KAMALA D. HARRIS
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
NICOLE R. TRAMA
Deputy Attorney General
State Bar No. 263607
110 West A Street, Suite 1100
San Diego, CA 92101
Telephone: (619) 645-2143
Facsimile: (619) 645-2061
Attorneys for Complainant

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

In the Matter of the Accusation Against: **SANSUM CLINIC PHARMACY, INC.;** **STEVEN CHARLES COOLEY** **317 W. Pueblo St.** **Santa Barbara, CA 93105** **Pharmacy Permit No. PHY 32685,** **and** **STEVEN CHARLES COOLEY** **P.O. Box 31210** **Santa Barbara, CA 93130-1210** **Pharmacist License No. RPH 28548** Respondents.	Case No. 4865 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about February 25, 1986, the Board of Pharmacy issued Pharmacy Permit Number PHY 32685 to Sansum Clinic Pharmacy, Inc.; Steven Charles Cooley (Respondents). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and expired on September 13, 2014, and has not been renewed.

3. On or about April 24, 1973, the Board of Pharmacy issued Pharmacist License Number RPH 28548 to Steven Charles Cooley (Respondents). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2015, unless renewed.

JURISDICTION

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

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

6. Section 4011 of the Code 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 & Safety Code, § 11000 et seq.].

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

8. 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.

STATUTORY PROVISIONS

9. Section 4022 of the Code states:

> "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.
>
> (b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a ____," "Rx only," or words of similar import,

the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(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.

10. Section 4040 of the Code states, in pertinent part:

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (3) of subdivision (b) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

11. Section 4113, subdivision (c) of the Code 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."

12. 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:

. . . .

(c) Gross negligence.

(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, of 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.

. . . .

13. 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.

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

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

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

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

15. Health and Safety Code section 11153 states in pertinent part:

(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

16. Code of Federal Regulations, title 21, section 1306.04 states in pertinent part:

(a) A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his 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. An order purporting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

. . . .

17. Code of Federal regulations, title 21, section 1306.11 states in part:

(a) A pharmacist may dispense directly a controlled substance listed in Schedule II that is a prescription drug as determined under section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)) only pursuant to a written prescription signed by the practitioner, except as provided in paragraph (d) of this section. A paper prescription for a Schedule II controlled substance may be transmitted by the practitioner or the practitioner's agent to a pharmacy via facsimile equipment, provided that the original manually signed prescription is presented to the pharmacist for review prior to the actual dispensing of the controlled substance, except as noted in paragraph (e), (f), or (g) of this section. The original prescription shall be maintained in accordance with §1304.04(h) of this chapter.

. . . .

18. 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

19. 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.

DRUGS

20. Alprazolam, the generic name for Xanax, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(1), and a dangerous drug pursuant to Business and Professions Code section 4022.

21. Acetaminophen/codeine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

22. Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(7), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

23. Fentanyl is the generic name for Duragesic, a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(8), and a dangerous drug pursuant to Business and Professions Code section 4022.

24. Hydrocodone Bitartrate is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

25. Hydromorphone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

26. Lorazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug pursuant to Business and Professions Code section 4022.

27. Methadone HCL is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022.

28. Morphine Sulfate, the generic name for MSContin and Avinza, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), and is a dangerous drug pursuant to Business and Professions Code section 4022.

29. Opana is a brand name for oxymorphone hydrochloride, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(N), and a dangerous drug pursuant to Business and Professions Code section 4022.

30. Oxycodone, the generic name for Oxycontin, Roxicodone, and OxyIR, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Business and Professions Code section 4022.

31. Vicodin, Norco, and Vicodin ES are brand names for acetaminophen and hydrocodone bitartrate, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Business and Professions Code section 4022.[1]

[1] As of October 6, 2014, acetaminophen and hydrocodone bitartrate has been rescheduled under the Controlled Substance Act as a Schedule II controlled substance.

FACTUAL ALLEGATIONS

32. At all times mentioned herein and since February 25, 1986, Steven Charles Cooley has been the Pharmacist-in-Charge (Respondent PIC) of Sansum Clinic Pharmacy, Inc. (Respondent Pharmacy) located in Santa Barbara, California.

33. In January 2012, the Board initiated an investigation of Respondents after discovering that Respondents dispensed a large number of controlled substance prescriptions prescribed by Dr. J. Diaz,[2] who was arrested by the Drug Enforcement Agency for distributing controlled substances without a legitimate medical purpose. Although Dr. Diaz was not a pain management specialist, his prescribing habits included numerous large quantities of strong pain narcotics in combination with anti-anxiety drugs. The usual combination included hydromorphone, hydrocodone/APAP, oxycodone, methadone, fentanyl, Oxycontin, morphine sulfate, with alprazolam, clonazepam, lorazepam, and/or diazepam.

34. In reviewing CURES[3] data, the inspector discovered that Respondents dispensed one of the highest volumes of controlled substance prescriptions written by Dr. Diaz (1,840 controlled substance prescriptions for a total of 269,224 dosage units) despite that Dr. Diaz's office was not located in the large medical building where Respondents practiced pharmacy.[4]

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[2] Dr. Diaz operated Family Medical Clinic in Santa Barbara, California. His medical license was revoked by the California Medical Board in 2012. Dr. Diaz was arrested by the Drug Enforcement Agency on January 4, 2012 after being linked to eleven drug-related patient deaths and more than 400 drug-related emergency room visits in a two year timeframe. Dr. Diaz, who was known by some patients as the "Candyman" because of his liberal prescribing practices, prescribed excessive amounts of narcotics to patients, who then filled the prescriptions and sold them on the streets or used them. On January 9, 2015, Dr. Diaz plead guilty in federal court to eleven federal drug trafficking charges for writing prescriptions for powerful painkillers to patients who were drug addicts. Dr. Diaz admitted that he distributed or dispensed the narcotics "while acting and intending to act outside the usual course of professional practice and without a legitimate medical purpose."

[3] Controlled Substance Utilization Review and Evaluation System, C.U.R.E.S, is a database that contains over 100 million entries of controlled substance drugs that were dispensed in California. CURES is part of a program developed by the California Department of Justice, Bureau of Narcotic Enforcement, which allows access to the Prescription Drug Monitoring Program (PDMP) system. The PDMP allows pre-registered users including licensed healthcare prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards to access patient controlled substance history information. (http://ag.ca.gov/bne/cures.php)

[4] The next highest pharmacy, a large chain pharmacy, dispensed 60 prescriptions (total of 3,906 dosage units) written by Dr. Diaz during the same timeframe.

35. Many of the patients that Respondents dispensed controlled substance medications to did not have a history of obtaining controlled substances to treat a pain or anxiety disorder prior to seeing Dr. Diaz. However, several of those patients received large doses at the start of treatment with Dr. Diaz. Respondents did not have access and did not utilize CURES when dispensing controlled substances to Dr. Diaz's patients. Had Respondents utilized CURES, Respondents would have discovered that many of Dr. Diaz's patients were pharmacy and/or doctor shopping. Respondents also did not maintain files or notes to monitor patient's pain control, except for a hardcopy of the prescription.

36. Respondents dispensed excessive controlled substances to Dr. Diaz's patients and/or repeatedly dispensed duplicate pain therapy to Dr. Diaz's patients. After Dr. Diaz's arrest, some patients had prescriptions filled by Respondents; however, they did not receive the quantity or therapy duplication they received from Dr. Diaz. Some patients did not fill any prescriptions at Respondent Pharmacy after Dr. Diaz's arrest.

37. The following is a sample of patients that Respondents had filled controlled substance prescriptions without regard of their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose:

38. **Patient JA:** Patient JA saw fourteen prescribers and obtained various controlled substances from Respondents from December 17, 2010 to December 20, 2012. Many of JA's pain medications were prescribed by primary care physician Dr. Diaz. Prior to December 2010, JA did not obtain significant amounts of controlled substances for treatment of pain. However, once JA started treatment with Dr. Diaz, JA received large starting doses of pain medication, including Fentanyl 75 mcg, hydromorphone 8 mg and Oxycontin 40 mg. JA had multiple addresses.[5] JA only had prescriptions dispensed at Respondent Pharmacy.

39. Between December 2010 to October 2012, Respondents repeatedly dispensed to JA excessive narcotics and duplicate pain therapy which included Fentanyl, hydromorphone, Oxycontin, oxycodone, and morphine sulfate. For example, on December 29, 2011, Respondents

[5] The address on JA's patient profile did not match the address on Respondents' prescription backers; in fact, there were at least three separate addresses for JA.

dispensed six narcotic pain medications, including fentanyl, hydromorphone HCL, morphine sulfate, oxycodone HCL, Oxycontin 40 mg and Oxycontin 80 mg, to JA on the same day.

