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

In the Matter of the Accusation Against: **Jay Scott Drugs** **PIC Albert Daher** 2200 N. Glenoaks Burbank, CA 91504 **Retail Pharmacy License Number PHY 40912,** **Albert Farah Daher** 456 Audraine Drive Glendale, CA 91202 **Pharmacist License Number RPH 39189,** **Ahmad Shati Nabhan** 3234 Henrietta Ave La Crescenta, CA 91214 **Pharmacist License Number RPH 41754,** and **Jun Yamasaki** 511 E. Mount Curve Ave. Altadena, CA 91001 **Pharmacist License Number RPH 19983** Respondents.	Case No. 3482 **ACCUSATION**

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Complainant alleges:

PARTIES

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

2. On or about June 27, 1995, the Board of Pharmacy issued Retail Pharmacy License Number PHY 40912 to Jay Scott Drugs (Respondent), located at 220 North Glenoaks, Burbank, California. Albert Farah Daher has been the sole owner of Jay Scott Drugs and Pharmacist-in-Charge of Jay Scott Drugs from 1998 to the present. The Retail Pharmacy License will expire on June 1, 2011, unless renewed.

3. On or about March 12, 1985, the Board of Pharmacy issued Pharmacist License Number RPH 39189 to Albert Farah Daher (Respondent Daher). The Pharmacist License will expire on January 31, 2011, unless renewed.

4. On or about April 20, 1988, the Board of Pharmacy issued Pharmacist License Number RPH 41754 to Ahmad Shati Nabhan (Respondent Nabhan). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2011, unless renewed.

5. On or about July 28, 1956, the Board of Pharmacy issued Pharmacist License Number RPH 19983 to Jun Yamasaki (Respondent Yamasaki). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2012, unless renewed.

JURISDICTION

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

7. Section 4300 of the Code provides, in part, that every license issued by the Board is subject to discipline, including suspension or revocation.

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8. Section 4302 of the Code states:

"The board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee."

9. Section 4113 of the Code states, in part:

"(b) The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

10. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

11. Section 4301 of the Code states:

"The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . 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.

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"(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.

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"(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."

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12. Section 4306.5 of the Code states:

"Unprofessional conduct for a pharmacist may include any of the following:

"(a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or her education, training, or experience as a pharmacist, whether or not the act or omission arises in the course of the practice of pharmacy or the ownership, management, administration, or operation of a pharmacy or other entity licensed by the board.

"(b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services.

"(c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate patient, prescription, and other records pertaining to the performance of any pharmacy function.

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

13. Section 4063 of the Code states:

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

14. Health and Safety Code section 11153 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."

REGULATORY PROVISIONS

15. California Code of Regulations, title 16, section 1707.3 states:

"Prior to consultation as set forth in section 1707.2, a pharmacist shall review a patient's drug therapy and medication record before each prescription drug is delivered. The review shall include screening for severe potential drug therapy problems."

16. California Code of Regulations, title 16, section 1716 states, in part:

"Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code."

17. 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

18. Section 125.3 of the Code provides, in 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.

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19. **DRUG CLASSIFICATIONS**

Brand Name(s)	Generic Name	Dangerous Drug Per Bus. & Prof. Code § 4022	Scheduled Drug per Health & Safety Code	Indications For Use
Ambien	Zolpidem (non-barbiturate, non-benzodiazepine sedative hypnotic)	Yes	Schedule IV	Insomnia
Desyrel	Trazodone	Yes	Not scheduled	Depression and anxiety
Halcion	Triazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Short-term treatment of insomnia
Heroin	Opium derivative	Not prescribed	Schedule I	no currently accepted medical use
Norco[1], Vicodin	Hydrocodone/ Acetaminophen (APAP)	Yes	Schedule III	Moderate to Severe Pain
OxyContin	Oxycodone	Yes	Schedule II	Moderate to Severe pain
Soma[2]	Carisoprodol	Yes	not scheduled	Muscle relaxant
Subutex, Suboxone	Buprenorphine	Yes	Schedule III	Narcotic Addiction
Valium	Diazepam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Anxiety
Vicodin	Hydrocodone/Acetaminophen	Yes	Schedule III	Pain
Xanax	Alprazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV	Anxiety

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[1] Norco 10/325 mg contains 10 mg of hydrocodone and 325 mg of acetaminophen (brand name, Tylenol). The maximum daily recommended dosage for acetaminophen is 4 grams.

[2] Drug abusers combine Soma with hydrocodone to produce similar effects to those of Heroin.

