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

In the Matter of the Accusation Against**:** **RAAFAT G. GERGES DBA DANIEL'S PHARMACY** **12730 Heacock Street, Ste. 1** **Moreno Valley, CA 92553** **Pharmacy Permit No. PHY 47339** **and** **RAAFAT GEORGE GERGES** **14405 Ashton Lane** **Riverside, CA 92508** **Pharmacist License No. RPH 45091** Respondents.	Case No. 5224 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about October 3, 2005, the Board of Pharmacy issued Pharmacy Permit Number PHY 47339 to Raafat G. Gerges to do business as Daniel's Pharmacy, with Raafat

Gerges as Pharmacist-in-Charge (Respondent). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and expired on October 1, 2013, and has not been renewed.

3. On or about March 9, 1992, the Board of Pharmacy issued Pharmacist License Number RPH 45091 to Raafat George Gerges (Respondent). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2017, 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. 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.].

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

7. 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

8. 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.

9. 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."

10. 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.

. . . .

11. 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.

12. 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.

13. Health and Safety Code section 11173 states in pertinent part:

> (a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation , or subterfuge; or (2) by the concealment of a material fact.

. . . .

REGULATORY PROVISIONS

14. 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.

. . . .

15. 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.
>
> . . . .

16. 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

17. 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

18. 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.

19. Fentanyl is 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.

20. 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.

21. Oxycodone, the generic name for Oxycontin, 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.

22. Vicodin, a brand name 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.

FACTUAL ALLEGATIONS

23. At all times mentioned herein and from October 3, 2005 to February 18, 2014, Raafat G. Gerges was the Pharmacist-in-Charge (Respondent PIC) of Daniel's Pharmacy (Respondent Pharmacy) located in Moreno Valley, California.

24. In or around January 2013, the Board of Pharmacy initiated an investigation of Respondents following notification from Cardinal Health that they suspended all sales of controlled substances to Respondent Pharmacy due to a risk for potential diversion. The Board inspector discovered that Respondents filled numerous prescriptions for patients and doctors outside of Moreno Valley, that different patients had filled sequential prescriptions from the same doctors at Respondent Pharmacy, and that Respondent filled prescriptions early.

25. Patient J.M., who resided in Los Angeles, lived approximately 67 miles from Respondent Pharmacy. On January 6, 2011, Respondents filled RX No. 143202 for Dilaudid 4 mg and RX No. 143203 for Promethazine with Codeine 6.25-10 syp for patient J.M., who was prescribed these drugs by P.A. S.W. located in Riverside, California. Patient J.M. paid cash for the drugs.

26. Immediately after filling patient J.M.'s drugs, Respondents filled RX No. 143204 for Dilaudid 4 mg and RX No. 143205 for Promethazine with Codeine 6.25-10 syp for patient R.C., who also resides in Los Angeles (approximately 68 miles from Respondent pharmacy) and who was also prescribed the same drugs in the same dosages as patient J.M. by the same P.A. (P.A. S.W.). Patient R.C. paid cash for the drugs.

27. Respondents also filled prescriptions for controlled substances to patients who were doctor shopping.[1] Respondents did not review information from CURES or their own patient profiles to determine that patients were doctor shopping, filling controlled substances early or filling controlled substance prescriptions at multiple pharmacies.

PATIENT CA

28. Patient C.A., who resided in Moreno Valley, saw physicians in Northridge, Perris, Corona, Redlands, Altadena, Moreno Valley, Colton, San Bernardino, and Riverside. During the period that Respondents were filling patient C.A.'s prescriptions, C.A. went to sixteen different doctors to obtain prescriptions for hydrocodone/APAP 7.5/750 and used at least sixteen different pharmacies to fill those prescriptions. Patient C.A. primarily paid cash for the controlled substances that were filled by Respondents.

a. On March 18, 2009, Respondents filled RX No. 71561 for 60 tablets of hydrocodone/APAP 7.5/750 for patient C.A., even though patient C.A. received 90 tablets of hydrocodone/APAP 7.5/750 (30 day supply) just nine days prior on March 9, 2009 from another pharmacy. On March 31, 2009, Respondents filled RX No. 72928 for 120 tablets of hydrocodone/APAP 7.5/750 for patient C.A., which was seven days too early from their last fill. Therefore, patient C.A. received a 74 day supply of hydrocodone/APAP 7.5/750 within 22 days.