40. In addition, Respondents dispensed early refills of controlled substance prescriptions to JA as follows:

a. On January 6, 2011 (and ten days early), Respondents dispensed 15 doses of Fentanyl 75 mcg to JA, even though JA had received a thirty day supply of Fentanyl 75 mg from Respondents on December 17, 2010, just twenty days prior.

b. On October 10, 2011 (and five days early), Respondents dispensed to JA, 15 doses of Fentanyl 75 mcg, 120 tablets of hydromorphone, 90 tablets of Oxycontin 40 mg and 90 tablets of Oxycontin 80 mg, even though JA had received a thirty day supply of all four of these medications from Respondents on September 15, 2011, just twenty-five days prior.

c. On November 2, 2011 (and seven days early), Respondents dispensed 90 tablets of Oxycontin 40 mg to JA, even though JA had received a thirty day supply of Oxycontin 40 mg from Respondents on October 10, 2011, just twenty-three days prior.

d. On November 3, 2011 (and six days early), Respondents dispensed 90 tablets of Oxycontin 80 mg to JA, even though JA had received a thirty day supply of Oxycontin 80 mg from Respondents on October 11, 2011, just twenty-four days prior.

e. On December 29, 2011 (and seven days early), Respondents dispensed 15 doses of Fentanyl 75 mcg to JA, even though JA had received a thirty day supply of Fentanyl from Respondents on December 6, 2011, just twenty-three days prior.

f. On September 21, 2012 (and five days early), Respondents dispensed 15 doses of Fentanyl 100 mcg (45 day supply) to JA, even though JA had received a thirty day supply of Fentanyl from Respondents on August 27, 2012, just twenty-five days prior. On October 25, 2012, (and eleven days early), Respondents dispensed another 15 doses Fentanyl 100 mcg to JA.

41. **Patient TA:** Between January 24, 2009 and December 14, 2012, patient TA saw five prescribers and traveled to ten pharmacies to obtain controlled substances. Patient TA's address was in Santa Maria and he filled prescriptions for controlled substances at multiple pharmacies, including Respondent Pharmacy, in Santa Maria, Lake Elsinore, Santa Barbara and

Goleta. TA travelled to Santa Maria, Santa Barbara and Goleta to see his prescribers. Although TA saw a pain specialist, TA received most of his pain medications from Dr. Diaz, his primary care physician. Prior to June 2009, TA did not obtain a significant amount of controlled substances for treatment of pain. However, beginning in June 2009, JA began receiving large doses of pain medication from Dr. Diaz, including Opana ER 40 mg and Oxycontin 80 mg. TA was also given a large starting dose of anxiety medication, diazepam 10 mg, even though he did not have any significant anxiety history prior to June 2009.

42. From June 2009 to March 2012, Respondents repeatedly dispensed to TA excessive narcotics and duplicate pain therapy which included Fentanyl, hydromorphone, Oxycontin, oxycodone and Opana ER. For example, during a two-day timeframe between July 5 and 6, 2011, Respondents dispensed four narcotic pain medications to TA including Oxycodone HCL, hydromorphone HCL, morphine sulfate and Opana.

43. In addition, Respondents dispensed early refills of controlled substance prescriptions to TA as follows:

a. On April 11, 2011 (and five days early), Respondents dispensed Opana ER 40 mg to TA, even though TA received a thirty day supply of Opana ER from Respondents on March 17, 2011, just twenty-five days prior.

b. On October 21, 2011 (and five days early), Respondents dispensed Opana ER 40 mg to TA, even though TA received a thirty day supply of Opana ER from Respondents on September 26, 2011, just twenty-five days prior.

44. **Patient GC:** Patient GC saw nine prescribers and travelled to four pharmacies from January 2009 to December 2012. Respondents dispensed multiple prescriptions for Lorazepam to GC that were written by several prescribers, including Dr. Diaz. From March 2009 to December 2011, Respondents repeatedly dispensed to GC excessive narcotics and duplicate pain therapy which included hydrocodone/acetaminophen, Opana ER (various strengths), hydromorphone (various strengths), methadone and oxycodone/acetaminophen. For example, between June 18 and 25, 2010, Respondents dispensed four narcotic pain medications, including

one prescription for APAP/Hydrocodone Bitartrate 325 mg/10 mg, one prescription for APAP/oxycodone, one prescription for hyromorphone HCL, and one prescription for Opana.

45. In addition, Respondents dispensed early refills of controlled substance prescriptions to GC as follows:

a. On May 5, 2009 (and ten days early), Respondents dispensed 60 tablets of oxycodone 40 mg to GC even though GC had received a thirty day supply of oxycodone from Respondents on April 15, 2009, just twenty days prior.

b. On June 22, 2009 (and eight days early) Respondents dispensed 100 tablets of hydromorphone 8 mg to GC, even though GC had received 25 day supply of hydromorphone 8 mg from Respondents on June 5, 2009, just seventeen days prior.

c. On September 17, 2009 (and nine days early), Respondents dispensed 180 tablets of hydrocodone/acetaminophen 10/325 mg to GC, even though GC had received a thirty day supply of hydrocodone/acetaminophen 10/325 from Respondents on August 27, 2009, just twenty-one days prior.

d. On January 22, 2010 (and five days early), Respondents dispensed 120 tablets of hydrocodone/acetaminophen 10/325 mg to GC, even though GC had received a thirty day supply of hydrocodone/acetaminophen 10/325 from Respondents on December 28, 2009, just twenty-five days prior.

e. On August 19, 2010 (and six days early), Respondents dispensed 180 tablets of hydromorphone 8 mg to GC, even though GC had received a thirty day supply of hydromorphone 8 mg on July 26, 2010 from Respondents, just twenty-four days prior.

f. On August 26, 2010 (and eight days early), Respondents dispensed 150 tablets of hydromorphone 8 mg to GC, even though GC had received a fifteen day supply of hydromorphone 8 mg from Respondents on August 19, 2010, just seven days prior.

g. On May 12, 2011 (and seven days early), Respondents dispensed 60 tablets of Opana ER 40 mg to GC, even though GC had received a thirty day supply of Opana ER 40 mg from Respondents on April 19, 2011, just twenty-three days prior.

46. **Patient AC:** Patient AC saw three prescribers, including Dr. Diaz, and travelled to six pharmacies from February 15, 2010 to October 8, 2012. AC had no history of filling prescriptions for the treatment of pain or anxiety from February 2009 to February 15, 2010. However, beginning in or around February 2010, AC began receiving prescriptions for large quantities of pain medications and was given a large starting dose of an anxiety medication, diazepam 10 mg. From April 2010 to December 2011, Respondents repeatedly dispensed to AC duplicate pain therapy which included morphine sulfate (various strengths), oxycodone (various strengths) and hydromorphone 8 mg, all at the same time. For example, between December 6 and 9, 2011, Respondents dispensed to AC one prescription for morphine sulfate and two prescriptions for Oxycodone HCL 30 mg.

47. In addition, Respondents dispensed early refills of controlled substance prescriptions to AC as follows:

a. On May 25, 2010 (and five days early), Respondents dispensed 90 tablets of morphine sulfate 30 mg and 140 tablets of oxycodone 30 mg to AC, even though AC had received 90 tablets of morphine sulfate 30 mg (thirty day supply) and 120 tablets of oxycodone 30 mg (thirty day supply) from Respondents on April 30, 2010, just twenty-five days prior.

b. On June 11, 2010 (and seven days early), Respondents dispensed 140 tablets of oxycodone 30 mg to AC, even though AC had received 140 tablets of oxycodone 30 mg (twenty-four day supply) from Respondents on May 25, 2010, just seventeen days prior.

c. On June 30, 2010 (and five days early), Respondents dispensed 140 tablets of oxycodone 30 mg to AC, even though AC had received 140 tablets of oxycodone 30 mg (twenty-four day supply) from Respondents on June 11, 2010, just nineteen days prior.

d. On August 11, 2010 (and five days early), Respondents dispensed 140 tablets of oxycodone 30 mg to AC, even though AC had received 140 tablets of oxycodone 30 mg (twenty-four day supply) from Respondents on July 23, 2010, just nineteen days prior.

e. On November 16, 2010 (and eight days early) Respondents dispensed 210 tablets of oxycodone 30 mg to AC, even though AC had received 180 tablets of oxycodone 30 mg (thirty day supply) from Respondents on October 25, 2010, just twenty-two days prior.

48. Respondents also dispensed RX Nos. 2279777 for Oxycodone HCL 30 mg and 2279778 for Morphine Sulfate 30 mg on January 6, 2011, one year after the date of the prescriptions (January 6, 2010).

49. **Patient EF:** Patient EF saw five prescribers, including Dr. Diaz, and travelled to eight pharmacies from January 2, 2010 to December 27, 2012. EF's address was in Santa Barbara; however, she saw prescribers in Santa Barbara, San Francisco, Goleta, and Arlington, Texas and obtained controlled substances from various pharmacies, including Respondent Pharmacy, in Santa Barbara, Oxnard, and Goleta. EF had no history of taking controlled substances for pain from February 2009 to December 2010 and no history of taking controlled substances for anxiety prior to March 2011. However, EF was prescribed large starting doses of pain medication including methadone 10 mg and hydrocodone/APAP 10/325 mg and a large starting dose of anxiety medication, alprazolam 2 mg. From December 2010 to December 2012, Respondents repeatedly dispensed to EF duplicate pain therapy which included methadone 10 mg and APAP/hydrocodone 10/325 at the same time.

