interpretation and clarity about use. The inclusion of auxiliary information on the patient prescription medication label (e.g., warnings and critical administration alerts) should be minimized and limited to critical information that is evidence based, standardized, and complementary to the patient prescription medication label.

Standardize Directions to Patients

In recognition of the nation's move toward e-prescribing, the HL AP recommends that standards should be developed for prescribing directions to patients (SIGs). This would lead to consistency of language and use across all health care professionals and systems. An important element is the elimination of Latin abbreviations (BID, QID, PRN, etc.), which are often misunderstood and susceptible to variation in translation.

####



California State Board of Pharmacy

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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

Subject: Agenda Item 3: Translations of Directions for Use

The California Endowment, to support ensuring quality labels for those who do not read English, funded a project with national PhD patient literacy researchers Stacy Bailey and Michael Wolf to develop and vet translations of the standardized directions for use that are contained in the board's patient-centered label requirements. The translations were vetted in local CA (and IL) communities with a survey of native speakers.

The board is fortunate that this funding and these researchers have been available to us in the development of these labeling requirements. As discussed early in the development of the regulation, the translations will be placed on the Web site with a disclaimer about board liability for use.

The regulation requires that the board place these translations on its Web site by October 2011.

The following pages contain the translations that have been made in Spanish, Korean, Russian, Vietnamese and Chinese.

There are several differences from the directions for use in the regulation:

- There was no translation of "if you have pain, take ___ at a time. Wait at least ___ hours before taking again. Do not take more than ___."
- They used the word pill in the translations, not "insert appropriate dosage form."

The board has access to a translation service for its publications. Between now and the time of the board meeting, I will have these translations reviewed by this service.

ENGLISH**SPANISH**

Take 1 pill at bedtime	Tome 1 pastilla a la hora de acostarse
Take 2 pills at bedtime	Tome 2 pastillas a la hora de acostarse
Take 3 pills at bedtime	Tome 3 pastillas a la hora de acostarse
Take 1 pill in the morning	Tome 1 pastilla por la mañana
Take 2 pills in the morning	Tome 2 pastillas por la mañana
Take 3 pills in the morning	Tome 3 pastillas por la mañana
Take 1 pill in the morning and 1 pill at bedtime	Tome 1 pastilla por la mañana y Tome 1 pastilla a la hora de acostarse
Take 2 pills in the morning and 2 pills at bedtime	Tome 2 pastillas por la mañana y Tome 2 pastillas a la hora de acostarse
Take 3 pills in the morning and 3 pills at bedtime	Tome 3 pastillas por la mañana y Tome 3 pastillas a la hora de acostarse
Take 1 pill in the morning 1 pill at noon and 1 pill in the evening	Tome 1 pastilla por la mañana, 1 pastilla al mediodía y 1 pastilla al atardecer
Take 2 pills in the morning 2 pills at noon and 2 pills in the evening	Tome 2 pastillas por la mañana, 2 pastillas al mediodía y 2 pastillas al atardecer
Take 3 pills in the morning 3 pills at noon and 3 pills in the evening	Tome 3 pastillas por la mañana, 3 pastillas al mediodía y 3 pastillas al atardecer
Take 1 pill in the morning 1 pill at noon and 1 pill at bedtime	Tome 1 pastilla por la mañana, 1 pastilla al mediodía, 1 pastilla a la hora de acostarse
Take 2 pills in the morning 2 pills at noon and 2 pills at bedtime	Tome 2 pastillas por la mañana, 2 pastillas al mediodía, 2 pastillas a la hora de acostarse
Take 3 pills in the morning 3 pills at noon and 3 pills at bedtime	Tome 3 pastillas por la mañana, 3 pastillas al mediodía, 3 pastillas a la hora de acostarse