b. On April 20, 2009, Respondents filled RX No. 75015 for 120 tablets of hydrocodone/APAP 7.5/750 for patient C.A., even though patient C.A. received 90 tablets of

[1] "Doctor Shopping" is a term used when a patient uses multiple providers and pharmacies to obtain multiple prescriptions for controlled substances, often without the providers and pharmacies knowing about the other prescriptions. Doctor shopping is against the law. California's primary doctor shopping law is Health and Safety Code section 11173(a) which prohibits a person from obtaining a prescription by fraud or concealing a material fact.

hydrocodone/APAP 7.5/750 (30 day supply) just sixteen days prior on April 4, 2009 from another pharmacy and doctor.

c. On June 4, 2009, Respondents filled RX No. 79929 for 90 tablets of hydrocodone/APAP 7.5/750 (30 day supply) for patient C.A. Eight days later on June 12, 2009 (and twenty-two days too early), Respondents filled RX No. 80894 for 120 tablets of hydrocodone/APAP 7.5/750 written by a different doctor for patient C.A.

d. On July 20, 2009, Respondents filled 90 tablets of hydrocodone/APAP 7.5/750 (23 day supply) for patient C.A. Fourteen days later on August 3, 2009, Respondents filled RX No. 85573 for 120 tablets of hydrocodone/APAP 7.5/750 (25 day supply) written by another doctor for patient C.A.

e. On August 18, 2009, Respondent filled RX No. 86932 for 90 tablets of hydrocodone/APAP 7.5/750 (23 day supply) for this patient. Nine days later on August 27, 2009, Respondent filled RX No. 87959 for 60 tablets of hydrocodone/APAP 7.5/750 (30 day supply) for patient C.A. Twelve days later, on September 8, 2009, Respondents filled RX No. 88956 for 120 tablets of hydrocodone/APAP 7.5/750 written by another doctor for patient C.A.

PATIENT RA

29. Patient R.A, who resided in Los Angeles, lived approximately 63 miles from Respondent pharmacy. R.A.'s treating physicians were located in Whittier and Downey, approximately 60 and 50 miles from Respondent pharmacy, respectively. R.A. only paid cash for the controlled substances filled by Respondent.

a. On August 7, 2009, Respondents filled RX No. 85992 for 100 tablets of Diazepam 10 mg (33 day supply). On September 4, 2009 (and seven days too early), Respondents filled RX No. 88778 for 100 tablets of Diazepam 10 mg (33 day supply) for patient R.A. On October 1, 2009, Respondents filled RX No. 91809 for 100 tablets of Diazepam (33 day supply) for patient R.A. On October 29, 2009, Respondents filled RX No. 95054 for 100 tablets of Diazepam for patient R.A. Therefore, Respondent's dispensed a 132 day supply of Diazepam to patient R.A. in a span of 83 days.

PATIENT KB

30. Patient K.B., who resided in San Jacinto, lived approximately 22 miles from Respondent pharmacy and saw physicians in Hemet, Perris, Los Angeles, Long Beach, Redlands, Coachella, Riverside, and Moreno Valley. From October 2009 to January 2012 and during the time that Respondents filled prescriptions for controlled substances for K.B., K.B. travelled to 6 different pharmacies and 8 doctors.