50. In addition, Respondents dispensed early refills of controlled substance prescriptions to EF as follows:

a. On February 4, 2011 (and six days early), Respondents dispensed 300 tablets of methadone HCL 10 mg to EF, even though EF had received 300 tablets of methadone HCL 10 mg (thirty day supply) from Respondents on January 11, 2011, just twenty-four days prior.

b. On February 25, 2011 (and seven days early), Respondents dispensed 300 tablets of APAP/Hydrocodone bitartrate 325/10 to EF, even though EF had received 300 tablets of APAP/Hydrocodone bitartrate 325/10 (thirty day supply) from Respondents on February 3, 2011, just twenty-two days prior.

c. On February 25, 2011 (and eight days early), Respondents dispensed 300 tablets of methadone HCL 10 mg to EF, even though EF had received 300 tablets of methadone HCL 10 mg (thirty day supply) from Respondents on February 4, 2011, just twenty-one days prior.

d. On March 7, 2012 (and sixteen days early), Respondents dispensed 85 tablets of APAP/Hydrocodone bitartrate 325/10 to EF, even though EF had received 115 tablets of

APAP/Hydrocodone bitartrate 325/10 (twenty-three day supply) from Respondents on February 28, 2012, just seven days prior.

e. On March 7, 2012 (and fifteen days early), Respondents dispensed 115 tablets of methadone HCL 10 mg to EF, even though EF had received 175 tablets of methadone HCL 10 mg (twenty-two day supply) from Respondents on February 28, 2012, just seven days prior.

f. On March 20, 2012 (and nine days early), Respondents dispensed 180 tablets of APAP/Hydrocodone bitartrate 325/10 to EF, even though EF had received 85 tablets of APAP/Hydrocodone bitartrate 325/10 (twenty-two day supply) from Respondents on March 7, 2012, just thirteen days prior.

g. On April 18, 2012 (and sixteen days early), Respondents dispensed 180 tablets of APAP/Hydrocodone bitartrate 325/10 to EF, even though EF had received 180 tablets of APAP/Hydrocodone bitartrate 325/10 (forty-five day supply) from Respondents on March 20, 2012, just twenty-nine days prior.

h. On November 30, 2012 (and five days early), Respondents dispensed 180 tablets of APAP/Hydrocodone bitartrate 325/10 to EF, even though EF had received 180 tablets of APAP/Hydrocodone bitartrate 325/10 (thirty day supply) from Respondents on November 5, 2012, just twenty-five days prior.

51. Respondents also dispensed RX Nos. 4564985 and 2279220 on December 16, 2010, even though the prescription written by Dr. Diaz was missing pertinent information, the prescribing date.

52. **Patient CF:** Patient CF saw seven prescribers, including Dr. Diaz, and travelled to seven pharmacies from January 5, 2009 to January 14, 2013. CF saw prescribers in Santa Barbara and Santa Maria and obtained controlled substances from pharmacies, including Respondent Pharmacy, in Santa Barbara and Carpentaria.

53. From January 2009 to December 2011, Respondents repeatedly dispensed to CF excessive pain narcotics and duplicate therapy which included acetaminophen (AP)/codeine 300mg/60mg, hydromorphone 8 mg, methadone 10 mg, lorazepam (various strengths), clonazepam (various strengths), alprazolam, morphine sulfate 30 mg, acetaminophen/oxycodone

325mg/10 mg, and oxycodone 30 mg. For example, on May 20, 2010, Respondents dispensed to CF a total of five controlled substances (Alprazolam, Hydromorphone HCL, Methadone HCL, Morphine Sulfate and Oxycodone HCL), four of which were narcotic pain medications.

54. In addition, Respondents dispensed early refills of controlled substance prescriptions to CF as follows:

a. On March 2, 2009 (and seven days early), Respondents dispensed 186 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 186 tablets (thirty-one day supply) of acetaminophen/codeine 300/60 mg from Respondents on February 6, 2009, just twenty-four days prior.

b. On April 23, 2009 (and seven days early), Respondents dispensed 186 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 186 tablets (thirty-one day supply) of acetaminophen/codeine 300/60 mg from Respondents on March 30, 2009, just twenty-four days prior.

c. On September 8, 2009 (and twelve days early), Respondents dispensed 120 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets (twenty day supply) of acetaminophen/codeine 300/60 mg from Respondents on September 1, 2009, just eight days prior.

d. On December 15, 2009 (and 5 days early), Respondents dispensed 180 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets (twenty day supply) of acetaminophen/codeine 300/60 mg from Respondents on November 30, 2009, just fifteen days prior.

e. On December 28, 2010 (and nine days early), Respondents dispensed 100 tablets of alprazolam 2 mg to Patient CF, even though CF had received 60 tablets (thirty day supply) of alprazolam from Respondents on December 7, 2010, just twenty-one days prior.

f. On January 20, 2011 (and six days early), Respondents dispensed 90 tablets of lorazepam 1 mg to Patient CF, even though CF had received 90 tablets (thirty day supply) of lorazepam 1 mg from Respondents on December 27, 2010, just twenty-four days prior.

g. On January 25, 2011 (and eight days early), Respondents dispensed 120 tablets of methadone HCL 10 mg to Patient CF, even though CF had received 120 tablets of methadone HCL (thirty day supply) from Respondents on January 3, 2011, just twenty-two days prior.

h. On May 9, 2011 (and nine days early), Respondents dispensed 120 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets (thirty day supply) of acetaminophen/codeine 300/60 mg from Respondents on April 18, 2011, just twenty-one days prior.

i. On May 30, 2011 (and nine days early), Respondents dispensed 120 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets (thirty day supply) of acetaminophen/codeine 300/60 mg from Respondents on May 9, 2011, just twenty-one days prior.

j. On June 17, 2011 (and twelve days early), Respondents dispensed 120 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets (thirty day supply) of acetaminophen/codeine 300/60 mg from Respondents on May 30, 2011, just eighteen days prior.

k. On July 11, 2011 (and six days early), Respondents dispensed 120 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets (thirty day supply) of acetaminophen/codeine 300/60 mg from Respondents on June 17, 2011, just twenty-four days prior.

l. On October 18, 2011 (and seven days early), Respondents dispensed 100 tablets of alprazolam 2 mg to Patient CF, even thought CF had received 100 tablets (twenty-five day supply) of alprazolam 2 mg from Respondents on September 30, 2011, just eighteen days prior.

m. On October 28, 2011 (and five days early), Respondents dispensed 120 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets (thirty day supply) of acetaminophen/codeine 300/60 mg from Respondents on October 3, 2011, just twenty-five days prior.

n. On November 18, 2011 (and nine days early), Respondents dispensed 120 tablets of acetaminophen/codeine 300/60 mg to Patient CF, even though CF had received 120 tablets of

acetaminophen/codeine 300/60 mg from Respondents on October 28, 2011, just twenty-one days prior.

o. On December 13, 2011 (and five days early), Respondents dispensed 90 tablets of lorazepam 1 mg to Patient CF, even though CF had received 90 tablets (a thirty day supply) of lorazepam 1 mg from Respondents on November 18, 2011, just twenty-five days prior.

55. **Patient CH:** Patient CH saw eight prescribers and travelled to fifteen pharmacies from November 20, 2009 to January 9, 2013. CH's address was in Los Angeles, yet CH travelled great distances to see Dr. Diaz and to have prescriptions filled at Respondent Pharmacy. CH also saw prescribers in Rowland Heights, Sherman Oaks, Santa Barbara, Encino, Ventura, West Hills, Newbury Park and Woodland Hills and obtained controlled substances from pharmacies in Ventura, Los Angeles, Santa Barbara, Sacramento, Oxnard, Encino, and Sherman Oaks. From November 2009 to January 2011, CH did not obtain a significant number of controlled substances to treat pain or anxiety disorders. However, once CH began to see Dr. Diaz, CH was prescribed excessive amounts of narcotics. Respondents dispensed excessive amounts of controlled substances to CH but did not know CH's diagnosis.

56. From January 2011 to December 2011, Respondents repeatedly dispensed to CH excessive duplicate pain therapy which included alprazolam, clonazepam, methadone, morphine sulfate, APAP/Hydrocodone bitartrate and oxycodone. For example, on January 13, 2011, Respondents dispensed to CH two anxiety controlled substances (alprazolam and clonazepam) and three pain narcotics (methadone HCL, morphine sulfate, and oxycodone HCL), all on the same day.

57. In addition, Respondents dispensed early refills of controlled substance prescriptions to CH as follows:

a. On February 7, 2011 (and five days early), Respondents dispensed 120 tablets of alprazolam 2 mg and 60 tablets of morphine sulfate 100 mg to Patient CH, even though CH had received a thirty day supply of alprazolam and morphine sulfate from Respondents on January 13, 2011, just twenty-five days prior.

b. On March 14, 2011 (and nine days early), Respondents dispensed 240 tablets of APAP/hydrocodone bitartrate 325/10 mg to Patient CH, even though CH had received a thirty day supply of APAP/hydrocodone bitartrate 325/10 mg from Respondents on February 21, 2011, just twenty-one days prior.

c. On December 9, 2011 (and five days early), Respondents dispensed 120 tablets of alprazolam 2 mg and 240 tablets of APAP/hydrocodone bitartrate 325/10 to Patient CH, even though CH had received a thirty day supply of alprazolam and APAP/hydrocodone bitartrate 325/10 from Respondents on November 14, 2011, just twenty-five days prior.