ENGLISH**RUSSIAN**

Take 1 pill at bedtime	Принимать по 1 таблетке перед сном
Take 2 pills at bedtime	Принимать по 2 таблетки перед сном
Take 3 pills at bedtime	Принимать по 3 таблетки перед сном
Take 1 pill in the morning	Принимать по 1 таблетке утром
Take 2 pills in the morning	Принимать по 2 таблетки утром
Take 3 pills in the morning	Принимать по 3 таблетки утром
Take 1 pill in the morning and 1 pill at bedtime	Принимать по 1 таблетке утром и по 1 таблетке перед сном
Take 2 pills in the morning and 2 pills at bedtime	Принимать по 2 таблетки утром и по 2 таблетки перед сном
Take 3 pills in the morning and 3 pills at bedtime	Принимать по 3 таблетки утром и по 3 таблетки перед сном
Take 1 pill in the morning 1 pill at noon and 1 pill in the evening	Принимать по 1 таблетке утром, по 1 таблетке в полдень и по 1 таблетке вечером
Take 2 pills in the morning 2 pills at noon and 2 pills in the evening	Принимать по 2 таблетки утром, по 2 таблетки в полдень и по 2 таблетки вечером
Take 3 pills in the morning 3 pills at noon and 3 pills in the evening	Принимать по 3 таблетки утром, по 3 таблетки в полдень и по 3 таблетки вечером
Take 1 pill in the morning 1 pill at noon and 1 pill at bedtime	Принимать по 1 таблетке утром, по 1 таблетке в полдень, по 1 таблетке перед сном
Take 2 pills in the morning 2 pills at noon and 2 pills at bedtime	Принимать по 2 таблетки утром, по 2 таблетки в полдень, по 2 таблетки перед сном
Take 3 pills in the morning 3 pills at noon and 3 pills at bedtime	Принимать по 3 таблетки утром, по 3 таблетки в полдень, по 3 таблетки перед сном

ENGLISH**VIETNAMESE**

Take 1 pill at bedtime	Uống 1 viên trước khi đi ngủ
Take 2 pills at bedtime	Uống 2 viên trước khi đi ngủ
Take 3 pills at bedtime	Uống 3 viên trước khi đi ngủ
Take 1 pill in the morning	Uống 1 viên vào buổi sáng
Take 2 pills in the morning	Uống 2 viên vào buổi sáng
Take 3 pills in the morning	Uống 3 viên vào buổi sáng
Take 1 pill in the morning and 1 pill at bedtime	Uống 1 viên vào buổi sáng và 1 viên trước khi đi ngủ
Take 2 pills in the morning and 2 pills at bedtime	Uống 2 viên vào buổi sáng và 2 viên trước khi đi ngủ
Take 3 pills in the morning and 3 pills at bedtime	Uống 3 viên vào buổi sáng và 3 viên trước khi đi ngủ
Take 1 pill in the morning 1 pill at noon and 1 pill in the evening	Uống 1 viên vào buổi sáng, 1 viên vào buổi trưa, và 1 viên vào buổi tối
Take 2 pills in the morning 2 pills at noon and 2 pills in the evening	Uống 2 viên vào buổi sáng, 2 viên vào buổi trưa, và 2 viên vào buổi tối
Take 3 pills in the morning 3 pills at noon and 3 pills in the evening	Uống 3 viên vào buổi sáng, 3 viên vào buổi trưa, và 3 viên vào buổi tối
Take 1 pill in the morning 1 pill at noon and 1 pill at bedtime	Uống 1 viên vào buổi sáng, 1 viên vào buổi trưa, và 1 viên trước khi đi ngủ

Take 2 pills in the morning 2 pills at noon and 2 pills at bedtime	Uống 2 viên vào buổi sáng, 2 viên vào buổi trưa, và 2 viên trước khi đi ngủ
Take 3 pills in the morning 3 pills at noon and 3 pills at bedtime	Uống 3 viên vào buổi sáng, 3 viên vào buổi trưa, và 3 viên trước khi đi ngủ

