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

In the Matter of the Accusation Against: **CVS PHARMACY #1666** **dba CVS PHARMACY # 1666** 846 West Avenue K Lancaster, CA 93534 Pharmacy Permit No. PHY 48255 **AND** **SUSAN JENEVIVE MEGWA** 2716 Paxton Avenue Palmdale, CA 93551 Pharmacist License No. RPH 59389 Respondents.	Case No. 4863 **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 11, 2006, the Board of Pharmacy issued Pharmacy Permit Number PHY 48255 to CVS Pharmacy #1666, a corporation, dba CVS Pharmacy #1666 (Respondent Pharmacy). Between May 28, 2007 and May 1, 2009, Susan Jenevive Megwa was the registered Pharmacist-in-Charge of Respondent Pharmacy. The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on June 1,

2016, unless renewed.

3. On or about March 12, 2007 the Board of Pharmacy issued Pharmacist License Number RPH 59389 to Susan Jenevive Megwa (Respondent Megwa). Respondent Megwa was the registered Pharmacist-in-Charge of Respondent CVS Pharmacy #1666 between May 28, 2007 and May 1, 2009. Respondent's Pharmacist License was in full force and effect at all times relevant to the charges brought herein, expired on July 31, 2012, and has not been renewed.

JURISDICTION

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

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.

5. Section 4300 of the Code states:

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

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

"(1) Suspending judgment.

"(2) Placing him or her upon probation.

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

"(4) Revoking his or her license.

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

"(c) The board may refuse a license to any applicant guilty of unprofessional conduct. The board may, in its sole discretion, issue a probationary license to any applicant for a license who is guilty of unprofessional conduct and who has met all other requirements for licensure. The board

may issue the license subject to any terms or conditions not contrary to public policy, including, but not limited to, the following:

"(1) Medical or psychiatric evaluation.

"(2) Continuing medical or psychiatric treatment.

"(3) Restriction of type or circumstances of practice.

"(4) Continuing participation in a board-approved rehabilitation program.

"(5) Abstention from the use of alcohol or drugs.

"(6) Random fluid testing for alcohol or drugs.

"(7) Compliance with laws and regulations governing the practice of pharmacy.

"(d) The board may initiate disciplinary proceedings to revoke or suspend any probationary certificate of licensure for any violation of the terms and conditions of probation. Upon satisfactory completion of probation, the board shall convert the probationary certificate to a regular certificate, free of conditions.

"(e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure."

6. Section 4300.1 of the Code states:

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

7. Section 4301 of the Code states:

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

. . .

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

. . .

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

. . .

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

. . .

8. Section 4059 of the Code states, in pertinent part, that a person may not furnish any dangerous drug except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. A person may not furnish any dangerous device, except upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7.

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

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

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 PROVISION(S)

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

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

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

DEFINITIONS

12. **Hydromorphone**— also commonly know by the brand name **Dilaudid** - is a Scheduled II controlled substance pursuant to Health and Safety Code Section 11055 (b)(1)(J) and is a dangerous drug within the meaning of Business and Professions Code section 4022. Hydromorphone/Dilaudid is a narcotic analgesic typically prescribed for the relief of severe pain.

13. **Oxycodone**—also commonly known by the brand names **Oxycontin or OxyIR**, is a Scheduled II controlled substance pursuant to Health and Safety Code Section 11055 (b)(1)(M) and is a dangerous drug within the meaning of Business and Professions Code section 4022. Oxycodone is a narcotic analgesic typically prescribed for the relief of severe pain.

FACTS COMMON TO ALL CAUSES FOR DISCIPLINE

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

A. At all times relevant herein, Respondent Megwa was the Pharmacist-in-Charge of Respondent Pharmacy, a retail store operated by CVS Pharmacy corporation, located in the city

of Lancaster, CA.

