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

In the Matter of the Accusation Against: **F D M EXCLUSIVE IMAGE, INC. dba COOVER PHARMACY;** FARIBORZ MASSOUDI, President 891 W. Ninth St. San Pedro, CA 90731 **Pharmacy Permit No. PHY 45471** **and** **JOHN DE SIMONE** 419 Ave. F Redondo, CA 90277 **Pharmacist License No. RPH 37984** Respondents.	Case No. 4851 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about September 8, 1983, the Board of Pharmacy (Board) issued Pharmacist License number RPH 37984 to Respondent JOHN ANTHONY DE SIMONE (Respondent De

Simone). The Pharmacist License was in full force and effect at all times relevant to the charges herein and will expire on July 31, 2015, unless renewed.

3. On or about February 8, 2003, the Board issued Pharmacy Permit number PHY 45471 to F D M EXCLUSIVE IMAGE, INC. dba COOVER PHARMACY. FARIBORZ MASSOUDI, a.k.a. David Massoudi, has been the President of F D M EXCLUSIVE IMAGE, INC. dba COOVER PHARMACY since October 10, 2002. Pharmacy Permit number PHY 45471 was in full force and effect at all times relevant to the charges brought herein and will expire on February 1, 2014, unless renewed.

4. Respondent De Simone was the Pharmacist-in-Charge of F D M EXCLUSIVE IMAGE INC. dba COOVER PHARMACY (Coover Pharmacy or Respondent Coover) from December 4, 2008 to June 1, 2013.

JURISDICTION

5. This Accusation is brought before the Board, under the authority of the following laws.

6. Business and Professions Code section 118, subdivision (b),[1] provides in pertinent part 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.

7. Section 4300, subdivision (a), provides that every license issued by the Board may be suspended or revoked.

8. Section 4300.1 states:

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

[1] All further statutory references are to the Business and Professions Code unless otherwise indicated.

9. Section 4011 provides that the Board shall administer and enforce both the Pharmacy Law [Bus. & Prof. Code, § 4000 et seq.] and the Uniform Controlled Substances Act [Health & Saf. Code, § 11000 et seq.].

STATUTORY PROVISIONS

10. Section 4301 states in pertinent part:

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

11. Section 4306.5 states:

> Unprofessional conduct for a pharmacist may include any of the following:
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> . . .
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> (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.
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> (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.

12. Section 4113, subdivision (c), states, "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."

13. Heath and Safety Code section 11153, subdivision (a), states:

> (a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispending 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. (Emphasis added.)

14. Health and Safety Code section 11165 provides, in pertinent part:

> (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.
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> . . .
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> (d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:
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> (1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.
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> (2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

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 1761, subdivision (a), 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.

CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

17. Section 4021 provides that a "controlled substance" means any substance listed in Schedules I through V contained in Health and Safety Code section 11053, et seq.

18. Section 4022 states in pertinent part:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

. . .

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

19. **Oxycontin** is the brand name for **oxycodone**, which is a Schedule II controlled substance as designated by Section 4021 and Health and Safety Code section 11055, subdivision (b)(1)(M). It is also a dangerous drug as defined by Section 4022 and is prescribed to treat pain.

20. **Endocet** is a brand name for a combination of **oxycodone/acetaminophen**, a Schedule II controlled substance as designated by Section 4021 and Health and Safety Code section 11055, subdivision (b)(7). It is also a dangerous drug as defined by Section 4022 and is prescribed to treat pain.

21. **Norco** and **Lortab** are Schedule III controlled substances as designated by Section 4021 and Health and Safety Code section 11056, subdivision (e)(4). It is also a dangerous drug as defined by Section 4022 and is prescribed to treat pain.

22. **Xanax** is the brand name for **alprazolam**, which is a Schedule IV controlled substance as designated by Section 4021 and Health and Safety Code section 11057, subdivision (d)(1). It is also a dangerous drug as defined by Section 4022 and is prescribed to treat anxiety.

23. **Roxicodone** is the brand name for **oxycodone**, which Schedule II controlled substance as designated by Section 4021 and Health and Safety Code section 11055, subdivision (b)(1)(M). It is also a dangerous drug as defined by Section 4022 and is prescribed to treat pain.