ENGLISH**CHINESE**

Take 1 pill at bedtime	睡前服一粒藥丸
Take 2 pills at bedtime	睡前服兩粒藥丸
Take 3 pills at bedtime	睡前服三粒藥丸
Take 1 pill in the morning	早上服一粒藥丸
Take 2 pills in the morning	早上服兩粒藥丸
Take 3 pills in the morning	早上服三粒藥丸
Take 1 pill in the morning and 1 pill at bedtime	早上服一粒藥丸和 睡前服一粒藥丸
Take 2 pills in the morning and 2 pills at bedtime	早上服兩粒藥丸和 睡前服兩粒藥丸
Take 3 pills in the morning and 3 pills at bedtime	早上服三粒藥丸和 睡前服三粒藥丸
Take 1 pill in the morning 1 pill at noon and 1 pill in the evening	早上服一粒藥丸 中午服一粒藥丸和 傍晚服一粒藥丸
Take 2 pills in the morning 2 pills at noon and 2 pills in the evening	早上服兩粒藥丸 中午服兩粒藥丸和 傍晚服兩粒藥丸
Take 3 pills in the morning 3 pills at noon and 3 pills in the evening	早上服三粒藥丸 中午服三粒藥丸和 傍晚服三粒藥丸
Take 1 pill in the morning 1 pill at noon and 1 pill at bedtime	早上服一粒藥丸 中午服一粒藥丸和 睡前服一粒藥丸
Take 2 pills in the morning 2 pills at noon and 2 pills at bedtime	早上服兩粒藥丸 中午服兩粒藥丸和 睡前服兩粒藥丸
Take 3 pills in the morning 3 pills at noon and 3 pills at bedtime	早上服三粒藥丸 中午服三粒藥丸和 睡前服三粒藥丸

ENGLISH**KOREAN**

Take 1 pill at bedtime	취침 전 1 알을 복용하십시오
Take 2 pills at bedtime	취침 전 2 알을 복용하십시오
Take 3 pills at bedtime	취침 전 3 알을 복용하십시오
Take 1 pill in the morning	아침에 1 알을 복용하십시오
Take 2 pills in the morning	아침에 2 알을 복용하십시오
Take 3 pills in the morning	아침에 3 알을 복용하십시오
Take 1 pill in the morning and 1 pill at bedtime	아침에 1 알, 취침 전 1 알씩 복용하십시오
Take 2 pills in the morning and 2 pills at bedtime	아침에 2 알, 취침 전 2 알씩 복용하십시오
Take 3 pills in the morning and 3 pills at bedtime	아침에 3 알, 취침 전 3 알씩 복용하십시오
Take 1 pill in the morning 1 pill at noon and 1 pill in the evening	아침에 1 알, 정오에 1 알, 저녁에 1 알씩 복용하십시오
Take 2 pills in the morning 2 pills at noon and 2 pills in the evening	아침에 2 알, 정오에 2 알, 저녁에 2 알씩 복용하십시오
Take 3 pills in the morning 3 pills at noon and 3 pills in the evening	아침에 3 알, 정오에 3 알, 저녁에 3 알씩 복용하십시오
Take 1 pill in the morning 1 pill at noon and 1 pill at bedtime	아침에 1 알, 정오에 1 알, 취침 전 1 알씩 복용하십시오
Take 2 pills in the morning 2 pills at noon and 2 pills at bedtime	아침에 2 알, 정오에 2 알, 취침 전 2 알씩 복용하십시오
Take 3 pills in the morning 3 pills at noon and 3 pills at bedtime	아침에 3 알, 정오에 3 알, 취침 전 3 알씩 복용하십시오



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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

Subject: Agenda Item 4: Discussion Regarding the Future Design of the Notice to Consumers Posters and Video Display

At the July 29, 2011 Board Meeting, the board completed its work on a new regulation to house all notice to consumer elements in one place. The regulation was amended during this meeting in response to comments received, released for the required 15-day period, and no responsive negative comments were received. Thus, the language as finalized by the board contains the new notice to consumer requirements

The rulemaking file for this regulation will now be compiled by board staff, and submitted to the Department of Consumer Affairs for review, then to the Office of Administrative Law. It will be approximately 6 months (perhaps a bit less) before the regulation would be in effect.