Exposure of Prescription Fraud Scheme

B. In or about August of 2010, the Board of Pharmacy was contacted by a CA Department of Health Care Services (DHCS) investigator who advised that a DHCS investigation had resulted in the discovery of hundreds of forged and falsified controlled substance prescriptions which had been filled at Respondent CVS Pharmacy #1666. DHCS' initial investigation had been triggered by a consumer complaint in April of 2008 to the effect that Medi-Cal card holders were being recruited to participate in a prescription fraud scheme ("scheme"). Investigators then conducted an undercover operation in which they learned that Medi-Cal card holders who agreed to participate in the scheme were instructed to contact "Rosa" – who scheduled participants for visits to a physician's office – where they filled out documents providing personal information in exchange for cash payments of $100 - $150.00. "Rosa" would then take the large volume of prescriptions thus obtained and fill them at various area pharmacies.

C. Pursuant to the DHCS investigation, Rosa was identified as LaShirley P., prosecuted, and convicted of Forgery (Business and Professions Code section 4324 B) and Burglary (Penal Code section 459) in Los Angeles Superior Court on May 13, 2010.

D. Board inspectors interviewed Respondent Pharmacy staff, and analyzed a total of 436 original prescriptions for drugs including Oxycontin 80 mg and Dilaudid 4 mg – all of which had been filled at Respondent Pharmacy and identified by DHCS investigators as related to the scheme.

E. While neither the DHCS investigation, nor the Board's investigation established with certainty that Respondent Megwa, or any other employee of Respondent Pharmacy was a knowing participant in the scheme for which Rosa was convicted, Respondents are linked to said scheme by the following facts:

(1) Rosa was well known to the pharmacy staff, and dropped off "a lot" of prescriptions – sometimes as many as 10-15 prescriptions at a time, to be filled.

(2) At the time of the subject events, it was the custom and practice of pharmacy staff to give Respondent Megwa all controlled substance prescriptions, and she was the

only one who determined whether such prescriptions were to be filled.

(3) Rosa appeared to avoid interacting with pharmacy staff other than Respondent Megwa. She appeared to know Respondent's work schedule, and to limit visits to times when Respondent was present.

(4) *All* of the 436 scheme-related prescriptions which were filled at Respondent Pharmacy were dispensed by Respondent Megwa.

F. Respondent Pharmacy staff interviewed by Board Inspectors indicated that at the time of the subject events, Respondent Pharmacy had no standardized policies and procedures for filling controlled substance prescriptions.

G. When asked in April of 2013 by a Board Inspector if she was at all suspicious of the multiple similar prescriptions Rosa was bringing to the pharmacy, Respondent Megwa stated she did not have time to question the prescriptions and did not think it was her place to question the prescriber about what they were prescribing.

Analysis of Prescriptions for Dilaudid and Oxycontin

H. Of the **436** original prescriptions which were reviewed, **73 were for Dilaudid** 4mg – with 35 purportedly issued by a Dr. Callis, and 38 issued by a Dr. Dibdin, and **363 were for Oxycontin** 80 mg, with 36 purportedly issued by Dr. Callis, 75 issued by Dr. Dibdin and 252 by Dr. Schwartz. All 436 prescriptions were dispensed by Respondent Megwa.

I. Board inspectors contacted and corresponded with Drs. Dibdin and Schwartz, and provided them with samples of the subject prescriptions. Each indicated that he had been a victim of identity theft or been made aware that unknown persons were falsifying prescriptions using his name. Drs. Dibdin and Schwartz both confirmed the prescriptions were forged and not authorized by them. However Dr. Callis - who had retired from medical practice - did not respond to Board attempts to contact him. [1]

[1] Due to the volume of prescription documents, and the Inspector's inability to contact Dr. Callis, only prescriptions purportedly issued by Drs. Dibdin and Schwartz for Oxycontin 80 mg and Dilaudid 4 mg (a total of 313) are charged in the Third Cause for discipline below. Additionally, due to uncertainty expressed by Dr. Dibdin about 10 prescriptions purportedly issued by him from a '6767 Sunset' office address - the 10 prescriptions showing this address have been excluded. Accordingly, a total of 303 prescriptions are charged in the Third Cause for (continued...)