58. **Patient ML:** Patient ML saw six prescribers and travelled to six pharmacies from January 2009 to January 2013. ML's address was in Ventura, yet she saw prescribers, including Dr. Diaz, in Santa Barbara, Monterey, Ventura, Bakersfield and Santa Paula and obtained controlled substances from pharmacies in Santa Paula, Santa Barbara, and Oxnard. During the time that ML obtained controlled substances from Respondents, ML was prescribed multiple narcotics by Dr. Diaz and travelled to numerous pharmacies to obtain them. Although Respondents repeatedly dispensed narcotics to ML, Respondents did not know the diagnosis of ML's pain.

59. From March 2009 to December 2011, Respondents repeatedly dispensed to ML excessive duplicate pain therapy which included APAP/hydrocodone bitartrate, morphine sulfate, fentanyl, hydromorphone, oxycodone, and Opana. For example, on January 7, 2011, Respondents dispensed six pain narcotics to ML including APAP/hydrocodone bitartrate, fentanyl, hydromorphone HCL, morphine sulfate, Opana, and Oxycodone HCL, all on the same day.

60. In addition, Respondents dispensed early refills of controlled substance prescriptions to ML as follows:

a. On October 14, 2010 (and ten days early), Respondents dispensed 280 tablets of hydromorphone HCL 8 mg to patient ML, even though ML had received a thirty-eight day supply of hydromorphone HCL 8 mg on September 16, 2010, just twenty-eight days prior.

b. On April 29, 2011 (and five days early), Respondents dispensed 15 doses of Fentanyl, 90 tablets of morphine sulfate and 60 tablets of Opana to patient ML, even though ML had

received a thirty day supply of all three of these medications on April 4, 2011, just twenty-five days prior.

c. On October 24, 2011 (and five days early), Respondents dispensed 15 doses of fentanyl, 240 tablets of hydromorphone, and 90 tablets of Opana to patient ML, even though ML had received a thirty day supply of all three of these medications on September 29, 2011, just twenty-five days prior.

d. On November 18, 2011 (and five days early), Respondents dispensed 90 tablets of hydromorphone and 60 tablets of Opana to patient ML, even thought ML had received a thirty day supply of these medications on October 24, 2011, just twenty-five days prior.

e. On November 21, 2011 (and 5 days early), Respondents dispensed 60 tablets of morphine sulfate to patient ML, even though ML had received a thirty-day supply of morphine sulfate from Respondents on October 27, 2011, just twenty-five days prior.

61. **Patient PP:** Patient PP saw six prescribers, including Dr. Diaz, and travelled to twelve pharmacies, including Respondent Pharmacy, from January 2009 to January 2013. PP's address was in Goleta; however, she traveled to Santa Barbara, Santa Maria, and Bulleton to obtain controlled substances. During the time that PP obtained controlled substances from Respondents, she also obtained excessive amounts of pain and anxiety medications prescribed by Dr. Diaz from several other pharmacies. On multiple occasions, Respondents dispensed thirty day supplies (240 tablets) of hydrocodone/APAP 10/500, which is the maximum dose (4000 mg or 4 grams) of acetaminophen per day. Respondent PIC did not know PP's diagnosis when he dispensed narcotics to her.

62. From January 2009 to December 2012, Respondents repeatedly dispensed to PP excessive narcotics and duplicate therapy which included APAP/hydrocodone bitartrate, morphine sulfate, oxycodone, Oxycontin, hydrocodone bitartrate/Ibuprofen, fentanyl, diazepam, clonazepam, alprazolam, lorazepam, oxycodone, Percodan, and hydromorphone. For example, in an approximately two week timeframe from November 10 to November 28, 2011, Respondents dispensed eight pain narcotics (with six dispensed in one day on November 17, 2011) including APAP/Hydrocodone, endodan, fentanyl, hydromorphone HCL, morphine sulfate, oxycodone

HCL, oxycontin, and hydrocodone/Ibuprofen. In another example, Respondents dispensed ten controlled substances, (two of which were anxiety medications and eight of which were pain narcotics) in December 2011 to PP.

63. In addition, Respondents dispensed early refills of controlled substance prescriptions to PP as follows:

a. On April 24, 2009 (and five days early), Respondents dispensed 240 tablets of oxycodone HCL 30 mg to patient PP, even though PP had received a thirty day supply of oxycodone HCL from Respondents on March 30, 2009, just twenty-five days prior.

b. On April 29, 2009 (and seven days early), Respondents dispensed 120 tablets of morphine sulfate 100 mg to patient PP, even though PP had received a thirty day supply of morphine sulfate 100 mg from Respondents on April 6, 2009, just twenty-three days prior.

c. On October 1, 2009 (and eight days early), Respondents dispensed 240 tablets of APAP/hydrocodone bitartrate 500/10 mg to patient PP, even though PP had received a thirty day supply of this medication from Respondents on September 9, 2009, just twenty-two days prior.

d. On November 19, 2009 (and six days early), Respondents dispensed 120 tablets of MS Contin, 240 tablets of oxycodone HCL, and 120 tablets of Oxycontin 80 mg to patient PP, even though PP had received thirty day supplies of all three of these drugs from Respondents on October 26, 2009, just twenty-four days prior.

e. On January 7, 2010 (and eight days early), Respondents dispensed 120 tablets of MS Contin, 240 tablets of oxycodone HCL, and 120 tablets of Oxycontin 80 mg to patient PP, even though PP had received thirty day supplies of all three of these drugs from Respondents on December 16, 2009, just twenty-two days prior.

f. On February 18, 2010 (and six days early), Respondents dispensed 240 tablets of APAP/hydrocodone bitartrate 500/10 mg to patient PP, even though PP had received a thirty day supply of this medication from Respondents on January 25, 2010, just twenty-four days prior.

g. On February 22, 2010 (and six days early), Respondents dispensed 60 tablets of alprazolam to patient PP, even though PP had received a thirty day supply of this medication from Respondents on January 29, 2010, just twenty-four days prior.

h. On April 22, 2010 (and 7 days early), Respondents dispensed 120 tablets of Oxycontin 80 mg and 120 tablets of Morphine Sulfate to patient PP, even though PP received a thirty day supply of these drugs from Respondents on March 30, 2010, just twenty-three days prior.

i. On May 17, 2010 (and five days early), Respondents dispensed 120 tablets of morphine sulfate and 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of these drugs from Respondents on April 22, 2010, just twenty-five days prior.

j. On June 10, 2010 (and six days early), Respondents dispensed 120 tablets of morphine sulfate and 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of these drugs from Respondents on May 17, 2010, just twenty-four days prior.

k. On July 1, 2010 (and six days early), Respondents dispensed 240 tablets of hydrocodone bitartrate/Ibuprofen 7.5/200 to patient PP, even though PP received a thirty day supply of this medication from Respondents on June 7, 2010, just twenty-four days prior.

l. On August 13, 2010 (twelve days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 180 tablets of oxycodone HCL 15 mg to patient PP, even though PP received a thirty day supply of these drugs from Respondents on July 26, 2010, just eighteen days prior.

m. On August 18, 2010 (and seven days early), Respondents dispensed Oxycontin 80 mg and hydrocodone bitartrate/Ibuprofen 7.5/200 to patient PP, even though PP received a thirty day supply of these medications from Respondents on July 26, 2010, just twenty-three days prior.

n. On September 7, 2010 (and ten days early), Respondents dispensed 240 tablets of APAP/hydrocodone 500/10 mg to patient PP, even though PP received a thirty-six day supply of this drug from Respondents on August 12, 2010, just twenty-six days prior.

o. On October 4, 2010 (and six days early), Respondents dispensed 120 tablets of MS Contin 100 mg to patient PP, even though PP received a thirty day supply of MS Contin 100 mg on September 10, 2010, just twenty-four days prior.

p. On October 8, 2010 (and six days early), Respondents dispensed 240 tablets of hydrocodone bitartrate/Ibuprofen 7.5/200 to patient PP, even though PP received a thirty day supply of this drug on September 14, 2010, just twenty-four days prior.

q. On October 27, 2010 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of these drugs on October 4, 2010, just twenty-three days prior.

r. On November 18, 2010 (and eight days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of these drugs on October 27, 2010, just twenty-two days prior.

s. On December 13, 2010 (and five days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of these drugs on November 18, 2010, just twenty-five days prior.

t. On December 28, 2010 (and five days early), Respondents dispensed 240 tablets of hydrocodone bitartrate/Ibuprofen 7.5/200 to patient PP, even though PP received a thirty day supply of this drug from Respondents on December 3, 2010, just twenty-five days prior.

u. On January 5, 2011 (and seven days early), Respondents dispensed 120 tablets of morphine sulfate 100 mg and 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of these drugs from Respondents on December 13, 2010, just twenty-three days prior.

v. On February 18, 2011 (and five days early), Respondents dispensed 120 tablets hydrocodone bitartrate/Ibuprofen 7.5/200 to patient PP, even though PP received a thirty day supply of this drug from Respondents on January 24, 2011, just twenty-five days prior.

w. On April 7, 2011 (and thirteen days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of Oxycontin 80 mg from Respondents on March 21, 2011, just seventeen days prior.

x. On May 9, 2011 (and five days early), Respondents dispensed morphine sulfate 100 mg to patient PP, even though PP received a thirty day supply of morphine sulfate 100 mg on April 14, 2011, just twenty-five days prior.