24. **Subutex** is the brand name for **buprenorphine**, which is a Schedule V controlled substance as designated by Section 4021 and Health and Safety Code section 11058, subdivision (d). It is also a dangerous drug as defined by Section 4022 and is prescribed primarily to treat opiate dependence.

COST RECOVERY

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

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FACTUAL BACKGROUND

26. On or about November 18, 2011, Board Inspector Sarah Bayley inspected Coover Pharmacy with Medical Board Investigator Kimberly Wilson. The inspectors found that Coover Pharmacy failed to transmit CURES[2] data for the past three years. The pharmacy had been transmitting the data weekly, but Foundation Systems, Inc. (FSI), the pharmacy software that Coover Pharmacy used, did not update the proper system to transmit the data successfully to Atlantic Associates.

27. On November 18, 2011, Massoudi, the owner of Coover Pharmacy, called FSI and transmitted three years of data to Atlantic Associates. The FSI File Relay Reports indicated that the files had been received and stated, "Even if the status of the relay to the intended recipient is indicated as successful, it is YOUR responsibility to verify with the recipient that it really was successful." (Original emphasis.)

28. On or about November 21, 2011, the Board received a complaint from the Medical Board of California (Medical Board) regarding Dr. Nicole Lippman's prescriptions and deaths of two patients, S.R.[3] and K.B.

29. Board Inspector Sejal Desai investigated the complaint and obtained and reviewed CURES data for Coover Pharmacy for January 1, 2010 to December 5, 2012. The CURES data revealed a total of 18,970 controlled substances prescriptions dispensed, 8,921 (47.03%) of which were prescribed by Dr. Lippman for 699,344 total dosage units. The top three drugs prescribed by Dr. Lippman and dispensed by Coover Pharmacy were APAP/Hydrocodone Bitartrate (325 mg-10mg, tab), Oxycontin (80 mg, ter), and Alprazolam (2 mg, tab). Inspector Desai found that a

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[2] The Controlled Substance Utilization Review and Evaluation System or CURES is a database maintained by the California Department of Justice, Bureau of Narcotic Enforcement. The program began in 1998 and required mandatory monthly pharmacy reporting of dispensed Schedule II controlled substances. The CURES program was amended in January 2005 to include mandatory weekly reporting of Schedule II-IV controlled substances. The data is sent to a data collection company, who sends the pharmacy confirmation that the data was received and informs the pharmacy if the data was rejected. The data is collected statewide and can be used by health care professionals to evaluate and determine whether their patients are utilizing controlled substances correctly.

[3] All patients are referred to by their initial to maintain their confidentiality.

large number of prescriptions dispensed by Coover Pharmacy were written by Dr. Lippman for her own family member.

30. K.B. and S.R. were two patients who died while under Dr. Lippman's care. K.B. was S.R.'s girlfriend and they both went to Coover Pharmacy to have Dr. Lippman's prescriptions dispensed. K.B. died on April 6, 2010. The coroner recorded the cause of death as "combined intoxication of oxycodone, oxymorphone, hydrocodone, morphine, alprazolam, hydroxyalprazolam, propoxyphene, norpropropxyphene, diclomine." There was evidence of injection sites on K.B.'s upper extremities. S.R. died on May 29, 2010. The coroner recorded that the cause of death was the combined effects of alprazolam, amphetamine, oxycodone, and oxymorphone. S.R.'s external post mortem exam showed multiple reddish discolorations on left and right wrists with needle puncture marks.

31. On or about May 9, 2013, Inspector Desai conducted an inspection of Coover Pharmacy. During the inspection, Inspector Desai requested controlled substance prescription hardcopies from May 9, 2010 to May 9, 2013 for K.B. and S.R., N.L. prescription hardcopy for RX #246375, and N.L. prescription hardcopies for "office use." In response, Inspector Desai received the requested documents including patient profiles for S.R., K.B., N.L. (Office Use), N.L, and S.L. and copies of prescriptions for S.L During the course of the investigation and upon examination of CURES data and documents from Coover Pharmacy, Inspector Desai determined the following:

A. K.B. only had controlled substance dispensed at Coover Pharmacy. On numerous occasions, Coover Pharmacy dispensed Oxycontin 80mg above the recommended dosing interval of twice daily. K.B. received it three times daily. K.B. lived in Rancho Santa Margarita and drove approximately 55 miles from home to see Dr. Lippman and have prescriptions dispensed at Coover Pharmacy. Coover Pharmacy dispensed controlled substance pain medications for K.B. written by Dr. Lippman, despite the fact that Dr. Lippman was not a pain specialist. CURES data for K.B. showed that prior to going to Coover Pharmacy, K.B. had prescriptions dispensed at 11 pharmacies in various cities. K.B. continued to use multiple pharmacies while going to Coover Pharmacy. K.B. went to multiple practitioners in different

cities while going to Dr. Lippman. If Respondents had reviewed CURES data for K.B., they would have been able to determine K.B. as a doctor and pharmacy shopper. In addition, a review of CURES data would have revealed that K.B. was placed on Suboxone (primarily used for treatment of opioid addiction).

B. S.R. only had controlled substances dispensed at Coover Pharmacy. He received therapy duplication of pain medications which included Oxycontin 40mg, oxycodone 30mg with hydrocodone/acetaminophen (HC/AP) 10/500 on numerous occasions prescribed by Dr. Lippman. S.R. was also prescribed alprazolam 2mg by Dr. Lippman. S.B. lived in Foothill Ranch and drove approximately 48 miles to see Dr. Lippman and have prescriptions dispensed at Coover Pharmacy. Coover Pharmacy dispensed controlled substance pain medications for S.R. written by Dr. Lippman, despite the fact that Dr. Lippman was not a pain specialist. CURES data for S.R. showed that prior to going to Coover Pharmacy, S.R. had prescriptions dispensed at eight different pharmacies in various cities. S.R. continued to use multiple pharmacies while going to Coover Pharmacy and went to multiple practitioners in different cities while seeing Dr. Lippman.

C. On June 30, 2009, Coover Pharmacy dispensed RX #192596 and 192594 to S.R. The handwriting on the prescription did not seem to be in the doctor handwriting and the RX was questionable. On April 9, 2010, Coover Pharmacy dispensed RX #207470 for hydrocodone/acetaminophen 10/500mg #90, 1 tab three times daily and RX #207473 for hydrocodone/acetaminophen 10/500mg #150, 1 tab every 4-5 hours, to S.R.. On February 11, 2010, Coover Pharmacy dispensed RX #204278 for oxycodone to S.R. but the prescription was dated February 12, 2010.

D. S.L. was the mother of Dr. Lippman. Dr. Lippman wrote an extensive number of prescriptions for pain medications for S.L., which were dispensed by Coover Pharmacy. CURES data showed that from January 1, 2010 to December 5, 2012, Coover Pharmacy dispensed 310 controlled substance prescriptions for a total dosage unites of 21,290 for patient S.L. Coover Pharmacy dispensed Oxycontin above the recommended dosing interval of twice daily for S.L. S.L. received it three to four times daily. S.L. was prescribed Subutex by Dr. Lippman and dispensed by Coover Pharmacy on numerous occasions. Since Subutex is primarily

used for treatment opioid dependence, this should have raised a question by the pharmacy. Coover Pharmacy dispensed mostly controlled substance pain medications for patient S.L. written by Dr. Lippman, despite the fact that Dr. Lippman was not a pain specialist.

E. N.L. (office use) were prescriptions written by Dr. Lippman for "office use." CURES data showed that from January 1, 2010 to December 5, 2012, Coover Pharmacy dispensed 154 controlled substances prescriptions for a total dosage of 7,757 for Dr. Lippman's office use. Coover Pharmacy dispensed mostly controlled substances for Dr. Lippman's office use, despite the fact that Dr. Lippman was not a pain specialist.

F. Inspector Desai noted that a review of the prescriptions showed a relationship of Dr. Lippman's patients being referred to Coover Pharmacy for the dispensing of prescriptions. Also, Coover Pharmacy's information was pre-printed on Dr. Lippman's prescription pads.

32. On or about May 16, 2013, Inspector Desai spoke to Coover Pharmacy's part-time Pharmacist H. Pharmacist H stated that Coover Pharmacy currently did not have access to PDMP (prescription drug monitoring program of CURES) and that Coover Pharmacy does not maintain any files or notes to manage patient pain therapy.