Corresponding Responsibility

J. Board inspectors analyzing the 436 prescriptions concluded that Respondents had failed in their corresponding responsibility to verify the medical legitimacy of prescriptions purportedly written by Drs. Callis, Dibdin and Schwartz, because they ignored **key objective factors** indicating prescriptions were not legitimate, including but not limited to the following:

(1) **Controlled substance prescribing pattern of prescribing physicians**

Drs. Callis, Dibdin and Schwartz had an unusually high percentage of controlled substance (vs. non-controlled substance prescriptions) – and an unusually high percentage of these prescriptions were for high abuse, high diversion potential medications.

(a) Dilaudid 4mg - Respondent Pharmacy did not dispense *any* prescriptions for this drug between January 2007 and approximately March, 2008. However, in April 2008, Respondent Pharmacy dispensed 68 prescriptions for Dilaudid 4mg – and continued to distribute high volumes of this drug in three months that followed.

(b) Oxycontin 80 mg - Respondent Pharmacy dispensed only 12 prescriptions for this drug in 2007. However, in March, 2008, Respondent Pharmacy dispensed 91 prescriptions for Oxycontin 80 mg, and continued to distribute high volumes of this drug for the following three months – with the highest volume occurring in July , 2008 – with 230 prescriptions.

(2) **Proximity of Respondent Pharmacy to patients and prescribers**

The typical customer of a retail pharmacy is someone who either lives in the community where the pharmacy is located, or has received a prescription from a physician practicing in or near that community. However, none of the subject prescribers were located within the normal trading area for the pharmacy.

(a) **Prescribers – Distance From Pharmacy**

(i) Calculating average distances for different addresses appearing for each prescriber - Dr. Callis was located 65 miles away with an approximate travel time of

(...continued)
discipline.

one hour; Dr. Dibdin was located an average of 60 miles away with an approximate travel time of one hour; and Dr. Schwartz's office was located more than 140 miles from Respondent Pharmacy with an approximate travel time exceeding 2 hours.

(ii) The majority of Dr. Schwartz's prescriptions listed an office located in Yuba City, which was located over 400 miles from the location of Respondent pharmacy.

(b) **Patients - Distance to pharmacy** - Board Inspectors pulled a sample group of 42 patients from the 436 prescriptions. 30 of the 42 patients were located outside of the community normal trading area of Respondent pharmacy, and all 30 had addresses exceeding 60 miles from the pharmacy. Eleven of the remaining 12 patients shared the same address – or had addresses which did not exist.

(3) **Suspicious similarity of prescriptions**

Prescriptions for all three prescribers were almost identical in appearance.

(a) Handwriting - The handwriting and "signatures" on prescriptions purportedly issued by two different prescribers (Dr. Callis and Dr. Dibdin) appear to be that of the same person. The same is true for prescriptions purportedly issued by Dr. Dibdin and Dr. Schwartz.

(b) One Size Fits All Prescriptions - Patients were repeatedly prescribed the same or similar drug, dosage, quantity and given the same directions by all three of the prescribers – rather than receiving the typical individualized therapy, 361 of the 363 Oxycontin prescriptions (99.45%) were written for a quantity of 90 tablets with directions to take three times daily.

(4) **Irregularities on face of prescriptions**

(a) Changing Signatures - The signatures of purported prescribers Dr. Dibdin and Dr. Schwartz are inconsistent and appear to have been written by multiple individuals.

(b) "Pain! Pain!" Instruction – Approximately 209 prescriptions for Oxycontin purportedly written by Dr. Schwartz show the irregular direction to take "one three times daily for pain! pain!"

(c) Serial Numbers - Many prescriptions show nearly consecutive serial numbers (pre-printed numbers on controlled substance prescription pads), but have dates out of sequence.

(5) **Manner in which prescriptions were presented**

Large numbers of prescriptions for Dilaudid 4mg and Oxycontin 80 mg were presented to the pharmacy at the same time for multiple patients – and there were instances when over 20 prescriptions for Oxycontin 80 mg were dispensed in a single day.

K. Looking at the totality of circumstances regarding the 436 prescriptions purportedly issued by Drs. Callis, Dibdin and Schwartz, including but not limited to objective factors set forth above, Respondents should have questioned the legitimacy of the 436 prescriptions presented from these prescribers.