BACKGROUND

20. The Board initiated investigations of Respondents based upon the following:

a. Three (3) complaints against Respondents Jay Scott Drugs and Daher alleging that they excessively dispensed controlled substances to patients, which resulted in the deaths of Patients A.S.[3] and A.C. and the drug addiction of J.S. Patients A.S. and J.S. were Dr. Bernard Bass' patients and Patient A.C. was Dr. Masoud Bamdad's patient.

b. Ventura County Sheriff Department's criminal investigation of Dr. Bass for his involvement in the overdose deaths of seven of his patients, five of which had Dr. Bass' prescriptions filled at Respondent Jay Scott Drugs' facility, namely, A.S., D.L., A.W., L.G., and D.K. Dr. Bass' office was located at 10843 Magnolia Boulevard, North Hollywood, California, which was approximately five miles from Jay Scott Drugs' facility.

c. California Medical Board's investigation into Dr. Bass' medical practice and subsequent discipline, which involved allegations of gross negligence, excessive prescribing of controlled substances, and other violations, with regard to seven (7) patients[4] and subsequent discipline against Dr. Bass' medical license. The California Medical Board's Decision and Order in *In re Matter of the Accusation against Bernard N. Bass, M.D.*, Case No. 05-2005-167939, dated January 21, 2009, provided that Dr. Bass' physician license No. G 28057 was revoked, with revocation stayed, 90 days suspension, placed on seven (7) years probation, and required to surrender his United States Drug Enforcement Administration (DEA) permit to prescribe controlled substances.[5]

21. Based on the foregoing and the C.U.R.E.S.[6] data, the Board investigator selected

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[3] For purposes of patient confidentiality, all patients are referred to by their initials. Upon a proper request for discovery, all patient records will be made available to Respondents.

[4] The seven patients involved in the California Medical Board's investigation regarding Dr. Bass are not the same seven patients involved in Ventura County Sheriff's investigation.

[5] In or about May 2008 Dr. Bass surrendered his DEA permit to Ventura County Sheriff's detectives.

[6] The Controlled Substance Utilization Review and Evaluation System or C.U.R.E.S. is a database maintained by the California Department of Justice, Bureau of Narcotic Enforcement, which allows pre-registered users, including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law

(continued...)

twenty six (26) patients (including deceased patients) of Dr. Bass, who received prescriptions from Jay Scott Drugs, and reviewed their patient profiles and original prescriptions.

22. Patient A.C.'s doctor, Dr. Bamdad, was investigated and federally indicated by the DEA for illegal drug distribution.[7] According to the indictments and a press release by United States Attorney's Office, dated May 6, 2009, in the criminal proceeding entitled *USA v. Masoud Bamdad*, United States District Court, Central District of California (Western Division - Los Angeles), Case No. 2:08-cr-00506-GW-1, Dr. Bamdad was convicted of 13 felony counts of federal narcotics charges[8] for writing prescriptions for Oxycodone for people he did not examine in exchange for as much as $300 in cash. Three of the charges upon which Bamdad was convicted concern prescriptions that were written for people under the age of 21.

FIRST CAUSE FOR DISCIPLINE

(Refill of prescriptions without prescriber's authorization)

23. Respondent Jay Scott Drugs and Respondent Daher are subject to discipline pursuant to Code sections 4300, 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents refilled prescriptions for controlled substances and dangerous drugs, without authorization, in violation of Code section 4063. Specifically, Respondent Daher refilled prescriptions, which did not contain authorized refills on the original prescription as follows:

Patient J.S.

a. On January 15, 2007, Respondent Daher refilled Rx no. 180576 (Norco 10/325 mg, 125 tablets) for J.S. without the prescribing doctor's authorization.

b. On January 22, 2007, Respondent Daher refilled Rx no. 182808 (Norco 10/325 mg, 125 tablets) for J.S. without the prescribing doctor's authorization.

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enforcement, and regulatory boards, to access patient controlled substance history information.

[7] According a press release by United States Attorney's Office, dated May 6, 2009, Dr. Bamdad has been in custody since his arrest in April 2008, by DEA special agents.

[8] The jury found Dr. Bamdad guilty of ten felony counts of violating 21 U.S.C. § 841(a)(1), (b)(1)(C) (knowing and intentional unlawful distribution of controlled substances) and three felony counts of violating 21 U.S.C. § 859 (unlawful distribution of controlled substances to persons under age 21).

SECOND CAUSE FOR DISCIPLINE

(Failure to Review Drug Therapy and Patient Medication Record)

24. Respondent Jay Scott Drugs and Respondent Daher are subject to discipline pursuant to Code sections 4300, 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents failed to review the patient's drug therapy and medication record prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3. The circumstances are as follows:

Patient J.S.

25. Respondent Daher filled prescriptions for highly addictive controlled substances early for J.S., without reviewing his patient profile, resulting in over dispensing controlled substances and/or dangerous drugs to J.S., as follows:

a. On January 24, 2007, Respondent Daher dispensed Rx No. 183632 (Norco 10/325mg) and Rx No. 183633 (Xanax 2mg, 60 tablets) for J.S. six (6) days earlier than the written directions indicated. The prescribing doctor dated the prescriptions January 30, 2007.

b. From January 15, 2007, to January 24, 2007, over a 10-day period, Respondent Daher dispensed 500 tablets of Norco, and from January 19, 2007, through January 24, 2007, over a 6-day period, Respondent Daher dispensed 120 tablets of Xanax, to J.S., as set forth in the table below:

Rx #	Drug	Date filled	RPH	Direction	Qty	
180576	Norco 10/325	1/15/07	AD	Take 1-2 tablets every 4 hours	125	Unauthorized refill
182808	Norco 10/325	1/19/07	AD	Take 1-2 tablets every 4 hours	125	
182809	Xanax 2mg	1/19/07	AD	Take 1 tablet every 6 hours	60	
182810	Soma 350 mg	1/19/07	AD	Take 1 tablet every night	10	
182808	Norco 10/325	1/22/07	AD	Take 1-2 tablets every 4 hours	125	Unauthorized refill
183632	Norco 10/325	1/24/07	AD	Take 1-2 tablets every 4 hours	125	Early fill
183633	Xanax 2mg	1/24/07	AD	Take 1 tablet every 6 hours	60	Early fill

The written directions for these medications are Norco 10/325mg, take 1-2 tablets every 4 hours (equals a maximum of 12 tablets per day); Xanax 2mg, take 1 every 6 hours (equals a maximum of 4 tablets per day); and Soma, take 1 tablet every night (1 tablet per day). Based on Respondent Daher's over dispensing, the patient was taking 20 tablets of Xanax per day and 50 tablets of Norco 10/325mg per day, which constitutes 16.25 grams of Tylenol per day. As a result, the patient was exposed to Tylenol toxicity.

Patient A.S.

26. Respondent Daher filled prescriptions for highly addictive controlled substances for A.S., without reviewing his patient profile, resulting over dispensing controlled substances and/or dangerous drugs to J.S., as follows:

a. On January 22, 2007, Respondent Daher dispensed Rx No. 183159 (Norco 10/325mg, 125 tablets), Rx No. 183160 (Xanax 2mg, 60 tablets), Rx 183162 (Soma, 15 tablets) for A.S. eight (8) days earlier than the written directions indicated. The prescribing doctor dated the prescriptions January 30, 2007.

b. In addition, three days earlier, on January 19, 2007, Respondent Daher had dispensed the identical prescriptions to A.S. (Norco 10/325 mg 125 tablets, Xanax 2mg 60 tablets, Soma 15 tablets). As a result, over a period of four days, from January 19, 2007, through January 22, 2007, Respondent Daher dispensed 250 tablets of Norco, 120 tablets of Xanax, and 30 tablets of Soma to A.S., as set forth in the table below:

Rx #	Date filled	Drug	RPH	Direction	Qty	
182811	1/19/07	Norco 10/325	AD	Take 1-2 tablets every 4 hours	125	
182812	1/19/07	Xanax 2mg	AD	Take 1 tablet every 6 hours	60	
182813	1/19/07	Soma 350 mg	AD	Take 1 tablet every night	15	
183159	1/22/07	Norco 10/325	AD	Take 1-2 tablets every 4 hours	125	
183160	1/22/07	Xanax 2mg	AD	Take 1 tablet every 6 hours	60	
183162	1/22/07	Soma 350 mg	AD	Take 1 tablet every night	15	

Based on Respondent Daher's over dispensing, the patient was taking 62 tablets of Norco 10/325mg, 30 tablets of Xanax 2mg, and 7 tablets of Soma per day. 62 tablets of Norco

10/325mg constitute 20 mg of Tylenol, five (5) times the recommended daily dose. As a result, the patient was exposed to Tylenol toxicity.

Patient N.V.

27. On seven (7) occasions Respondent Jay Scott Drugs dispensed prescriptions for highly addictive controlled substances early for N.V., without reviewing N.V.'s patient profile. By filling the prescriptions early, Respondents over dispensed controlled substances and/or dangerous drugs to N.V., as follows:

a. On March 29, 2007, Respondent Daher dispensed a refill of Norco 10/325mg six (6) days early.

b. On May 29, 2007 Respondent Nabhan dispensed a refill of Norco 10/325mg seven (7) days early.

c. On June 26, 2007. Respondent Yamasaki dispensed a refill of Norco 10/325mg nine (9) days early.

d. On October 15, 2007, Respondent Daher dispensed a refill of Norco 10/325mg five (5) days early.

e. On February 12, 2008, Respondent Daher dispensed a refill of Norco 10/325mg six (6) days early.

f. On March 13, 2008, Respondent Daher dispensed a refill of Norco 10/325mg five (5) days early.

g. On April 4, 2008, Respondent Daher dispensed a refill of Norco 10/325mg six (6) days early.

THIRD CAUSE FOR DISCIPLINE

(Failure to Exercise Professional Judgment)

28. Respondents are subject to discipline pursuant to Code sections 4300 and 4301, subdivision (d), (j) and (o), on the grounds of unprofessional conduct, in that they failed to exercise professional judgment and failed to share a corresponding responsibility with regard to the dispensing or furnishing of controlled substances and/or dangerous drugs, in violation of Code section 4306.5, subdivision (b), Health and Safety Code section 11153, and California Code of

Regulations, title 16, section 1761, subdivision (b), which put their patients at risk. Respondents dispensed prescriptions that they knew or had an objective reason to know that said prescriptions were not issued for a legitimate medical purpose. The circumstances are as follows:

Dr. Bass' prescribing pattern

29. Respondents failed to adequately evaluate and/or address Dr. Bass' suspect prescribing pattern or his patients' profiles prior to dispensing controlled substances to Dr. Bass' patients, which presented clear indications that numerous prescriptions written by Dr. Bass were not issued for a legitimate medical purpose. Respondents failed to evaluate the totality of the circumstances presented by Dr. Bass' prescribing pattern, including, but not limited to, the fact that Dr. Bass wrote an unusually large number of controlled substance prescriptions, wrote few if any prescriptions that were not controlled substances except Soma, he prescribed the same drugs with the same dosages, directions and quantities without adjustments for numerous patients, including patients in the same family, he prescribed illogical drug combinations, his practice included an unusually large number of young patients for pain management, who traveled 30 or 40 miles to see Dr. Bass or have their prescriptions filled at Respondent Jay Scott Drugs, and paid for their prescriptions in cash.

Unusually large number of controlled substance prescriptions

30. Dr. Bass wrote an unusually large number of controlled substance prescriptions. From October 2006 through April 2008, Respondent Jay Scott Drugs dispensed 33,742 controlled substance prescriptions written by Dr. Bass, not including the approximately 9,481 prescriptions for Soma.[9] During that period the pharmacy operated approximately 493 days. Therefore, Respondent Jay Scott Drugs dispensed approximately 1775 controlled substance prescriptions written by Dr. Bass per month or an average of approximately 68 controlled substance prescriptions per day for 19 months. The large number of controlled substance prescriptions dispensed per day written by Dr. Bass should have alerted Respondents to carefully monitor patients and carefully document that monitoring, which they failed to do.

[9] Dr. Bass' prescription history with Jay Scott Drugs was 608 pages long for the time period January 1, 2006, through May 8, 2009, with very few prescriptions dispensed during 2006.

Few if any prescriptions other than controlled substances and Soma

31. Respondents failed to consider that Dr. Bass patients had very few if any prescriptions other than those pain medications and Soma ordered by Dr. Bass, filled at Jay Scott Drugs. Normally patients have a number of different types of prescriptions dispensed, not just controlled substance prescriptions. Most patients reviewed either had no other prescriptions for other types of medications or abnormally few other types of prescriptions dispensed by Respondent Jay Scott Drugs.

Same drug regimen

32. The typical drug regimen that Dr. Bass used and was dispensed by Respondent Jay Scott Drug was for the same drugs, Norco 10/325mg, Xanax 2mg (or Valium 10mg), and Soma, with the same dosages, quantities, and directions, as follows:

Drug name	Quantity (tablet)	Direction
Norco 10/325mg	125	Take 1-2 tablets every 4 hours
Xanax 2mg	60	Take 1 tablet every 6 hours
Soma	60	Take 1 tablet four times a day

The prescriptions were rarely varied for a patient from the first visit to the last or from patient to patient. There were no indications of any dosage adjustments according to the severity of the pain. Dr. Bass rarely prescribed other pain management drugs other than Norco 10/325mg. Respondents failed to adequately evaluate why a pain management specialist, Dr. Bass, would prescribe the same drug regimen for so many of their patients, without differentiation for age, weight, degree of pain, and medical history.

Illogical drug combinations

33. Respondents failed to question illogical drug combinations. There are two subtypes of nonbarbiturate sedative hypnotics, benzodiazepine and non-benzodiazepine. Valium, Xanax, and Halcion are examples of benzodiazepines and Ambien is an example of a non-benzodiazepine hypnotic. Seven (7) of Dr. Bass' patients that filled their prescriptions at Jay Scott Drugs were prescribed more than one non-barbiturate sedative hypnotic, as follows:

a. D.L. - Ambien and Valium

b. D.K. - Xanax, Ambien, and Valium

c. K.P. - Xanax and Valium

d. B.G. - Xanax and Valium

e. D.S. - Xanax, Ambien, and Valium

f. J.V. - Ambien and Halcion

g. L.G. - Xanax and Valium.

There is no documentation of any inquiry of Dr. Bass by Respondents about the duplicate therapy for these patients.

Unusual Age of Patients for Pain Management

34. Respondents did not consider the fact that most of Dr. Bass' patients for whom he prescribed pain killers on a regular basis were in their 20's or early 30's. The five deceased individuals investigated by Ventura County Sheriff's Department who had prescriptions filled at Respondent Jay Scott Drugs ranged in age from 19 to 31. Respondents dispensed these same controlled substances and Soma to 16 younger adults less than 25 years old, primarily during a 19-month period from October 2006 through April 2008, in addition to other patients of Dr. Bass. Late teens and early 20's is an unusual age for pain management. Most of the teens or young adults were apparently healthy individuals that would be expected to have occasional antibiotics for infections or for the females, perhaps birth control pills. These patients were rarely treated for common medical problems or typical medical care for this age group. They were regularly on very high dosages of pain control medications, benzodiazepine controlled substance anti-anxiety agents, and muscle relaxants.

Distances traveled

35. Respondents failed to consider that many of Dr. Bass' patients traveled approximately 30 or 40 miles to see Dr. Bass or have their prescriptions filled at Respondent Jay Scott Drugs, especially since Dr. Bass' patients were allegedly in pain and had to return to see Dr. Bass every 12 to 15 days to obtain a new prescription.