y. On May 11, 2011 (and seven days early), Respondents dispensed 240 tablets hydrocodone bitartrate/Ibuprofen 7.5/200 to patient PP, even though PP received a thirty day supply of this drug from Respondents on April 18, 2011, just twenty-three days prior.

z. On May 25, 2011 (and seven days early), Respondents dispensed 240 tablets of APAP/hydrocodone 500/10 mg to patient PP, even though PP received a thirty day supply of this drug from Respondents on May 2, 2011, just twenty-three days prior.

aa. On May 26, 2011 (and thirteen days early), Respondents dispensed 120 tablets of morphine sulfate 100 mg to patient PP, even though PP received a thirty day supply of morphine sulfate 100 mg on May 9, 2011, just seventeen days prior.

bb. On May 27, 2011 (and seven days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of Oxycontin 80 mg from Respondents on May 2, 2011, just twenty-three days prior.

cc. On June 20, 2011 (and five days early), Respondents dispensed 120 tablets of morphine sulfate 100 mg to patient PP, even though PP received a thirty day supply of this drug from Respondents on May 26, 2011, just twenty-five days prior.

dd. On June 20, 2011 (and six days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of this drug from Respondents on May 27, 2011, just twenty-four days prior.

ee. On July 13, 2011 (and seven days early), Respondents dispensed 120 tablets of morphine sulfate 100 mg and 120 tablets of Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of this drug from Respondents on June 20, 2011, just twenty-three days prior.

ff. On August 12, 2011 (and nine days early), Respondents dispensed 300 tablets of APAP/hydrocodone 500/10 mg to patient PP, even though PP received a thirty-eight day supply of this drug from Respondents on July 14, 2011. just twenty-nine days prior.

gg. On September 12, 2011 (and eight days early), Respondents dispensed 300 tablets of APAP/hydrocodone 500/10 mg to patient PP, even though PP received a thirty-eight day supply of this drug from Respondents on August 12, 2011. just thirty days prior.

hh. On September 12, 2011 (and six days early), Respondents dispensed 100 tablets of lorazepam 1 mg to patient PP, even though PP received a twenty-five day supply of lorazepam 1 mg from Respondents on August 24, 2011, just nineteen days prior.

ii. On October 26, 2011 (and nine days early), Respondents dispensed 150 tablets of Endodan to patient PP, even though PP received a twenty-five day supply of this medication from Respondents on October 10, 2011, just sixteen days prior.

jj. On November 17, 2011 (and eight days early), Respondents dispensed 120 tablets of morphine sulfate 100 mg and Oxycontin 80 mg to patient PP, even though PP received a thirty day supply of these drugs from Respondents on October 26, 2011, just twenty-two days prior.

kk. On December 7, 2011 (and ten days early), Respondents dispensed 300 tablets of APAP/hydrocodone 500/10 mg to patient PP, even though PP received a thirty-eight day supply of this drug from Respondents on November 10, 2011, just twenty-eight days prior.

ll. On December 20, 2011 (and nine days early), Respondents dispensed 120 doses of Fentanyl to patient PP, even though PP received a thirty day supply of Fentanyl from Respondents on November 29, 2011, just twenty-one days prior.

mm. On August 2, 2012 (and ten days early), Respondents dispensed 30 tablets of morphine sulfate and thirty tablets of lorazepam to patient PP, even though PP received a thirty day supply of these medications on July 12, 2012.

64. Respondents also did not maintain prescription hardcopies for the following prescriptions: RX 2271636 for MS Contin 100 mg; RX 2271637 for oxycodone HCL 30 mg; and RX 2271635 for Oxycontin 80 mg.

65. **Patient UR:** Patient UR saw four prescribers, including Dr. Diaz, and travelled to three pharmacies from April 2009 to July 2011. Prior to seeing Dr. Diaz, UR was not prescribed a significant amount of controlled substances for treatment of pain. However, after starting treatment with Dr. Diaz, UR was prescribed excessive amounts of pain narcotics. From June 2009 to July 2011, Respondents repeatedly dispensed to UR excessive duplicate pain therapy which included Opana, oxycodone, hydromorphone and morphine sulfate all at the same time.

66. In addition, Respondents dispensed early refills of controlled substance prescriptions to UR as follows:

a. On February 5, 2010 (and seven days early), Respondents dispensed 60 tablets of oxycodone HCL to patient UR, even though UR received a thirty day supply of oxycodone HCL from Respondents on January 13, 2010, just twenty-three days early.

b. On May 11, 2010 (and eight days early), Respondents dispensed 60 tablets of Opana 10 mg and 90 tablets of oxycodone HCL to patient UR, even though UR received a thirty day supply of these drugs from Respondents on April 19, 2010, just twenty-two days prior.

c. On August 2, 2010 (and six days early), Respondents dispended 120 tablets of hydromorphone HCL 8 mg and 60 tablets of Opana 20 mg to patient UR, even though UR received a thirty day supply of these drugs from Respondents on July 9, 2010, just twenty-four days prior.

d. On November 23, 2010 (and eight days early), Respondents dispensed 100 tablets of hydromorphone HCL 8 mg to patient UR, even though UR received a thirty day supply of hydromorphone HCL 8 mg from Respondents on November 1, 2010, just twenty-two days prior.

67. **Patient MS:** Patient MS saw three prescribers, including Dr. Diaz, and used two pharmacies to fill controlled substance prescriptions between January 2010 to December 2012. Prior to seeing Dr. Diaz, MS did not receive controlled substance pain medications or anxiety medications. However, after seeing Dr. Diaz, MS was prescribed excessive amounts of narcotic pain medications. MS obtained different strengths of hydrocodone/APAP from different pharmacies. On multiple occasions, Respondents dispensed to MS 180 tablets of hydrocodone/APAP 7.5/750 (30 day supply), or 4500 mg of acetaminophen per day, which is over the recommended daily dose of 4000 mg of acetaminophen per day.

68. From March 2010 to December 2012, Respondents repeatedly dispensed to MS excessive narcotics and duplicate pain therapy which included morphine sulfate, oxycodone, Oxycontin (various strengths), Opana ER, methadone, hydrocodone/APAP, and fentanyl. For example, on December 3, 2010, Respondents dispensed to MS hydrocodone/APAP, methadone HCL, Opana ER, and Oxycodone HCL. In another example on May 27, 2011, Respondents dispensed to MS, fentanyl, methadone HCL, Opana ER, and oxycodone HCL all at the same time.

69. In addition, Respondents dispensed early refills of controlled substance prescriptions to MS as follows:

a. On April 28, 2010 (and seven days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient MS, even though MS received a thirty day supply of Oxycontin 80 mg from Respondents on April 5, 2010, just twenty-three days prior.

b. On July 9, 2010 (and seven days early), Respondents dispensed 60 tablets of Oxycontin 40 mg to patient MS, even though MS received a thirty day supply of Oxycontin 40 mg from Respondents on June 16, 2010, just twenty-three days prior.

c. On May 2, 2011 (and five days early), Respondents dispensed 180 tablets of APAP/Hydrocodone bitartrate 750 mg/7.5 mg to patient MS, even though MS received a thirty day supply of this medication on April 7, 2011 just twenty-five days prior.

70. Respondents also dispensed to MS dispensed RX No. 2272921 for Oxycontin 80 mg from a prescription with an altered strength. Indeed, the original prescription appears to have been altered from "Oxycontin 40" to "Oxycontin 80."

71. **Patient JS:** Patient JS[6] (DOB 11/20/62) saw eight prescribers, including Dr. Diaz, and used five pharmacies, including Respondent Pharmacy, to fill controlled substance prescriptions between January 2009 to December 2012. JS was prescribed excessive amounts of narcotic pain medications by Dr. Diaz. From January 2009 to August 2012, Respondents repeatedly dispensed to JS excessive narcotics and duplicate pain therapy which included hydromorphone, Oxycontin, methadone, oxycodone, Opana ER, hydrocodone/APAP, clonazepam, morphine sulfate, alprazolam, and lorazepam. For example, on March 24, 2011, Respondents dispensed to JS, hydromorphone HCL, methadone HCL, morphine sulfate, oxycodone and alprazolam, all on the same day. In another example, on December 6, 2011, Respondents dispensed to JS, alprazolam, lorazepam, APAP/hydrocodone, methadone HCL, and Oxycodone HCL all at the same time.

[6] Because there are two patients with the initials "JS," their dates of birth are included in order to differentiate between the two.

72. In addition, Respondents dispensed early refills of controlled substance prescriptions to JS as follows:

a. On March 2, 2009 (and seven days early), Respondents dispensed 240 tablets of methadone HCL to patient JS, even though JS received a thirty-four day supply of methadone HCL from Respondents on February 3, 2009, just twenty-seven days prior.

b. On June 1, 2009 (and five days early), Respondents dispensed 270 tablets of methadone HCL and 240 tablets of oxycodone HCL to patient JS, even though JS received thirty day supplies of these drugs from Respondents on May 7, 2009, just twenty-five days prior.

c. On March 22, 2010 (and five days early), Respondents dispensed 120 tablets of hydromorphone HCL to patient JS, even though JS received a thirty day supply hydromorphone HCL from Respondents on February 25, 2010, just twenty-five days prior.

d. On December 29, 2010 (and ten days early), Respondents dispensed 120 tablets of methadone HCL, 30 tablets of morphine sulfate, and 90 tablets of oxycodone HCL to patient JS, even though JS received thirty day supplies of these medications from Respondents on December 9, 2010, just twenty days prior.

e. On May 16, 2011 (and five days early), Respondents dispensed 90 tablets of hydromorphone HCL and 90 tablets of morphine sulfate to patient JS, even though JS received thirty day supplies of these drugs from Respondents on April 21, 2011 just twenty-five days prior.

f. On June 13, 2011 (and nine days early), Respondents dispensed 180 tablets of methadone HCL to patient JS, even though JS received a thirty day supply of methadone HCL from Respondents on May 23, 2011, just twenty-one days prior.