PATIENT OB

31. Patient O.B., who resided in Riverside, saw physicians in Perris, Temecula, Moreno Valley, Murrieta, Orange, Pomona, San Bernardino, Pico Rivera, and San Diego. During the time that Respondents filled prescriptions for controlled substances for O.B., O.B. travelled to 11 different pharmacies and 9 doctors. During the time period that Respondents filled prescriptions for O.B., there were multiple instances where O.B. received duplicate therapy from Respondents and other pharmacies.

a. On April 13, 2009, Respondents filled RX No. 74204 for 120 tablets of Vicodin ES for patient O.B., even though O.B. had received 100 tablets of Vicodin ES (25 day supply) from a different prescriber at a different pharmacy 12 days prior on April 1, 2009.

b. On June 5, 2009, Respondents refilled RX No. 74204 for 120 tablets of Vicodin ES for patient O.B., even though O.B. had received 120 tablets of Vicodin ES (30 day supply) from a different pharmacy just 15 days prior.

c. On June 26, 2009, Respondents filled RX No. 74201 for 60 tablets of alprazolam .5 mg (30 day supply) for patient O.B. Just five days later on July 1, 2009 (and 25 days too early), Respondents refilled RX No. 74201 for 60 tablets of alprazolam (30 day supply) for patient O.B. Seven days later on July 8, 2009, Respondents filled RX 82560 for 60 tablets of alprazolam for patient O.B.

d. On November 16, 2009, Respondents filled RX No. 96915 for 120 tablets of Vicodin ES (30 day supply) for patient O.B. On December 3, 2009 (and twelve days too early), Respondents filled RX No. 98752 for 120 tablets of Vicodin ES (30 day supply) for patient O.B. On December 28, 2009, Respondents filled RX No. 101496 for 120 tablets of Vicodin ES (30 day supply) for patient O.B. On January 18, 2010, Respondents filled RX No. 104031 for 120 tablets

of Vicodin ES for patient O.B. Therefore, Respondents dispensed a 120 day supply of Vicodin ES to patient O.B. in a span of 63 days.

e. On January 26, 2010, Respondents filled RX No. 105185 for 60 tablets of diazepam 10 mg (30 day supply) for patient O.B. and then refilled that prescription for another 60 tablets of diazepam 10 mg (30 day supply) the very next day on January 27, 2010 (twenty-nine days early).

f. On May 17, 2010, Respondents filled RX No. 118528 for 120 tablets of Vicodin ES (30 day supply) for patient O.B. and then refilled that prescription for another 120 tablets of Vicodin ES on June 4, 2010 (twelve days early). On June 25, 2010, Respondents filled RX No. 122653 for 120 tables of Vicodin ES for patient O.B. (nine days early).

g. On September 23, 2010, Respondents filled RX No. 129765 for 180 tablets of Vicodin ES (30 day supply) and then refilled that prescription for another 180 tablets of Vicodin ES the very next day on September 24, 2010 (twenty-nine days early). On October 15, 2010, Respondents refilled RX No. 129765 for 180 tablets of Vicodin ES (30 day supply) for patient O.B. (nine days early). Therefore, Respondents dispensed a 90 day supply of Vicodin ES to patient O.B. over a span of 22 days,

h. On October 25, 2010, Respondents filled RX No. 113249 for 60 tablets of diazepam 10 mg (30 day supply) for patient O.B., and then refilled that prescription for another 60 tablets of diazepam 10 mg two days later on October 27, 2010 (twenty-eight days early). On November 15, 2010, Respondents filled RX No. 135770 for 60 tablets of diazepam 10 mg for patient O.B. (eleven days early). Therefore, Respondents dispensed a 90 day supply of Vicodin ES to patient O.B. within 21 days.

i. On May 4, 2011, Respondents filled RX No. 157754 for 180 tablets of Vicodin ES (30 day supply). Twenty days later on May 24, 2011, Respondents refilled RX No. 15774 for 180 tablets of Vicodin ES for patient O.B. (ten days early).

j. On July 6, 2011, Respondents filled RX No. 162386 for 180 tablets of Vicodin ES (30 day supply) for patient O.B. On July 18, 2011, Respondents filled RX No. 165430 for 150 tablets of Vicodin ES for patient O.B. (eighteen days early).