Method of Payment: Cash

36. Respondents failed to consider that numerous patients of Dr. Bass paid for their prescriptions only in cash. For example, Respondent Jay Scott Drugs' Daily Log for Controlled Substance for Schedule III to V, dated September 7, 2007, indicated that 93 out of 132 prescriptions filled on that date were for Dr. Bass' patients. 71 out of 93 prescriptions were paid by cash. Therefore, 76% of prescriptions written by Dr. Bass and dispensed by Respondents were paid by cash on that date. Similarly, the Daily Log on September 19, 2007, for Controlled Substance for Schedule III to V indicated that 75 prescriptions out of 105 prescriptions were for Dr. Bass' patients. 56 out of 75 prescriptions were paid by cash. Therefore, 74% of prescriptions written by Dr. Bass were paid by cash. Also, four out of five patients of both Dr. Bass and Respondent Jay Scott Drugs who died (A.S., D.L., A.W., L.G., and D.K.) paid only in cash for their prescriptions. Only patient D.L. appeared to have some other method of payment.

Family members

37. Respondents did not question the fact that Dr. Bass wrote the same pain killer prescriptions for family members of his patients, with no differentiation for age, weight or degree of pain.

Patients B.G. and C.G.

a. Per the patient's profile, B.G. and C.G., who are siblings, started to visit Dr. Bass and Respondent Jay Scott Drugs in October 2006, when B.G. was 25 years old and his sister, C.G., was 23 years old. They always paid for their prescriptions in cash. They lived at the same residence and the distance from their residence to Dr. Bass' office or Jay Scott Drugs was approximately 40 miles.

b. Respondents dispensed Dr. Bass' prescriptions for the same drugs (Norco 10/325mg and Xanax 2mg) to B.G. and C.G., who are brother and sister. On eight (8) occasions Respondents dispensed the same drugs on the same day to B.G. and C.G. for a total of 32 such prescriptions. Of these 32 prescriptions, Respondent Daher and Respondent Yamasaki each dispensed 16 such prescriptions to the siblings. Between October 30, 2006, and March 31, 2008, Respondent Jay Scott Drugs dispensed 103 prescriptions written by Dr. Bass for B.G., all for

Norco, Xanax, Soma or Valium. Between October 30, 2006, and April 9, 2008, Respondents dispensed 72 prescriptions, written by Dr. Bass for C.G., all for Norco or Xanax.

c. Respondent Jay Scott Drugs did not have any record indicating communication with Dr. Bass about the medical conditions and/or drug therapy of the siblings.

d. B.G. and C.G. later admitted to Ventura County detectives that they had these prescriptions dispensed to support B.G.'s addiction to the drugs. B.G. also admitted that he paid T.P., Dr. Bass' secretary, $80 in cash for prescriptions without seeing Dr. Bass.

Patient T.P. and Family

e. T.P. was the only employee of Respondent that worked in his office. Respondents dispensed Dr. Bass' controlled substance prescriptions to T.P., her husband, K.P., and their 20-year-old daughter, S.P. Per T.P.'s patient profile, between November 1, 2006, and April 7, 2008, 84 prescriptions, written by Dr. Bass, were dispensed for T.P. 77 out of 84 prescriptions were for drugs most commonly ordered by Dr. Bass, Norco 10/325mg and Soma. Out of these 77 prescriptions, Respondent Daher dispensed 66 prescriptions and Yamasaki dispensed 11 prescriptions. Per K.P.'s patient profile, between November 3, 2006, and April 1, 2008, 134 prescriptions were dispensed for K.P., all written by Dr. Bass. 104 out of 134 prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Xanax, Valium and Soma, and also OxyContin. Out of these 104 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed 23 prescriptions, and Respondent Nabhan dispensed 6 prescriptions. Per S.P.'s patient profile, between September 13, 2007 and April 7, 2008, 23 prescriptions written by Dr. Bass were dispensed for S.P. for drugs most commonly ordered by Dr. Bass, Norco and Soma. Of these 23 prescriptions, Respondent Daher dispensed 21 prescriptions and Respondent Nabhan dispensed two prescriptions. From November 2006, to April 2008 (17 months) Respondents dispensed a total of 9,000 Norco, 1,960 OxyContin, 1,230 Xanax, 480 Valium and 2,765 Soma to this family.

f. Based on family relationship, prescribing the same narcotics, excessive furnishing and association with Dr. Bass, Respondents did not take proper steps to review the family's drug

history and failed to verify if prescriptions were for a legitimate medical purpose, or ultimately stop dispensing these prescriptions.

Failed to use C.U.R.E.S.

38. Respondents failed to use the C.U.R.E.S. program as a tool to evaluate new or existing patients to determine if they appeared to be substance abusers, doctor shoppers, utilizing more than one pharmacy, or if the patient was breaking their pain management contract with Dr. Bass, which required that all controlled substances be obtained at the same pharmacy.