A copy of the proposed notice to consumers regulation follows this memorandum.

This is a good time to start the design of the new poster(s). At this meeting the committee can begin discussion of what it would like to see in the design for the new poster(s). Thereafter, staff will work with various graphic designers to develop prototypes for the new posters and bring these to the next committee meeting, which will be scheduled before the January Board Meeting.

To facilitate the discussion, at the meeting, staff will display the current posters.

Three discussions are proposed under this agenda item:

1. Proposed design elements
2. Concepts for the video display.
3. Concepts for interpreter services, which is likely a separate notice.

Add § 1707.6. to Article 2 of Division 17 of Title 16 of the California Code of Regulations to read as follows:

§ 1707.6. Notice to Consumers.

(a) In every pharmacy there shall be prominently posted, in a place conspicuous to and readable by a prescription drug consumer, a notice containing the text in subdivision (b). Each pharmacy shall use the standardized poster-sized notice provided or made available by the board, unless the pharmacy has received prior approval of another format or display methodology from the board. The board may delegate authority to a committee or to the Executive Officer to give the approval. As an alternative to a printed notice, the pharmacy may also or instead display the notice on a video screen located in a place conspicuous to and readable by prescription drug consumers, so long as: (1) The video screen is at least 24 inches, measured diagonally; (2) The pharmacy utilizes the video image notice provided by the board; (3) The text of the notice remains on the screen for a minimum of 60 seconds; and (4) No more than five minutes elapses between displays of any notice on the screen, as measured between the time that a one-screen notice or the final screen of a multi-screen notice ceases to display and the time that the first or only page of that notice re-displays.

(b) The notice shall contain the following text:

NOTICE TO CONSUMERS

You have the right to ask for and receive from any pharmacy prescription drug labels in 12-point font.

Interpreter services are available to you upon request at no cost.

Before taking your medicine, be sure you know: the name of the medicine and what it does; how and when to take it, for how long, and what to do if you miss a dose; possible side effects and what you should do if they occur; whether the new medicine will work safely with other medicines or supplements; and what foods, drinks, or activities should be avoided while taking the medicine. Ask the pharmacist if you have any questions.

This pharmacy must provide any medicine or device legally prescribed for you, unless: it is not covered by your insurance; you are unable to pay the cost of a copayment; or the pharmacist determines doing so would be against the law or potentially harmful to health. If a medicine or device is not immediately available, the pharmacy will work with you to help you get your medicine or device in a timely manner.

You may ask this pharmacy for information on drug pricing and use of generic drugs.

(c) Every pharmacy, in a place conspicuous to and readable by a prescription drug consumer, at or adjacent to each counter in the pharmacy where dangerous drugs are dispensed or furnished, shall post or provide a notice containing the following text:

Point to your language. Interpreter services will be provided to you upon request at no cost.

This text shall be repeated in at least the following languages: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese.

Each pharmacy shall use the standardized notice provided or made available by the board, unless the pharmacy has received prior approval of another format or display methodology from the board. The board may delegate authority to a committee or to the Executive Officer to give the approval.

The pharmacy may post this notice in paper form or on a video screen if the posted notice or video screen is positioned so that a consumer can easily point to and touch the statement identifying the language in which he or she requests assistance. Otherwise, the notice shall be made available on a flyer or handout clearly visible from and kept within easy reach of each counter in the pharmacy where dangerous drugs are dispensed or furnished, available at all hours that the pharmacy is open. The flyer or handout shall be at least 8 1/2 inches by 11 inches.

Note: Authority cited: Sections 4005 and 4122, Business and Professions Code. Reference: Sections 733, 4005, 4076.5 and 4122, Business and Professions Code, and Section 1707.5 of Division 17 of Title 16 of the California Code of Regulations.