PATIENT LB

32. Patient L.B., who resided in Moreno Valley, saw physicians in Compton, Inglewood, San Clemente, Moreno Valley, Rancho Cucamonga, San Bernardino, Yucipa, Riverside, Lakewood, Los Angeles, Long Beach, Studio City, Perris, Northridge, Loma Linda, Corona, Santa Ana, Laguna Beach, Wildomar, and Huntington Beach. During the period that Respondents filled prescriptions for Patient L.B., L.B. travelled to 28 different pharmacies and 39 doctors. Respondents also dispensed duplicate pain therapy from different doctors.

a. On April 27, 2009, Respondents filled RX No. 75923 for 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient L.B., and then refilled this prescription seven days later on May 4, 2009 (eighteen days early). Eleven days later on May 15, 2009, Respondents again refilled RX No. 75923 for 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient L.B. On June 2, 2009, Respondents again refilled RX No. 75923 for 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient L.B. On June 17, 2009, Respondents filled RX No. 81311 for 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient L.B. Five days later on June 22, 2009, Respondents refilled RX No. 75923 for 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient L.B. Therefore, between April 27, 2009 and June 22, 2009 (56 days), Respondents dispensed a 150 day supply of hydrocodone/APAP to this patient.

b. On June 23, 2011, Respondents filled RX No. 163041 for 120 tablets of oxycodone 30 mg (24 day supply). Fifteen days later on July 8, 2011, Respondents filled RX No. 164458 for 240 tablets of oxycodone 30 mg (30 day supply) written by a different doctor, for patient L.B. (fifteen days early).

PATIENT MB

33. Patient M.B., who resided in Moreno Valley, saw physicians in Perris, Los Angeles, Moreno Valley, Redlands, Fontana, Corona, Loma Linda, Lake Elsinore, Hemet, Riverside, San Clemente, and Murrieta. During the period that Respondents were filling prescriptions for controlled substances for patient M.B., M.B. traveled to 11 pharmacies and 27 doctors.

a. On September 20, 2010, Respondents filled RX No. 125440 for 50 tablets of hydrocodone/APAP 7.5/750 (13 day supply) and then refilled that prescription for another 120 tablets of hydrocodone/APAP 7.5/750 just two days later on September 22, 2010 (eleven days early).

b. On October 22, 2010, Respondents filled RX No. 133871 for 120 tablets of hydrocodone/APAP 7.5/750 (30 day supply) to patient M.B. On November 15, 2010, Respondents filled RX No. 133871 (30 day supply) for another 120 tablets of hydrocodone/APAP 7.5/750 for patient M.B. On December 6, 2010, Respondents filled RX No. 133871 for another 120 tablets of hydrocodone/APAP 7.5/750 (30 day supply) for this patient. Therefore, Respondents dispensed a 90 day supply of hydrocodone/APAP 7.5/750 to patient M.B. within 45 days.

PATIENT LH

34. Patient L.H., who resided in Moreno Valley, saw physicians in Lake Elsinore, Corona, Perris, Moreno Valley, Fontana, Oklahoma City, Riverside, and Redlands. During the period that Respondents filled controlled substance prescriptions for patient L.H., L.H. traveled to 6 different pharmacies and 14 doctors to obtain prescriptions.

a. On April 13, 2009, Respondents filled RX No. 74317 for 100 tablets of hydrocodone/APAP 10/325 (20 day supply) for patient L.H. Fifteen days later on April 28, 2009 (and five days early), Respondents filled RX No. 76103 for 150 tablets of hydrocodone/APAP 10/325, written by a different doctor, for patient L.H.

PATIENT LM

35. Patient L.M., who resided in San Jacinto, saw physicians in Perris, Moreno Valley, Riverside, San Jacinto, Long Beach, West Covina, Coachella, San Bernardino, Banning, and Altadena. During the time that Respondents filled controlled substance prescriptions for patient L.M., L.M. travelled to 13 different pharmacies and 12 doctors to obtain controlled substances. Patient L.M. only paid cash for the controlled substances that were filled by Respondents.

a. On February 12, 2009, Respondents filled RX No. 68342 for 120 tablets of acetaminophen #3 with codeine ("Apap #3")(30 day supply) for patient L.M. On March 2, 2009,

(and twelve days early), Respondents filled RX No. 70088 for 120 tablets of Apap #3 (30 day supply), written by a different doctor, for patient L.M. Ten days later on March 12, 2009 (and twenty days early), Respondents filled RX No. 71129 for 120 tablets of Apap #3 (30 day supply) for patient L.M. Therefore, Respondents dispensed a 90 day supply of Apap #3 to patient L.M. within 28 days.