Failed to adequately evaluate patients

39. Despite the foregoing red flags of excessive prescribing, Respondents did not have records to show Dr. Bass' patients' diagnosis, laboratory testing, or communication with Dr. Bass regarding appropriateness of therapy or legitimate medical need or evaluation of the patients. Respondents' decision to ignore these clear indications of excessive prescribing of controlled substances by Dr. Bass and drug seeking behavior of many of his patients and Respondents' decision to not aggressively work to determine the patients' diagnosis and evaluate patients for potential drug intoxication, adverse effects, signs of addiction or adequate pain control, placed numerous patients at risk, including, but not limited to, Patients A.S., D.L., A.W., L.G., D.K., J.S., and A.C., as follows:

Patient A.S.

40. Per A.S.' patient profile, A.S. started to visit Dr. Bass and Respondent Jay Scott Drugs in January 2007, at the age of 21. A.S. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

41. Between January 5, 2007, and March 18, 2008 (approximately 14 months), Respondent Jay Scott Drugs dispensed 89 prescriptions for A.S, all written by Dr. Bass. 88 out of 89 prescriptions were for Norco, Xanax, or Soma. During this time period, A.S. received a total of 3,875 tablets of Norco 10/325mg, 1860 tablets of Xanax 2mg, 375 tablets of Soma, and one antibiotic. Of these 88 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent

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Yamasaki dispensed nine prescriptions, and Respondent Nabhan dispensed one prescription for this patient.

42. Dr. Bass did not change A.S.' drug regimen. Dr. Bass regularly prescribed Norco 10/325mg and Xanax 2mg in the same quantities with the same directions every 12-15 days, and Respondent Jay Scott Drugs was usually filling these prescriptions every 12 to 15 days.

43. If Respondents obtained a C.U.R.E.S. report for A.S. after December 1, 2007, they would have seen that on October 26, 2007, and November 5, 2007, the patient was treated with Subutex, a drug used to treat opiate addiction. Respondent Jay Scott Drugs would have known to inquire of Dr. Bass before dispensing further prescriptions to an addict. Obtaining a C.U.R.E.S. report would also have informed Respondents that A.S. was filling his controlled substance prescriptions at two other pharmacies, in violation of his pain treatment contract with Dr. Bass.

44. Respondent Jay Scott Drugs did not have any written records supporting consultations with Dr. Bass regarding A.S.' existing diagnosis, medical conditions or legitimate medical purpose of the prescriptions. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

45. A.S. died on March 20, 2008, at the age of 22. A.S.' Death Investigation Report states that the cause of death was hydrocodone intoxication. Empty prescription containers for Norco (Hydrocodone/125 tablets) and Xanax (60 tablets), which were prescribed by Dr. Bass and dispensed by Respondent Daher on March 18, 2008, were found near his body.

Patient D.L.

46. Per D.L.'s patient profile, D.L. started to visit Dr. Bass and Respondent Jay Scott Drugs in May 2007, at the age of 24. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

47. From May 2, 2007 to March 24, 2008 (10 months), Respondent Jay Scott Drugs dispensed 30 controlled substances and/or dangerous drugs prescriptions for D.L. All of these prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Soma, Ambien, and Valium. During this time period, D.L. received a total of 2,375 tablets of Norco 10/325mg, 120

tablets of Valium 10mg, 520 tablets of Soma and 90 tablets of Ambien. According to D.L.'s patient profile, Respondent Daher dispensed 23 prescriptions, Respondent Nabhan dispensed three (3) prescriptions, and Respondent Yamasaki dispensed four (4) prescriptions for this patient.

48. If Respondents obtained a C.U.R.E.S. report for D.L. after December 1, 2007, they would have seen that in September 2007 and October 2007, the patient was treated with Suboxone, a drug used to treat opiate addiction. Respondent Jay Scott Drugs would have known to inquire of Dr. Bass before dispensing further prescriptions to an addict.

49. Respondent Jay Scott Drugs did not have any records to show D.L.'s diagnosis, medical history, any laboratory testing, communication with Dr. Bass for patient care, evaluation of D.L.'s condition, and effectiveness of his medication regimen although D.L. was regularly on Norco, Soma, Valium, and Ambien, all prescribed by Dr. Bass. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

50. D.L. died on April 10, 2008, at the age of 25. D.L.'s Death Investigation Report states that the cause of death was Ambien, Soma, Valium and Cocaine toxicity. According to the C.U.R.E.S. report, the last prescriptions filled for D.L. before his death were for Norco, Valium, and Ambien, which were prescribed by Dr. Bass and dispensed by Respondent Jay Scott Drugs on March 24, 2008.

Patient A.W.

51. Per A.W.'s patient profile, A.W. started to visit Dr. Bass and Respondent Jay Scott Drugs in February 2008, at the age of 31. A.W. always paid cash for her prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 28 miles.

52. Between February 6, 2008, and March 25, 2008 (48 days), Respondent Jay Scott Drugs dispensed 12 controlled substance prescriptions for A.W. All of these prescriptions were for drugs most commonly ordered by Dr. Bass, Norco, Valium and Soma. During this time period, A.W. received a total of 500 tablets of Norco 10/325mg, 300 tablets of Valium 10mg, 240

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tablets of Soma. Of these 12 prescriptions, Respondent Daher dispensed nine (9) prescriptions and Respondent Yamasaki dispensed three (3) prescriptions for this patient.