L. Respondent Megwa resigned from employment at Respondent Pharmacy on or about June 5, 2009, following a suspension related to events here described.

FIRST CAUSE FOR DISCIPLINE

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

15. Respondents CVS PHARMACY and MEGWA are subject to disciplinary action under Business and Professions Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (d) and (o) in conjunction with Health and Safety Code section 11153, subdivision (a) and title 16 California Code of Regulations section 1761, in that, approximately between March 17, 2008 and September 20, 2008, they failed to comply with their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose. Specifically, Respondents furnished approximately 436 prescriptions for controlled substances even though "red flags" were present to indicate those prescriptions were not issued for a legitimate medical purpose, as set forth in paragraph 14 above.

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SECOND CAUSE FOR DISCIPLINE

(Dispensing Controlled Substance Prescriptions with Significant Errors, Omissions, Irregularities, Uncertainties, Ambiguities or Alterations)

16. Respondents CVS PHARMACY and MEGWA are subject to disciplinary action under Business and Professions Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) for violating title 16, California Code of Regulations, sections 1761(a) and (b), in that approximately between July 17, 2008 and September 26, 2008, on at least 209 instances, they dispensed Oxycontin, a controlled substance, pursuant to prescriptions which contained significant errors, omissions, irregularities, uncertainties and/or ambiguities, which Respondents failed to observe or address in a manner compliant with corresponding responsibility requirements, said irregularities including but not limited to filling 209 Oxycontin 80mg prescriptions purportedly written by Dr. Schwartz, each of which had the instruction to take the medication "one three times daily for pain! pain!" - as set forth in paragraph 14 above.

THIRD CAUSE FOR DISCIPLINE

(Furnishing Dangerous Drugs Without a Valid Prescription)

17. Respondents CVS PHARMACY and MEGWA are subject to disciplinary action under Business and Professions Code section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with section 4059 subdivision (a) in that between March 20, 2008 and September 20, 2008, Respondents filled and dispensed at least 303 forged, falsified and unauthorized prescriptions for Oxycontin and Dilaudid as set forth in paragraph 14 above.

DISCIPLINARY CONSIDERATIONS

18. To determine the degree of penalty to be imposed on Respondent(s), if any, Complainant makes the following additional allegations:

Prior Citation – Respondent CVS Pharmacy #1666

a. On or about March 25, 2010, a representative of the Board inspected and investigated Respondent CVS Pharmacy #1666. Pursuant to that inspection, on March 25, 2010,

Administrative Citation/Assessment of Fine No. CI 200840670 was issued to Respondent for violating Codes and Regulations as set forth below, resulting in the issuance of a $500.00 fine, which Respondent paid in full. The citation is now final.

Code/Regulation(s) Violated	Description
1. California Code of Regulations (CCR), title 16, § 1716/ § 1716 (a)	Variation from prescription/erroneous or uncertain prescription; no pharmacist shall compound or dispense any prescription which contains any significant error or omission.
2. CCR, title 16, § 1711(e)	Quality assurance program shall advance error prevention.

Prior Citation – Respondent Megwa

a. On or about March 25, 2010 a representative of the Board inspected and investigated Respondent Pharmacy. Pursuant to that inspection, on March 25, 2010, Administrative Citation/Assessment of Fine No. **CI 2009 42825** was issued to Respondent Megwa for violating Codes and Regulations as set forth below, resulting in the issuance of a 1300.00 fine, which Respondent paid in full. The citation is now final.

Code/Regulation(s) Violated	Description
1.CCR, title 16, § 1716/§ 1761 (a)	Variation from prescription/erroneous or uncertain prescription; no pharmacist shall compound or dispense any prescription which contains any significant error or omission.
2.CCR, title 16, § 1711(e)	Quality assurance program shall advance error prevention.

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 48255, issued to CVS Pharmacy #1666;

2. Revoking or suspending Pharmacist License Number RPH 59389 issued to Susan

Jenevive Megwa;

3. Ordering Respondents CVS Pharmacy #1666 and Susan Jenevive Megwa 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: 7/11/16

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

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