b. On April 13, 2009, Respondents filled RX No. 73977 for 120 tablets of Apap #3 (30 day supply) for patient L.M., even though L.M. received 100 tablets of Apap #3 (33 day supply) from a different pharmacy and a different doctor eight days prior on April 5, 2009. On May 4, 2009 (and nine days early), Respondents filled RX No. 76711 for 100 tablets of Apap #3 (20 day supply), written by a different physician, for patient L.M. Therefore, Respondents dispensed an 83 day supply of Apap #3 within 29 days.

c. On July 19, 2011, Respondents filled RX No. 165693 for 90 tablets of Apap #3 (30 day supply) for patient L.M. On August 4, 2011 (and seventeen days early), Respondents refilled RX No. 165693 for 50 tablets of Apap #3 (17 day supply) for patient L.M.

PATIENT KM

36. Patient K.M., who resided in Perris, saw physicians in Downey (approximately 55 miles away), Whittier (approximately 55 miles away), Los Angeles (approximately 69 miles away), and Riverside. During the time that Respondents filled controlled substance prescriptions for patient K.M., K.M. travelled to 11 pharmacies and obtained controlled substance prescriptions from 7 doctors. K.M. filled prescriptions for controlled substances at pharmacies in Moreno Valley, Long Beach, Los Angeles, Lynwood, Hawthorne, and Riverside. K.M. only paid cash for the controlled substances filled by Respondents.

a. On April 6, 2009, Respondents filled RX No. 71167 for 150 tablets of Apap #4 (25 day supply) for patient K.M. Nine days later on April 15, 2009 (and sixteen days early), Respondents filled RX No. 74528 for 150 tablets of Apap #4 for patient K.M.

b. On May 14, 2009, Respondents filled RX No. 77996 for 100 tablets of diazepam 10 mg (33 day supply) for patient K.M., even though K.M. had received 60 tablets of diazepam 10

mg (30 day supply) just thirteen days prior on May 1, 2009 from another pharmacy and by another doctor.

c. On August 7, 2009, Respondents filled RX No. 85989 for 100 tablets of diazepam 10 mg and RX No. 85991 for 120 tablets of hydrocodone/APAP 7.5/750 for patient K.M., even though K.M. received 60 tablets of diazepam 10 mg (30 day supply) and 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) just ten days prior from another pharmacy and by another doctor on July 28, 2009.

d. On November 27, 2009, Respondents filled RX No. 98150 for 100 tablets of diazepam 10 mg and RX No. 98149 for 120 tablets of hydrocodone/APAP 7.5/750 for patient K.M., even though K.M. received 60 tablets of diazepam 10 mg (30 day supply) and 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) just ten days prior on November 17, 2009.

e. On February 16, 2010, Respondents filled RX No. 107700 for 120 tablets of hydrocodone/APAP 7.5/750 (30 day supply) for patient K.M., even though K.M. received a 25 day supply of hydrocodone/APAP 7.5/750 just seventeen days prior on January 30, 2010 from another pharmacy and doctor.

f. On March 16, 2010, Respondents filled RX No. 111123 for 120 tablets of hydrocodone/APAP 7.5/750 (20 day supply) for patient K.M., even though K.M. received a 25 day supply of hydrocodone/APAP 7.5/750 just eighteen days prior on February 26, 2010 from another pharmacy and doctor.

g. On October 12, 2010, Respondents filled RX No. 134024 for 150 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient K.M., even though K.M. received a 16 day supply of hydrocodone/APAP 7.5/750 from another pharmacy just eight days prior on October 4, 2010.

h. On December 17, 2010, Respondents filled RX No. 138138 for 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient K.M., even though K.M. received a 25 day supply of hydrocodone/APAP 7.5/750 from another pharmacy just fourteen days prior on December 3, 2010.

i. On March 16, 2011, Respondents filled RX No. 154042 for 100 tablets of hydrocodone/APAP 7.5/750 (25 day supply) for patient K.M., even though K.M. received a 25 day supply of hydrocodone/APAP 7.5/750 from another pharmacy just eleven days prior on March 5, 2011.