53. Respondent Jay Scott Drugs did not have any records to show A.W.'s diagnosis, medical history, any laboratory testing, communication with Dr. Bass for patient care, evaluation of A.W.'s condition and effectiveness of her medication regimen although A.W. was regularly on Norco, Xanax, and Soma, prescribed by Dr. Bass. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

54. A.W. died on April 11, 2008, at the age of 31. A.W.'s Death Investigation Report states that she died from an overdose of Norco 10/325mg, Valium, and Morphine. According to A.W.'s patient profile, A.W.'s last prescriptions filled at Respondent Jay Scott Drugs before her death were Norco, Soma and Valium, prescribed by Dr. Bass and dispensed by Respondent Yamasaki on March 25, 2008.

Patient L.G.

55. Per L.G.'s patient profile, L.G. started to visit Dr. Bass and Respondent Jay Scott Drugs in June 2006, at the age of 19 years old. L.G. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 30 miles.

56. Between September 20, 2006 and March 28, 2008 (18 months), Respondent Jay Scott Drugs dispensed 117 prescriptions for L.G. Out of 117 prescriptions, 105 were for drugs that were most commonly ordered by Dr. Bass, Norco, Xanax and Soma. During this time period, L.G. received a total of 3,500 tablets of Norco 10/325mg, 2160 tablets of Xanax, 2340 tablets of Soma, and 240 tablets of Desyrel.[10] Of these 105 prescriptions, Respondent Daher dispensed 75 prescriptions, Respondent Yamasaki dispensed 18 prescriptions, and Respondent Nabhan dispensed 12 prescriptions.

57. Respondent Jay Scott Drugs did not know the reason L.G. was taking the medications. There was no documentation of communication with Dr. Bass, documentation of

[10] Desyrel is an antidepressant.

discussions with the patient, or review of C.U.R.E.S. data for a person who was either 19 or 20 years old when he started receiving these prescriptions and paid cash for all of these prescriptions. Respondents failed to continually evaluate the patient's needs and assure each prescription was written for a legitimate need, which ultimately resulted in the patient's death.

58. L.G. died on April 13, 2008, at the age of 21. The Death Investigation Report states that the cause of death was an Oxycodone and Methamphetamine overdose. His toxicology report (blood) detected: Methamphetamine, Soma, benzodiazepines, opiates, and oxycodone 840ng/ml. Per the C.U.R.E.S. report, L.G.'s last prescription before his death was for Norco and Xanax on March 28, 2008, which was prescribed by Dr. Bass and dispensed by Respondent Jay Scott Drugs.

Patient D.K.

59. Per D.K.'s patient profile, D.K. started to visit Dr. Bass and Respondent Jay Scott Drugs in December 2006, at the age of 31. D.K. always paid cash for his prescriptions. The distance from the patient's residence to Dr. Bass' office or to Jay Scott Drugs was approximately 40 miles.

60. Between December 7, 2006, and March 14, 2008, the date of D.K.'s death[11] (16 months), Respondent Jay Scott Drugs dispensed approximately 60 prescriptions for D.K. Out of the 60 prescriptions, approximately 57 were for drugs most commonly ordered by Dr. Bass, Norco, Xanax, Soma, Ambien, and Valium. During this period, D.K. received a total of 2,750 tablets of Norco, 1,200 tablets of Xanax, 240 tablets of Valium, and 64 tablets of Ambien. Of these 54 prescriptions, Respondent Daher dispensed 43 prescriptions, Respondent Nabhan dispensed 8 prescriptions, and Respondent Yamasaki dispensed 6 prescriptions.

61. There was no documentation that Respondents ever determined the legitimate need for these prescriptions. Respondent Jay Scott Drugs failed to share a corresponding responsibility while dispensing highly addictive medications to D.K., which put this patient at risk.

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[11] D.K. died of lobar pneumonia.

Patient J.S.

62. Per J.S.' patient profile, J.S. started to visit Dr. Bass and Respondent Jay Scott Drugs in October 2006, at the age of 21. The distance from the patient's residence to Jay Scott Drugs or Dr. Bass' office was approximately 40 miles. When prescriptions were filled too soon, Respondents alternated payment methods by J.S. between the insurance company and cash in order to dispense prescriptions without consulting Dr. Bass. When a new prescription for the same medication is billed too soon, the prescription insurance company would immediately reject the billing claim. J.S. was alternating types of payment between his insurance and cash because his insurance would not pay for the amount of drugs being prescribed and the frequency it was being dispensed.

63. Between October 31, 2006, and April 5, 2007 (approximately five months), Respondents dispensed a total of 36 controlled substance and/or dangerous drugs prescriptions for J.S., all of which were written by Dr. Bass. During this period, Respondent Daher dispensed a total of 1,625 tablets of Norco (including Nortab 10/500 mg, one incident), a total of 780 tablets of Xanax 2mg, and a total of 120 tablets of Soma, to J.S. Of these 36 prescriptions, Respondent Daher dispensed 22 prescriptions and Respondent Yamasaki dispensed 14 prescriptions to J.S.