73. **Patient JS:** Patient JS (1/28/53) saw two prescribers, including Dr. Diaz, and used four pharmacies to fill controlled substance prescriptions between October 2009 to January 2013. JS' address was in Santa Ynez; however, he travelled to prescribers and pharmacies in Santa Barbara and Buellton. Prior to seeing Dr. Diaz, JS did not receive controlled substances for pain or anxiety. However, once JS started treatment with Dr. Diaz, he was prescribed excessive amounts of narcotic pain medications. From October 2009 to December 2011, Respondents repeatedly dispensed to JS excessive narcotics and duplicate pain therapy which included

methadone, hydrocodone/APAP, and oxycodone. For example, on May 2, 2011, Respondents dispensed APAP/Hydrocodone 325/10 mg, methadone HCL 10 mg, and morphine sulfate 30 mg to JS, all on the same day.

74. In addition, Respondents dispensed early refills of controlled substance prescriptions to JS as follows:

a. On July 13, 2010 (and twenty days early), Respondents dispensed 100 tablets of hydrocodone/APAP to patient JS, even though JS received a twenty-five day supply of this drug on July 8, 2010, just five days prior.

b. On March 3, 2011 (and six days early), Respondents dispensed 200 tablets of APAP/hydrocodone to patient JS, even though JS received a thirty-four day supply of this drug on February 3, 2011, just twenty-eight days prior.

c. On December 6, 2011 (and nine days early), Respondents dispensed 300 tablets of methadone HCL and 120 tablets of oxycodone HCL to patient JS, even though JS received a thirty day supply of these drugs from Respondents on November 15, 2011, just twenty-one days prior.

75. **Patient LV:** Patient LV saw eight prescribers, including Dr. Diaz, and used thirteen pharmacies to fill controlled substance prescriptions between January 2009 to January 2013. JS' address was in Santa Barbara; however, she travelled to prescribers in Santa Barbara, San Francisco, Santa Maria and Lompoc to obtain controlled substances. LV traveled to various different pharmacies, including Respondent Pharmacy, in Santa Barbara, Lompoc, Ventura and Goleta to obtain controlled substances. Prior to seeing Dr. Diaz, LV did not have a history of receiving alprazolam or other anxiety medications. However, Dr. Diaz started LV with a high dose of anxiety medication, 2 mg of alprazolam. Dr. Diaz also prescribed excessive amounts of narcotic pain medications to LV. On multiple occasions, Respondents dispensed to LV 180 tablets of hydrocodone/APAP 10/325 mg (30 day supply) and 120 tablets of hydrocodone/APAP 7.5/750 mg (30 day supply), or 4950 mg of acetaminophen per day, which is over the recommended daily dose of 4000 mg of acetaminophen per day. Although Respondents repeatedly dispensed controlled substances to LV, Respondents did not know LV's diagnosis, other than that she was disabled.

76. From October 2009 to May 2012, Respondents repeatedly dispensed to LV excessive narcotics and duplicate pain therapy which included methadone and hydrocodone/APAP. For example, between March 4 and March 5, 2009, Respondents dispensed to LV two prescriptions for a thirty-day supply of APAP/Hydrocodone 750/7.5 mg (120 tablets in each prescription) and one prescription for 600 tablets of methadone HCL.

77. In addition, Respondents dispensed early refills of controlled substance prescriptions to JS as follows:

a. On March 5, 2009 (and twenty-nine days early), Respondents dispensed 120 tablets of APAP/hydrocodone 750/7.5 mg to patient LV, even though LV received a thirty day supply of APAP/hydrocodone 750/7.5 on March 4, 2005, just the day before.

b. On October 22, 2010 (and five days early), Respondents dispensed 240 tablets of APAP/hydrocodone 325/10 mg to patient LV, even though LV received a thirty day supply of this drug from Respondents on September 27, 2010, just twenty-five days prior.

c. On January 21, 2011 (and twenty days early), Respondents dispensed 1800 tablets of methadone HCL 10 mg to patient LV, even though LV received a ninety day supply (1800 tablets) of this medication from Respondents on November 12, 2010, seventy days prior.

d. On January 28, 2011 (and five days early), Respondents dispensed 240 tablets of APAP/hydrocodone 325/10 mg to patient LV, even though LV received a thirty day supply of this drug from Respondents on January 3, 2011, just twenty-five days prior.

e. On March 21, 2011 (and five days early), Respondents dispensed 240 tablets of APAP/hydrocodone 325/10 mg to patient LV, even though LV received a thirty day supply of this drug from Respondents on February 24, 2010, just twenty-five days prior.

f. On April 11, 2011 (and 10 days early), Respondents dispensed 1800 tablets of methadone HCL 10 mg to patient LV, even though LV received a ninety day supply (1800 tablets) of this medication from Respondents on January 21, 2011, eighty days prior.

g. On June 15, 2011 (and twenty-five days early), Respondents dispensed 1800 tablets of methadone HCL 10 mg to patient LV, even though LV received a ninety day supply (1800 tablets) of this medication from Respondents on April 11, 2011, sixty-five days prior.

h. On August 15, 2011 (and twenty-nine days early), Respondents dispensed 1800 tablets of methadone HCL 10 mg to patient LV, even though LV received a ninety day supply (1800 tablets) of this medication from Respondents on June 15, 2011, sixty-one days prior.

i. On October 27, 2011 (and seventeen days early) Respondents dispensed 1800 tablets of methadone HCL 10 mg to patient LV, even though LV received a ninety day supply (1800 tablets) of this medication from Respondents on August 15, 2011, seventy-three days prior.

j. On January 6, 2012 (and nineteen days early), Respondents dispensed 140 tablets of methadone HCL 10 mg to patient LV, even though LV received a ninety day supply (1800 tablets) of this medication from Respondents on October 27, 2011, seventy-one days prior.

k. On January 11, 2012 (and five days early), Respondents dispensed 540 tablets of methadone HCL 10 mg to patient LV, even though LV received a ten day supply of this medication from Respondents on January 6, 2012, just five days prior.

l. On May 18, 2012 (and five days early), Respondents dispensed 270 tablets methadone HCL 10 mg to patient LV, even though LV received a thirty day supply of this medication from Respondents on April 23, 2012, twenty-five days prior.

78. **Patient SV:** Patient SV obtained controlled substances from three prescribers, including Dr. Diaz, between January 2009 and November 2012. SV was prescribed excessive amounts of narcotic pain medications by Dr. Diaz. From January 2009 to November 2012, Respondents repeatedly dispensed to SV excessive narcotics and duplicate pain and anxiety therapy. Duplicate pain therapy included MS Contin, Oxycontin, oxycodone, methadone, duragesic (various forms and strengths), Opana ER, Percocet, hydrocodone/APAP. Duplicate anxiety therapy included alprazolam and clonazepam. For example, on August 15, 2011, Respondents dispensed to SV Fentanyl transdermal 50 mcg/hr, MS Contin 100 mg and Oxycontin 80 mg, all at the same time. In another example, between July 7 and July 10, 2009, Respondents dispensed two prescriptions for thirty day supplies of anxiety medications: alprazolam .5 mg and clonazepam 1 mg. In yet another example, during a two day time frame between April 20 and 22, 2010, Respondents dispensed five pain narcotics to SV, including duragesic 50 mcg/hr, methadone HCL, oxycodone HCL, MS Contin, and Oxycontin.