33. On or about May 17, 2013, Respondent De Simone completed and returned pharmacy questionnaires for Coover Pharmacy regarding K.B. and S.R. to the Board. On the questionnaires, Respondent De Simone indicated that the patients lived outside the pharmacy trading area of five miles and were sent to Coover Pharmacy from Dr. Lippman's office. Respondent knew that K.B.'s diagnosis was "pain/detox." Respondent did not know S.R.'s diagnosis or reason for therapy. As to both K.B. and S.R., Respondent did not know whether the prescription was new, and Respondent did not know the patients' appearance or demeanor or any other information about the patients other than identity and mode of payment [insurance]. On both questionnaires, Respondent indicated that the pharmacy did not maintain a file or notes on the patient monitoring the patient's pain control, and that they did not speak to the doctor about any of the prescriptions. On the questionnaire regarding K.B., Respondent wrote that "the doctor used CURES before writing RX then gave us the information prescription." Respondent wrote that Dr. Lippman was a pain management and addiction specialist.

34. On or about May 17, 2013, Respondent De Simone completed and returned a pharmacy questionnaire for Coover Pharmacy regarding S.L. to the Board. On the questionnaire, Respondent De Simone indicated that S.L. was the mother of the physician and that S.L. had terminal breast cancer. The prescriptions were always picked up by Dr. Lippman, and the pharmacy never saw S.L. Respondent indicated that the doctor's office had access to CURES. Regarding the maintenance of a file or notes the patient, Respondent only wrote, "Spoke to MD on many occasions MD stated nature of pain."

35. Inspector Desai determined that despite Dr. Lippman's claim that she was a pain specialist, if Coover Pharmacy had checked the Medical Board's website, they would have been able to see that Dr. Lippman did not have specific certifications or specialty in pain.

36. On February 12, 2013, the Medical Board of California filed First Amended Accusation number 06-2010-210845[4] against Dr. Lippman for unprofessional conduct and gross negligence [Bus. & Prof. Code, § 2227.2234, subd. (b)] and prescribing for or administering to herself controlled substances and or dangerous drugs [Bus. & Prof. Code, § 2239], and alleged that Dr. Lippman self-administered oxycodone, oxymorphone, benzodiazepines and barbituates. The First Amended Accusation alleged improper self use of drugs as well as gross negligence in the care and treatment of K.B. and S.R.

FIRST CAUSE FOR DISCIPLINE

(Failure to Exercise Professional Judgment or Corresponding Responsibility)

37. Respondents Coover and De Simone (collectively, Respondents) are subject to disciplinary action under Sections 4301 and 4306.5, subdivision (b), and/or Section 4113, subdivision (c), in conjunction with California Code of Regulations, title 16, sections 1707.3 and 1761, in that Respondents committed one or more acts of unprofessional conduct when they failed to exercise or implement their best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances or dangerous drugs to K.B., S.R.,

[4] On August 8, 2013, Dr. Lippman stipulated to a surrender of her Physician's and Surgeon's Certificate No. A-62947 and admitted to the allegations contained in Accusation No. 06-2010-210845. ON September 4, 2013 the Medical Board adopted the decision and order, which became effective on September 11, 2013.

S.L., and N.L. (office use). If Respondents had reviewed CURES data prior to dispensing controlled substances to K.B. and S.R., Respondents would have been able to determine that both patients were doctor and pharmacy shoppers. In addition, as to K.B., a review of CURES would have revealed that K.B. was placed on Suboxone which is used for treatment of opioid addiction. Even without reviewing CURES reports, based on a review of the patients' drug profiles, Respondents would have been able to see questionable drug therapies. Moreover, the prescribing pattern of one physician, Dr. Lippman, was repetitive and redundant with respect to the same controlled substances prescribed repeatedly for the majority of her patients. Despite Dr. Lippman claiming to be a pain specialist, if Respondents had checked the Medical Board's website, Respondents would have seen that Dr. Lippman did not have a certification or specialty in pain. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 27–35 including all subparagraphs.