64. Respondents did not provide any records of communication with Dr. Bass regarding any of J.S.' prescriptions. Respondents failed to share a corresponding responsibility while dispensing highly addictive medications to J.S., which put this patient at risk.

65. During this period, J.S. became addicted to these drugs. He became extremely depressed, suicidal and violent. He quit school and could not hold a job. He was in a rehabilitation center on several occasions: December 2006, April 2007, July 2007 and late 2007.

Dr. Bambad's prescribing pattern.

66. As with Dr. Bass, Respondents failed to evaluate and/or address Dr. Masoud Bamdad's suspect prescribing pattern. Dr. Bamdad's Prescriber Activity Report for the period of December 2006 through May 2008, provided that Respondents dispensed the following prescriptions written by Dr. Bamdad:

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a. 543 prescriptions for Schedule II controlled substances, out of which all but eight (8) prescriptions were written for oxycodone products,

b. 136 prescriptions for Schedule III controlled substances, out of which all but two (2) prescriptions were hydrocodone products, mainly Norco,

c. 302 prescriptions for Schedule IV controlled substances, out of which all but 13 prescriptions were written for Xanax or Valium, mainly Xanax 2mg, and

d. 7 prescriptions of Schedule V controlled substances.

67. From December 2006 through May 2008, Respondent Jay Scott Drugs dispensed a total of 1,357 prescriptions written by Dr. Bamdad, out of which 980 prescriptions were controlled substances and 369 were dangerous drugs. This meant that 73% of the prescriptions written by Dr. Bamdad were for controlled substances, which is a much higher percentage of controlled substances written by one prescriber than normal. Despite the foregoing factors, Respondent Jay Scott Drugs continuously filled 1,357 prescriptions for Dr. Bamdad's patients between December 2006 and May 2008.

Patient A.C.

68. Respondent failed to review A.C.'s patient profiles prior to dispensing controlled substances to him, which presented clear indications that the prescriptions written by Dr. Bamdad for A.C. were generally not issued for a legitimate medical purpose. Per A.C.'s patient profile, A.C. started to visit Dr. Bamdad and Respondent Jay Scott Drugs in December 2007, at the age of 22. A.C. always paid cash for his prescriptions. The distance from the patient's residence to Jay Scott Drugs or Dr. Bamdad's office was approximately 40 miles.

69. From December 11, 2007 to April 10, 2008 (5 months), Respondent Daher filled eight (8) controlled substance prescriptions for A.C., all of which were written by Dr. Bamdad. During this period, Respondent Daher dispensed to A.C. 270 tablets of Oxycodone and 240 tablets of Xanax 2mg.

70. Respondent Jay Scott Drugs did not have any documentation of consultations with Dr. Bamdad regarding A.C.'s diagnosis, medication conditions or the legitimate medical purpose of the prescriptions. Respondent Daher failed to continually evaluate the patient's needs and

assure each prescription was written for a legitimate need, which contributed to A.C.'s death.

71. A.C. was found dead on April 14, 2008, at the age of 23. A.C.'s Death Investigation Report states that the cause of death was multiple drug effects, including significantly high Oxycodone levels. His last prescription was on April 10, 2008, for 90 tablets of OxyContin and 60 tablets of Xanax, written by Dr. Bamdad and dispensed by Respondent Daher.

FOURTH CAUSE FOR DISCIPLINE

(Failure to review patient profiles prior to dispensing prescriptions)

72. Respondents Ahmad Nabhan and Jun Respondent Yamasaki are subject to discipline pursuant to Code sections 4300 and 4301, subdivision (o), on the grounds of unprofessional conduct, in that Respondents Nabhan and Yamasaki failed to review N.V.'s profiles prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3. Specifically, Respondent Nabhan filled one (1) prescription and Respondent Yamasaki filled one (1) prescription for N.V. early, namely Norco, without reviewing N.V.'s patient profile, resulting in over dispensing of controlled substances, and/or, dangerous drugs, as set forth in paragraph 25, above.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

73. Respondents are subject to discipline pursuant to Code sections 4300 and 4301, in that Respondents committed unprofessional conduct, as more fully discussed in paragraphs 23 through 72, above.

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 Pharmacist License Number RPH 39189, issued Albert Farah Respondent Daher;

2. Revoking or suspending Pharmacist License Number RPH 41754, issued to Ahmad Nabhan;

3. Revoking or suspending Pharmacist License Number RPH 19983, issued to Jun Respondent Yamasaki;

4. Revoking or suspending Retail Pharmacy License Number PHY 40912, issued to Jay Scott Drugs, with Albert Farah Respondent Daher as Pharmacist-in-Charge;

5. Ordering Jay Scott Drugs, Albert Respondent Daher, Ahmad Nabhan, and Jun Respondent Yamasaki to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 8/4/10

VIRGINIA K. HEROLD
Executive Officer
Board of Pharmacy
State of California
Complainant

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