79. In addition, Respondents dispensed early refills of controlled substance prescriptions to SV as follows:

a. On March 13, 2009 (and six days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on February 17, 2009, just twenty-four days prior.

b. On April 6, 2009 (and six days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on March 13, 2009, just twenty-four days prior.

c. On April 29, 2009 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on April 6, 2009, just twenty-three days prior.

d. On July 17, 2009 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on June 24, 2009, just twenty-three days prior.

e. On September 4, 2009 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on August 12, 2009, just twenty-three days prior.

f. On December 18, 2009 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on November 25, 2009, just twenty-three days prior.

g. On January 12, 2010 (and five days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on December 18, 2009, just twenty-five days prior.

h. On March 4, 2010 (and six days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on February 9, 2010, just twenty-four days prior.

i. On April 22, 2010 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on March 30, 2010, just twenty-three days prior.

j. On May 17, 2010 (and five days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on April 22, 2010, just twenty-five days prior.

k. On June 10, 2010 (and six days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on May 17, 2010, just twenty-four days prior.

l. On July 1, 2010 (and nine days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on June 10, 2010, just twenty-one days prior.

m. On July 26, 2010 (and five days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on July 1, 2010, just twenty-five days prior.

n. On August 18, 2010 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on July 26, 2010, just twenty-three days prior.

o. On September 10, 2010 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on August 18, 2010, just twenty-three days prior.

p. On October 4, 2010 (and six days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on September 10, 2010, just twenty-four days prior.

q. On October 27, 2010 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received

thirty day supplies of these drugs from Respondents on October 4, 2010, just twenty-three days prior.

r. On November 19, 2010 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on October 27, 2010, just twenty-three days prior.

s. On December 14, 2010 (and five days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on November 19, 2010, just twenty-five days prior.

t. On February 4, 2011 (and seven days early), Respondents dispensed 120 tablets of MS Contin 100 mg and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received thirty day supplies of these drugs from Respondents on January 12, 2011, just twenty-three days prior.

u. On March 28, 2011 (and six days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of this drug from Respondents on March 4, 2011, just twenty-four days prior.

v. On April 20, 2011 (and seven days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of this drug from Respondents on March 28, 2011, just twenty-three days prior.

w. On May 13, 2011 (and seven days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of this drug from Respondents on April 20, 2011, just twenty-three days prior.

x. On June 6, 2011 (and six days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of this drug from Respondents on May 13, 2011, just twenty-four days prior.

y. On June 29, 2011 (and seven days early), Respondents dispensed 90 tablets of MS Contin and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of these drugs from Respondents on June 6, 2011, just twenty-three days prior.

z. On July 22, 2011 (and seven days early), Respondents dispensed 90 tablets of MS Contin and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of these drugs from Respondents on June 29, 2011, just twenty-three days prior.

aa. On August 15, 2011 (and six days early), Respondents dispensed 90 tablets of MS Contin and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of these drugs from Respondents on July 22, 2011, just twenty-four days prior.

bb. On August 15, 2011 (and five days early), Respondents dispensed 10 doses of fentanyl transdermal 50 mcg/hr to patient SV, even though SV received a thirty day supply of fentanyl from Respondents on July 21, 2011, just twenty-five days prior.

cc. On September 7, 2011 (and seven days early), Respondents dispensed 90 tablets of MS Contin and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of these drugs from Respondents on August 15, 2011, just twenty-three days prior.

dd. On September 30, 2011 (and seven days early), Respondents dispensed 90 tablets of MS Contin and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of these drugs from Respondents on September 7, 2011, just twenty-three days prior.

ee. On October 24, 2011 (and six days early), Respondents dispensed 90 tablets of MS Contin and 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of these drugs from Respondents on September 30, 2011, just twenty-four days prior.

ff. On November 16, 2011 (and seven days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of this drug from Respondents on October 24, 2011, just twenty-three days prior.

gg. On December 9, 2011 (and six days early), Respondents dispensed 120 tablets of Oxycontin 80 mg to patient SV, even though SV received a thirty day supply of this drug from Respondents on November 16, 2011, just twenty-four days prior.

hh. On December 29, 2011 (and seven days early), Respondents dispensed 120 tablets of Opana ER to patient SV, even though SV received a thirty day supply of Opana ER from Respondents on December 6, 2011, just twenty-three days prior.

80. **Patient AW:** Patient AW saw six prescribers, including Dr. Diaz, and travelled to ten pharmacies, including Respondent Pharmacy, to obtain controlled substances between January 2009 and December 2012. AW's address was in Port Hueneme; however, she travelled to prescribers in Santa Paula, Santa Barbara, San Diego and Santee and filled controlled substance prescriptions in Santa Paula, Santa Barbara, Ventura, Oxnard, and San Diego. Prior to seeing Dr. Diaz, AW was only prescribed, on average, two pain medications and one anti-anxiety medication. However, once AW was a patient of Dr. Diaz, AW was prescribed three to four pain medications at double or triple the quantities that she was receiving before.

81. From May 2010 to December 2011, Respondents repeatedly dispensed to AW excessive narcotics and duplicate pain therapy which included hydromorphone, oxycodone, Oxycontin, and hydrocodone/APAP. For example, on September 15, 2011, Respondents dispensed to AW, APAP/hydrocodone 325/10 mg, hydromorphone HCL 8 mg, oxycodone HCL 30 mg and Oxycontin 80 mg, all at the same time.

82. In addition, Respondents dispensed early refills of controlled substance prescriptions to AW as follows:

a. On December 7, 2010 (and twenty-four days early), Respondents dispensed 300 tablets of oxycodone HCL to patient AW, even though AW received a fifty day supply of this drug from Respondents on November 11, 2010, twenty-six days prior.

b. On February 10, 2011 (and eight days early), Respondents dispensed 240 tablets of hydrocodone/APAP 10/325 mg to patient AW, even though AW received a thirty day supply of this drug from Respondents on January 19, 2011, just twenty-two days prior.

c. On June 17, 2011 (and eight days early), Respondents dispensed 240 tablets of hydrocodone/APAP 10/325 mg to patient AW, even though AW received a thirty day supply of this drug from Respondents on May 26, 2011, just twenty-two days prior.

d. On September 15, 2011 (and six days early), Respondents dispensed 30 tablets of Oxycontin 80 mg to patient AW, even though AW received a thirty day supply of this drug from Respondents on August 22, 2011, just twenty-four days prior.

e. On October 10, 2011 (and five days early), Respondents dispensed 240 tablets of hydrocodone/APAP 10/325 mg to patient AW, even though AW received a thirty day supply of this drug from Respondents on September 15, 2011, just twenty-five days prior.

f. On November 3, 2011 (and six days early), Respondents dispensed 240 tablets of hydrocodone/APAP 10/325 mg to patient AW, even though AW received a thirty day supply of this drug from Respondents on October 10, 2011, just twenty-four days prior.

83. Respondents also did not maintain the hardcopy of the following prescriptions dispensed to AW: RX No. 2283429 for hydromorphone HCL 8 mg; RX No. 2283428 for oxycodone HCL 30 mg; RX No. 2283427 for Oxycontin 80 mg; RX No. 2285659 for hydromorphone HCL 8 mg; RX No. 2285661 for oxycodone HCL 30 mg; and RX No. 4574179 for APAP/hydrocodone 325/10 mg.

84. Respondents also dispensed RX No. 2285121 to patient AW on August 22, 2011 even though the prescription was missing required information, the date that it was written.

85. **Patient CW:** Patient CW's address was in Port Hueneme and she travelled approximately forty miles to Santa Barbara to see Dr. Diaz. She also travelled to four different pharmacies, including Respondent Pharmacy, in Santa Barbara and Oxnard to obtain controlled substances between February 2009 and December 2011. As a patient of Dr. Diaz, CW was prescribed excessive amounts of controlled substances. Although Respondents did not know CW's diagnosis, Respondents dispensed controlled substances to CW.

86. From February 2009 to December 2011, Respondents repeatedly dispensed to CW excessive narcotics and duplicate pain therapy which included hydromorphone, oxycodone, Oxycontin, and hydrocodone/APAP. For example, on November 17, 2011, Respondents dispensed to AW, APAP/hydrocodone 325/10 mg, hydromorphone HCL 8 mg, and oxycodone HCL 30 mg, all at the same time.

87. In addition, Respondents dispensed early refills of controlled substance prescriptions to CW as follows:

a. On April 13, 2009 (and six days early), Respondents dispensed 240 tablets of hydromorphone HCL 8 mg to patient CW, even though CW received a thirty day supply of this drug from Respondents on March 20, 2009, twenty-four days prior.

b. On April 13, 2009 (and eleven days early), Respondents dispensed 280 tablets of oxycodone HCL 30 mg to patient CW, even though CW received a thirty-five day supply of this drug from Respondents on March 20, 2009, twenty-four days prior.

c. On June 18, 2010 (and eight days early), Respondents dispensed 200 tablets of hydromorphone HCL 8 mg to patient CW, even though CW received a thirty day supply of this drug from Respondents on May 27, 2011, twenty-two days prior.

d. On August 8, 2011 (and six days early), Respondents dispensed 60 tablets of hydromorphone HCL 8 mg to patient CW, even though CW received a thirty day supply of this drug from Respondents on July 15, 2011, twenty-four days prior.

e. On September 2, 2011 (and five days early), Respondents dispensed 120 tablets of APAP/Hydrocodone 325/10 mg to patient CW, even though CW received a thirty day supply of this drug on August 8, 2011, twenty-five days prior.

f. On October 24, 2011 (and six days early), Respondents dispensed 120 tablets of hydromorphone HCL 8 mg to patient CW, even though CW received a thirty day supply of this drug from Respondents on September 30, 2011, twenty-four days prior.

g. On November 17, 2011 (and six days early), Respondents dispensed 120 tablets of hydromorphone HCL 8 mg to patient CW, even though CW received a thirty day supply of this drug from Respondents on October 24, 2011, twenty-four days prior.

h. On December 12, 2011 (and five days early), Respondents dispensed 120 tablets of hydromorphone HCL 8 mg to patient CW, even though CW received a thirty day supply of this drug from Respondents on November 17, 2011, twenty-five days prior.