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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

Subject: Agenda Item 5: Update of the Emergency Contraception Protocol

Earlier this year, the Board of Pharmacy initiated the process to update the emergency contraception protocol authorized by California Business and Professions Code section 4052.3 and 16 California Code of Regulations section 1746. These sections authorize a pharmacist to initiate emergency contraception pursuant to a state protocol developed by the Medical Board of California and the Board of Pharmacy, and with the assistance of the American College of Obstetricians and Gynecologists, the California Pharmacists Association and other entities.

The existing state protocol was developed by the Medical Board in 2004 and then later adopted by the Board of Pharmacy as a regulation. Since the time of adoption, there have been changes in the availability of emergency contraception medication, the manufacturers who produce the medication, and there is a typo that needs correction (mcg instead of mg).

After the May Board Meeting, the executive officer compiled edits into a revised protocol from changes submitted from CPhA's representative (a women's health specialist pharmacist Katherine Besinque from USC, and two representatives of the American College of Obstetricians and Gynecologists (Shannon Smith Crowley and Phillip Diamond, MD).

At the July Board Meeting, the board reviewed the proposed changes. After this meeting, the executive officer attended the Medical Board of California's meeting to request their adoption of the updated protocol. With the EO was Dr. Besinque and Ms. Smith Crowley.

The Medical Board approved the protocol at this meeting.

Next, the Board of Pharmacy will need to proceed with a rulemaking to update the requirements as a regulation. A copy of the proposed regulation protocol follows this page.

At this Meeting:

The Communication and Public Education Committee needs to review and if it agrees, recommend approval to the board for action at the October Board Meeting. If the board moves forward with the regulation changes, the regulation will be released for the formal 45 day comment period.

While the rulemaking is underway, the board will need to update the patient information fact sheet, which is required to be provided to patients by the pharmacists using the protocol to dispense emergency contraception.



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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

**Subject: Agenda Item 6: Discussion Surrounding a Proposal to Develop a
Standardized Form for Pharmacies to Use to Request Refills**

For Discussion:

Recently the board received a proposal from Assembly Member Feuer that had been submitted to him by a constituent as a possible legislative proposal. The problem is that physicians receive numerous refill requests via fax daily from pharmacies that are not standardized, and there is potential for a physician to make an error when reviewing and approving such diverse refill requests daily. The proposal is to require use of a specific form.

I took the proposal and sought the reaction or need from Cedars Sinai (where the MD constituent practices), from the California Pharmacists Association and the California Retailers Association. I also ran it past various board inspectors. No one was opposed, but no one was especially motivated either. Several thought that a pharmacy may need to seek different refill elements depending upon the patient, the medication or the medical condition, so standardization may not be achievable.

Following this page is the correspondence on this subject.

Alan W. Weinberger, M.D.
8631 West Third Street, Suite 540-E
Los Angeles, California 90048
Diplomate American Board of Medicine

Facsimile (310) 657-4769
Telephone (310) 854-7224
Fellow American College of Rheumatology

July 22, 2011

Assembly Member Mike Feuer
9200 Sunset Blvd. Suite 1212
West Hollywood, CA 90069

Re: Pharmacy Forms

Dear Representative Feuer:

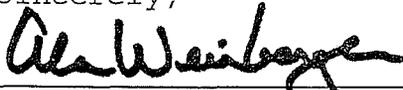
I am a physician at Cedars-Sinai. Every day I sign faxed prescription forms from a variety of pharmacies, often as many as 30.

The problem is that every pharmacy uses a different format, and the potential for making a mistake is much bigger than it needs to be because of this variation.

I think that the State should mandate that pharmacies use a standard prescription refill facsimile form, one approved by the State, so that all pharmacies use the same standard form and doctors don't have to study each form to be sure they fill it out correctly.

I would love if you made a bill or something to set this in motion, and I would be more than happy to discuss it or help.

Sincerely,



Alan W. Weinberger, M.D.

AWW:mc



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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

September 6, 2011

The Honorable Mike Feuer
Member, California State Assembly
9200 Sunset Boulevard, Suite 1212
West Hollywood, CA 90069

RE: July 22, 2011 Letter from Alan Weinberger, M.D.