PATIENT CR

37. Patient C.R., who resides in Sun City, saw physicians in Moreno Valley, Los Angeles, Perris, Murrieta, Loma Linda, Lake Elsinore, and Temecula. During the period that Respondents filled controlled substance prescriptions for patient C.R., C.R. travelled to 13 different pharmacies and obtained controlled substance prescriptions from 8 doctors.

a. On April 7, 2010, Respondents filled RX No. 114029 for 60 tablets of alprazolam 2 mg (30 day supply) for patient C.R. Nine days later on April 16, 2010 (and twenty one days early), Respondents filled RX No. 115176 for 60 tablets of alprazolam 2 mg, written by a different physician, for patient C.R.

b. On May 5, 2010, Respondents filled RX No. 117060 for 60 tablets of alprazolam (30 day supply) for patient C.R. Twelve days later on May 17, 2011 (and eighteen days early), Respondents filled RX No. 118482 for 60 tablets of alprazolam (30 day supply), written by a different physician, for patient C.R. On June 4, 2010, Respondents filled RX No. 120605 for 60 tablets of alprazolam 2 mg (30 day supply) for patient C.R. That same day, on June 4, 2010, Respondents filled another prescription (RX No. 120685) for 60 tablets of alprazolam 2 mg (30 day supply), written by a different doctor, for patient C.R. Therefore, Respondents dispensed a 180 day supply of alprazolam to patient C.R. within 58 days.

c. On April 13, 2011, Respondents filled RX No. 155302 for 60 tablets of alprazolam (30 day supply) for patient C.R. Nine days later on April 22, 2011, Respondents filled RX No. 155302 for another 60 tablets of alprazolam (30 day supply) for patient C.R. (twenty-one days early).

d. On June 29, 2011, Respondents filled RX No. 163622 for 90 tablets of alprazolam (30 day supply) for patient C.R. Fifteen days later on July 14, 2011, Respondents filled RX No. 165159 for 60 tablets of alprazolam (30 day supply) for patient C.R. (fifteen days early).

e. On June 11, 2012, Respondents filled RX No. 110250 for 90 tablets of carisoprodol 350 mg (30 day supply) for patient C.R. Eight days later on June 19, 2012, Respondents refilled RX No. 110250 for another 90 tablets of carisoprodol 350 mg (30 day supply). Eight days later on June 27, 2012, Respondents filled RX. No. 111144 for another 90 tablets of carisoprodol 350 mg (30 day supply). Therefore, Respondents dispensed a 90 day supply carisoprodol 350 mg to patient C.R. within 16 days.

f. On July 24, 2012, Respondents filled RX No. 112438 for 90 tablets of carisoprodol 350 mg (30 day supply) for patient C.R. On August 15, 2012, Respondents refilled RX No. 12438 for 90 tablets of carisoprodol 350 mg (30 day supply). Twelve days later on August 27, 2012, Respondents filled RX No. 114067 for another 90 tablets of carisoprodol 350 mg (30 day supply). Therefore, Respondents dispensed a 90 day supply of carisoprodol 350 mg to patient C.R. within 34 days.

PATIENT SS

38. Patient S.S., who resided in Moreno Valley, saw physicians in Downey (approximately 60 miles away), Los Angeles (approximately 65 miles away), Huntington Park (approximately 65 miles away), Riverside, and Murrieta. Patient S.S. filled prescriptions for controlled substances at pharmacies in Long Beach, Compton, Gardena, Moreno Valley, and Riverside. During the period that Respondents filled controlled substance prescriptions for patient S.S., S.S travelled to five different pharmacies and obtained controlled substance prescriptions from twelve doctors.

a. On December 16, 2010, Respondents filled RX No. 141154 for 90 tablets of hydrocodone/APAP 7.5/750 (45 day supply) to patient S.S., and then refilled this prescription for another 90 tablets of hydrocodone/APAP 7.5/750 (45 day supply) nine days early on January 21, 2011. On February 8, 2011, (and twenty-seven days early), Respondents refilled RX No. 141154 again for 90 tablets of hydrocodone/APAP 7.5/750 (45 day supply) for patient S.S. Therefore, within 54 days, Respondents dispensed 135 day supply of hydrocodone/APAP to patient S.S.