88. In January 2014, the Board opened an additional investigation against Respondents after receiving notification that Respondents settled a civil case against them regarding improper management and dispensing of controlled substances to patient AM.[7]

89. AM saw four prescribers, including Dr. Diaz, and travelled to eight pharmacies, including Respondent Pharmacy, to obtain controlled substances. AM's address was in Solvang; however, he saw prescribers in Santa Barbara, Solvang, and Shell Beach, and had prescriptions filled in Santa Barbara, Lompoc, and Solvang. Respondents did not evaluate the totality of the circumstances before dispensing excessive narcotics to AM, including accessing CURES or contacting Dr. Diaz to discuss AM's therapy or history. Respondents dispensed multiple pain narcotics to AM with high dosages. For example, Respondents dispensed oxycodone with instructions to take 60-90 mg every 4 to 6 hours, even though the normal dosage instructions are to take 5-15 mg every 4 to 6 hours. On multiple occasions, Respondents also received and dispensed off of two prescription hardcopies for the same drug but with two different directions. For example, on January 4, 2010, Respondents dispensed RX 2270900 for 180 tablets of oxycodone 30 mg with directions of "one every six hours" and RX 2270899 for 60 tablets of oxycodone 30 mg with directions of "two every six hours." Respondents did not question the legitimacy of the following controlled substances prescribed by Dr. Diaz prior to dispensing them to AM:

Date	RX No.	Drug
10/23/2009	44551315	Alprazolam 2 mg #120 1q6h[8]
10/23/2009	2269174	Oxycodone 30 mg #120 2q6h
10/23/2009	2269175	Hydromorphone 8 mg #120 2q6h
1/4/2010	2270901	Hydromorphone 8 mg #180 2q6h
1/4/2010	2270900	Oxycodone 30 mg #180 1q6h
1/4/2010	2270899	Oxycodone 30 mg #60 2q6h
1/4/2010	2270898	Hydromorphone 8 mg #60 1-2q6h
1/4/2010	4553651	Diazepam #60 1-2 qd prn[9]
2/1/2010	2271583	Oxycodone 30 mg #60 2q4-6h

[7] AM died of an overdose from controlled substances in late 2011.

[8] "Alprazolam 2 mg #120 1q6h" means 120 tablets of Alprazolam 2 mg with instructions to take one tablet every six hours.

[9] "Diazepam #60 1-2 qd prn" means 60 tablets of Diazepam with instructions to take 1-2 tablets daily as needed for pain.

2/1/2010	2271584	Hydromorphone 8 mg #60 1q2-4h
2/1/2010	2271585	Methadone 10 mg #90 3qd
2/23/2010	2272071	Methadone 10 #120 2bid[10]
2/23/2010	2272073	Oxycodone 30 mg #60 2q46h
2/23/2010	2272072	Hydromorphone 8 mg #60 1q2-4h
3/18/2010	2272673	Hydromorphone 8 mg #60 1q2-4h
3/18/2010	2272672	Oxycodone 30 mg #60 2q46h
3/18/2010	2272671	Oxycodone CR 80 mg #20 1hs[11]
3/18/2010	2272670	Methadone 10 mg 2bid #120
4/14/2010	2273286	Methadone 10 mg 2q12 h #120
4/14/2010	4557095	Alprazolam 2 mg #120 1q6h
4/14/2010	2273282	Oxycontin 80 mg #60 1q12h
4/14/2010	2273283	Oxycodone 30 mg #60 2q4-6h
4/14/2010	2273284	Hydromorphone 8 mg #60 2q4-6h
5/7/2010	2273868	Oxycontin 80 mg #60 1q12h
5/7/2010	2273867	Oxycodone 30 mg #60 1-2q2-4h
5/7/2010	2273869	Hydromorphone 8 mg #60 1-2q2-4h
6/3/2010	2274485	Hydromorphone 8 mg #60 2q4-6h
6/3/2010	2274486	Oxycodone 30 mg #60 2q4-6h
7/21/2010	2275677	Methadone 10 mg 1q12h
7/21/2010	2275678	Hydromorphone 8 mg # 60 1q6h
7/21/2010	2275679	Oxycodone 30 mg # 60 1q6h
8/27/2010	4561483	Alprazolam 2 mg #120 1qid[12]
8/27/2010	2276582	Methadone 10 mg #90 3qd
9/17/2010	2277055	Hydromorphone 8 mg #60 2q4-6h
9/17/2010	2277056	Oxycodone 30 mg #60 2q4-6h
9/17/2010	2277057	Methadone 10 mg 2q12h
10/14/2010	2277702	Methylphenidate 20 mg #30 1qd
10/14/2010	2277704	Hydromorphone 8 mg 2q3-4h #60
10/14/2010	2277703	Oxycodone 30 mg 2q 3-4h #60
11/11/2010	2278331	Hydromorphone 8 mg #60 2q4-6h
11/11/2010	2278332	Oxycodone 30 mg #60 2q4-6h
11/11/2010	2278333	Methadone 10 mg #120 2q12h
11/11/2010	2278334	Fentanyl 1600mcg 1qdprn pain
12/9/2010	2279024	Opana ER #60 1q12h
12/9/2010	2279025	Oxycodone 30 mg #180 2-3q4-6h
12/9/2010	2279026	Hydromorphone 8 mg #180 2-3q4-4h
12/10/2010	4564772	Alprazolam 2 mg #120 1q6h
12/10/2010	2279067	Hydromorphone 8 mg #180 2-3q4-6h
12/10/2010	2279068	Oxycodone 30 mg #180 2-3q6h
12/10/2010	2279069	Methadone 10 mg #120 2 bid

[10] "2bid" means the instructions are to take two tablets twice per day.
[11] "1hs" means the instructions are to take 1 tablet at night/at bedtime.
[12] "1qid" means the instructions are to take 1 tablet four times per day.

90. Respondent PIC admitted that he did not maintain any records or notes with respect to patient AM and that he never offered AM counseling for opioid addiction. In addition, Respondent PIC admitted Respondents excessively dispensed drugs to AM, when it dispensed 940 tablets of oxycodone in 76 days to AM.

OTHER MATTERS

91. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 32685, issued to Sansum Clinic Pharmacy, Inc., it shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 32685 is placed on probation or until Pharmacy Permit Number PHY 32685 is reinstated if it is revoked.

92. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License No. RPH 28548, issued to Steven Charles Cooley, he shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License No. RPH 28548 is placed on probation or until Pharmacist License Number RPH 28548 is reinstated if it is revoked.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Failure to Implement Corresponding Responsibility)

93. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (j), for violation of Health and Safety Code section 11153, subdivision (a), in that Respondents failed to comply with their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose. The circumstances are that Respondents failed to evaluate the totality of the circumstances (information from the patient, physician, CURES and other sources) to determine the prescriptions' were issued for a legitimate medical purpose in light of information showing that several patients demonstrated drug seeking behaviors such as doctor and pharmacy shopping, patients requested early refills of strong pain narcotics, patients were outside the normal trade area, prescriptions were written for the same combinations of drugs and for potentially duplicative drugs, prescriptions were written for

unusually large quantities, prescriptions were written outside of Dr. Diaz's specialty, among other things, as set forth in paragraphs 32 through 90, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Filling of Erroneous or Uncertain Prescriptions)

94. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (o), as it relates to California Code of Regulations, title 16, section 1761, for unprofessional conduct in that Respondents dispensed prescriptions which contained significant errors, irregularities, uncertainties, or ambiguities, as set forth in paragraphs 32 through 90, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Excessive Furnishing of Controlled Substances)

95. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (d), for unprofessional conduct in that Respondents clearly excessively furnished controlled substances to patients, as set forth in paragraphs 32 through 90, which are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

96. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (c), in that Respondents were grossly negligent in dispensing controlled substances. The circumstances are that Respondents knew or should have known that the controlled substances prescribed were likely to be used for other than a legitimate medical purpose and Respondents failed to take appropriate steps when presented with numerous prescriptions for controlled substances from doctor/pharmacy shopping patients, patients residing outside Respondent's normal trade area, patients seeking early refills of controlled substances, and/or patients seeking to fill prescriptions for duplicative therapy. Respondent failed to perform additional investigation to determine whether the prescriptions were issued for a legitimate medical purpose, as set forth in paragraphs 32 through 90, which are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Negligence)

97. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, in that Respondents were negligent in dispensing controlled substances when Respondents knew or should have known that the controlled substances prescribed were likely to be used for other than a legitimate medical purpose and Respondents failed to take appropriate steps when presented with numerous prescriptions for controlled substances from doctor-shopping patients, patients residing outside Respondent's normal trade area, patients seeking early refills of controlled substances, and/or patients seeking to fill prescriptions for duplicative therapy. Respondents failed to perform additional investigation to determine whether the prescriptions were issued for a legitimate medical purpose, as set forth in paragraphs 32 through 90, which are incorporated herein by reference.

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 32685, issued to Sansum Clinic Pharmacy, Inc.;

2. Revoking or suspending Pharmacist License Number RPH 28548, issued to Steven Charles Cooley;

3. Prohibiting Sansum Clinic Pharmacy Inc., from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 32685 is placed on probation or until Pharmacy Permit Number PHY 32685 is reinstated if Pharmacy Permit Number PHY 32685 issued to Sansum Clinic Pharmacy, Inc., is revoked;

4. Prohibiting Steven Charles Cooley from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 28548 is placed on probation or until Pharmacist License Number RPH 28548 is reinstated if Pharmacist License Number RPH 28548 issued to Steven Charles Cooley is revoked;

5. Ordering Respondents to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

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

DATED: 5/28/15

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

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