Dear Assembly Member Feuer:

I am responding to a letter forwarded to the board from your office in late July from Dr. Weinberger (copy attached). Dr. Weinberger suggests the introduction of legislation to require pharmacies to use a state-mandated form when requesting refill authorization from a prescriber. I apologize for the delay in responding to this inquiry.

As background to this inquiry: pharmacies fairly routinely seek refill authorizations on behalf of patients for their prescription medication. This authorization is often done by fax, although telephone authorization and less often electronic requests (e-prescribing) from the pharmacy to the prescriber's office are used to secure this refill approval. There is no standardized refill request form to do this; instead only certain information is required to authorize a refill between a pharmacy and a prescriber.

This is also typical for how drugs are initially ordered for patients by prescribers: there is no standardized prescription order form that prescribers must use, only required elements for what must appear on the prescription blank (see California Business and Professions Code section 4076). For the most highly regulated prescribed medication, controlled substances, again there is not a standardized prescription form, although California law has: (1) a separate set of required elements for the security prescription form, (2) requirements that only state-approved printers can print security prescription forms to prescribe from, and (3) mandates that specialized security features appear on the prescription documents (see California Health and Safety Code sections 11161.5, 11162.1).

Dr. Weinberger suggests that it would benefit prescribers if pharmacies used a standardized form for refill authorizations. We appreciate the opportunity to respond. The board has no policy in this area. I have contacted both the California Pharmacists Association and Cedars Sinai with whom Dr. Weinberger is associated to respond. No one I have spoken with is especially eager to establish a law that requires a specialized form, although no one specifically opposed it.

So that the board may provide its input to your inquiry, I will add this suggestion to the agenda of the board's Communication and Public Education Committee meeting on

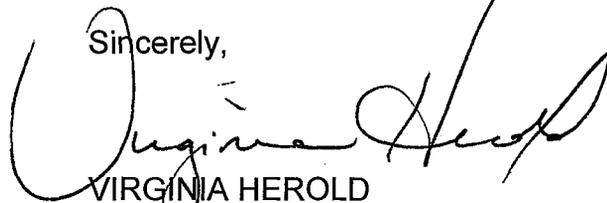
The Honorable Mike Feuer
September 6, 2011
Page Two

September 26. This will provide the committee, and perhaps later the board, with the opportunity to provide comments.

We will provide you with a more specific response after the committee discusses the proposal.

Should you have questions, please do not hesitate to contact me at (916) 574-7911.

Sincerely,

A handwritten signature in black ink, appearing to read "Virginia Herold". The signature is fluid and cursive, with a large initial "V" and a long, sweeping tail.

VIRGINIA HEROLD
Executive Officer

Enclosure

Alan W. Weinberger, M.D.
8631 West Third Street, No. 540-E
Los Angeles, California 90048

RECEIVED BY CLERK
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2011 SEP 15 PM 1:11

Telephone (310) 854-7224
Fax (310) 652-2499

Diplomate of American Board of Internal Medicine

Fellow of the American College of Rheumatology

September 9, 2011

Virginia Herold
Executive Officer
California State Board of Pharmacy
1625 N. Market Blvd, N219
Sacramento, California 95834

Re: Pharmacy Faxed Refill

Dear Ms. Herold:

I am taking the liberty of communicating directly with you regarding a suggestion I made to the Honorable Mike Feuer regarding the faxed refill forms pharmacies routinely fax to physician offices to get refills.

By way of background, I have been involved in various quality control measures at Cedars-Sinai for many years, and one of the things we try hardest to prevent is medication errors.

I easily do as many as 20 of these faxed refill forms a day. And it seems some days that there are as many as 20 different formats, each pharmacy using its own proprietary form.

A simple truism in processes is that unnecessary variation promotes errors. As a busy physician, it's difficult and time consuming to study each new form to see who the patient is, what medicine they want, how many refills are requested, what the directions are, whether generic is ok, etc. It's especially confusing when more than one medicine is listed on the form.