b. On December 14, 2011, Respondents filled RX No. 172964 for 60 tablets of hydrocodone/APAP 7.5/750 (30 day supply). Eight days later on December 22, 2011 (and

twenty-two days early), Respondents filled RX No. 183220 for 90 tablets of hydrocodone/APAP 7.5/750 for patient S.S.

c. On January 20, 2012, Respondents filled RX No. 185717 for 90 tablets of hydrocodone/APAP 7.5/750 (30 day supply) for patient S.S. On February 8, 2012 (and twelve days early), Respondents filled RX No. 187494 for 120 tablets of hydrocodone/APAP 7.5/750, written by a different physician, for patient S.S.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Failure to Implement Corresponding Responsibility)

39. 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 had addresses outside Respondents' normal trade area, patients saw providers outside Respondents' normal trade area, patients from out of the area came in groups from the same out of area doctor for only controlled substances, having no personal knowledge about prescribers' practice or patients' treatment histories, among other things, as set forth in paragraphs 23 through 38, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Filling of Erroneous or Uncertain Prescriptions)

40. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (o), for unprofessional conduct as it relates to California Code of Regulations section 1761, in that Respondents dispensed prescriptions which contained significant errors, irregularities, uncertainties, or ambiguities, as set forth in paragraphs 23 through 38, which are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Excessive Furnishing of Controlled Substances)

41. 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 23 through 38, which are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Assisting/Abetting the Violation of State Law)

42. Respondents are subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (o), for unprofessional conduct in that Respondents assisted in or abetted doctor-shopping patients in obtaining controlled substance prescriptions by fraud, deceit, misrepresentation, or subterfuge, or by concealment of a material fact in violation of Health and Safety Code section 11173(a), as set forth in paragraphs 23 through 38, which are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence)

43. Respondent Gerges is subject to disciplinary action for unprofessional conduct under Code section 4301, subdivision (c), in that Respondent was grossly negligent in dispensing controlled substances. The circumstances are that Respondent knew or should have known that the controlled substances prescribed were likely to be used for other than a legitimate medical purpose and Respondent 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 written by prescribers outside Respondent's normal trade area. Respondent failed to perform additional investigation to determine whether the prescriptions were issued for a legitimate medical purpose, as set forth in paragraphs 23 through 38, which are incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Negligence)

44. Respondent Gerges is subject to disciplinary action for unprofessional conduct under Code section 4301, in that Respondent was negligent in dispensing controlled substances when Respondent knew or should have known that the controlled substances prescribed were likely to be used for other than a legitimate medical purpose and Respondent 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 written by prescribers outside Respondent's normal trade area. Respondent failed to perform additional investigation to determine whether the prescriptions were issued for a legitimate medical purpose, as set forth in paragraphs 23 through 38, which are incorporated herein by reference.

OTHER MATTERS

45. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 47339, issued to Daniel's Pharmacy, 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 47339 is placed on probation or until Pharmacy Permit Number PHY 47339 is reinstated if it is revoked.

46. Pursuant to Code section 4307, if discipline is imposed on Pharmacist License No. RPH 45091 issued to Raafat George Gerges, 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 45091 is placed on probation or until Pharmacist License Number RPH 45091 is reinstated if it is revoked.

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 47339, issued to Daniel's Pharmacy;

2. Revoking or suspending Pharmacist License Number RPH 45091, issued to Raafat George Gerges;

3. Prohibiting Daniel's Pharmacy from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 47339 is placed on probation or until Pharmacy Permit Number PHY 47339 is reinstated if Pharmacy Permit Number PHY 47339 issued to Daniel's Pharmacy is revoked;

4. Prohibiting Raafat George Gerges from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacist License Number RPH 45091 is placed on probation or until Pharmacist License Number RPH 45091 is reinstated if Pharmacist License Number RPH 45091 issued to Raafat George Gerges 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: 5/12/15

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

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