SECOND CAUSE FOR DISCIPLINE

(Excessive Furnishing of Controlled Substances)

38. Respondents are subject to disciplinary action under Sections 4301, subdivisions (d) and/or (j), and 4306.5, subdivision (c), and/or Section 4113, subdivision (c), in conjunction with California Code of Regulations, title 16, section 1761, in that Respondents committed one or more acts of unprofessional conduct when they excessively furnished controlled substances in violation of Health and Safety Code section 11153, subdivision (a). Respondents dispensed erroneous or uncertain prescriptions, as described more fully above in paragraph 30, subparagraph C. Respondents also failed to assume their corresponding responsibility for proper prescribing when they dispensed controlled substances to habitual doctor and pharmacy shoppers. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 27–35 including all subparagraphs.

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THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain and Consult Patient-Specific Records)

39. Respondents are subject to disciplinary action under Sections 4301 and 4306.5, subdivisions (c) and (d), and/or Section 4113, subdivision (c), in conjunction with California Code of Regulations, tile 16, section 1707.3, in that Respondents committed one or more acts of unprofessional conduct by failing to consult appropriate patient, prescription, and other records, and failing to fully maintain and retain appropriate patient-specific information pertaining to the dispensing of controlled substances. Respondents did not maintain files and notes on any of its patients to monitor their pain therapy, and also did not consult any records on its patients. The only documentation that Respondents maintained were prescription hardcopies. In addition, Respondents failed to review the patients' medication records and drug therapy prior to dispensing controlled substances. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 25–26, 30, subparagraphs A–D, and 31–33.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Report Controlled Substance Prescriptions to CURES)

40. Respondents are subject to disciplinary action under Section 4301, subdivisions (j) and/or (o), and/or Section 4113, subdivision (c), by reference to Health and Safety Code section 11165, for violating statutes regulating controlled substances or dangerous drugs and/or directly or indirectly violating, attempting to violate, or assisting in or abetting a violation of laws or regulations governing the practice of pharmacy. Specifically, Respondents failed to transmit CURES data for a period of approximately three years and thus were not in compliance with Health and Safety Code section 11165, subdivision (d). Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 25 and 26.

FIFTH CAUSE FOR DISCIPLINE

(Violation of Laws and Regulations Governing Pharmacy)

41. Respondents are subject to disciplinary action under Section 4301, subdivision (o), and/or Section 4113, subdivision (c), in that Respondents committed one or more acts of unprofessional conduct when they violated or attempted to violate, directly or indirectly, or

assisted in or abetted the violation of laws and regulations governing pharmacy. Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 25–39.

DISCIPLINARY CONSIDERATIONS

(As to Respondent De Simone only)

42. To determine the degree of discipline, if any, to be imposed on Respondent De Simone, Complainant alleges that on or about June 12, 2012, in a prior action, the Board of Pharmacy issued Citation number CI 2011 52796 and ordered Respondent to pay $2,500.00 for a violation of Business and Professions Code section 4110, subdivision (a) ["No person shall conduct a pharmacy in the State of California unless he or she has obtained a license from the board..."]. Respondent De Simone was pharmacist-in-charge of Griffith Drugs (PHY 45422 and PHY 50714). Specifically, on or about February 2010 to July 12, 2011, Massoudi and Respondent De Simone operated Griffith Drugs as a pharmacy without licensure by the Board. In the same Citation, Respondent De Simone was also issued a citation without a fine for a violation of Business and Professions Code section 4201, subdivisions (f) and (i) ["Application form; required information; renew annually..., report change in ownership within 30 days."] Specifically, on or about February 2010, the ownership of Griffith Drugs was transferred to Massoudi and Respondent De Simone without notifying the Board. Citation no. CI 2011 52796 is now final and is incorporated by reference as if fully set forth.

PRAYER

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

1. Revoking or suspending Pharmacy Permit number PHY 45471, issued to Respondent F D M EXCLUSIVE IMAGE, INC., dba COOVER PHARMACY; FARIBORZ MASSOUDI as President;

2. Revoking or suspending Pharmacist License number RPH 37984, issued to Respondent JOHN DE SIMONE;

3. Ordering Respondents F D M EXCLUSIVE IMAGE, INC., dba COOVER PHARMACY and JOHN DE SIMONE to pay the Board of Pharmacy the reasonable costs of the

investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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

DATED: 3/27/14

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

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