My idea of standardizing this form was not to make life easier for physicians, although it would. Rather, it is simply to eliminate the additional opportunity for medication errors that having a large variety of refill forms creates. I have no special interest in the format, only that it should be the same format every time.

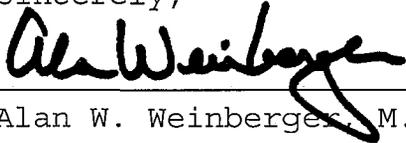
Re: Pharmacy Faxed Refill
September 9, 2011
Page 2

The Pharmacy Board could certainly create such a form, with appropriate input from pharmacists, and implement it at a cost that would be essentially zero.

The need for phone calls for clarification, the number of inadvertant medication errors, and the time spent filling out those forms would be significantly reduced.

Thanks for considering this suggestion, and for presenting it to the Board's Communication and Public Education Committee meeting this September 26th.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Weinberger". The signature is written in a cursive style and is positioned above a horizontal line.

Alan W. Weinberger, M.D.

AWW:mc



California State Board of Pharmacy

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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

Subject: Agenda Item 7: Discussion Surrounding the Assessment of the Board's Public Education Materials

For Discussion:

Last year the committee determined that it wishes to assess its public education materials. A subcommittee of Board Members Castellblanch and Veale agreed to perform this function. After reviewing the number and diversity of materials, the committee decided first to focus on improving the Web site placement of these materials. However, all state agencies are being directed to transfer to a new state government web design, and the board will make the Web site changes when it migrates to the new web format.

In June, Board Associate Analyst Karen Abbe retired. Ms. Abbe was the board's public education and outreach staffer, but over the last year while the board had undergone a 15 percent operations cut and directed to reduce all unnecessary expenditures, she was reassigned to perform the reporting of board discipline taken against licensees to the HIPDB data bank.

Recently the board recruited a public information officer to aid the board in its public outreach, Web site maintenance, social media applications and in developing the new notice to consumers and education on patient-centered labels. We selected Kim Brown from the department's press office who previously assisted us with the development of the consumer education videos. However, DCA Director Stiger blocked her transfer to the board and instead directed that she be assigned to work for us, but remain a DCA employee, denying the transfer to our board. So while not our employee, she will be working exclusively on our projects. This business relationship will be evaluated in three months. However, we are delighted to have her working on our projects.

Ms. Brown will attend this meeting. She will be an asset to this committee in a number of ways including assessing the board's public education materials.

The committee may wish to ask Ms. Brown to develop a method/process to assess our materials.



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GOVERNOR EDMUND G. BROWN JR.

September 16, 2011

To: Members, Communication and Public Education Committee

Subject: Agenda Item 8: Update on *The Script*

The next issue of *The Script* has been written and has been with legal for review for a while. We hoped to release it in September, but this will not now happen.

Meanwhile work on the January issue's articles has begun. This issue will focus on new laws.



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STATE AND CONSUMER SERVICES AGENCY

DEPARTMENT OF CONSUMER AFFAIRS

GOVERNOR EDMUND G. BROWN JR.

Date: September 19, 2011

To: Communication and Public Education Committee

Subject: Agenda Item 9 – Outreach Activities

Since late spring, state government has been subject to a travel freeze that restricts all but the most essential travel. Moreover, the Department of Consumer Affairs has to preapprove all travel where a travel claim will be submitted. This has restricted board operations in all areas, including public and licensee outreach.

Public and licensee outreach activities performed during the first quarter of Fiscal Year 2011/12 include:

- July 8: Executive Officer Herold and President Weisser attend the CSHP's Board of Directors meeting in Sacramento to provide an update on board activities.
- August 18: Executive Officer Herold provides a Webinar on California's e-pedigree requirements to a conference hosted by Axway.
- September 14: Executive Officer Herold attend a California Pharmacy Council Meeting to discuss pharmacist manpower today and in the future.