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

In the Matter of the Accusation Against: **TAN DO D.B.A. MOJAVE PHARMACY** **16912 Highway 14** **Mojave, CA 93501** **Original Pharmacy Permit No. PHY 47150** **TAN DO** **3014 Caruso Lane** **Lancaster, CA 93534** **Original Pharmacist License No. 47372** Respondent.	Case No. 5315 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On July 14, 2005, the Board issued Pharmacy Permit Number PHY 47150 to Respondent Tan Do, doing business as Mojave Pharmacy. Mr. Do is Mojave Pharmacy's individual licensed owner and its pharmacist-in-charge. The Pharmacy Permit was in force at all times relevant to this Accusation's charges. It will expire on July 1, 2015, unless renewed.

3. On October 17, 1994, the Board issued Pharmacist License No. 47372 to Respondent Tan Do. The license was also in force at all times relevant to this Accusation's charges and will expire on February 29, 2016, unless renewed.

JURISDICTION

4. This Accusation is brought before the Board under the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

5. Section 4300 authorizes the Board to discipline its license holders:

> "(a) Every license issued may be suspended or revoked.
>
> (b) The board shall discipline the holder of any license issued by the board, whose default has been entered or whose case has been heard by the board and found guilty, by any of the following methods:
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> (1) Suspending judgment.
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> (2) Placing him or her upon probation.
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> (3) Suspending his or her right to practice for a period not exceeding one year.
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> (4) Revoking his or her license.
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> (5) Taking any other action in relation to disciplining him or her as the board in its discretion may deem proper.
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> . . .
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> (e) The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code, and the board shall have all the powers granted therein. The action shall be final, except that the propriety of the action is subject to review by the superior court pursuant to Section 1094.5 of the Code of Civil Procedure."

6. Section 118 grants the Board jurisdiction to initiate and proceed with discipline against a suspended or expired license during the period when it can be renewed or reinstated.

STATUTES

7. Section 4301 authorizes discipline for unprofessional conduct:

> "The board shall take action against any holder of a license who is guilty of unprofessional conduct or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:
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> . . .
>
> (d) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153 of the Health and Safety Code.
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> . . .
>
> (j) The violation of any of the statutes of this state, or any other state, or of the United States regulating controlled substances and dangerous drugs."

8. In pertinent part, Section 4306.5 provides that unprofessional conduct can include a pharmacist's failure to exercise his best professional judgment or corresponding responsibility when dispensing controlled substances:

> "Unprofessional conduct for a pharmacist may include any of the following:
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> . . .
>
> (b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement his or her best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with regard to the provision of services...."

9. Healthy and Safety Code section 11153 subdivision (a) requires pharmacists to exercise corresponding responsibility with the physician for proper prescribing and dispensing of controlled substances:

> (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."

COST RECOVERY

10. Section 125.3 authorizes the Board to ask an administrative law judge to direct licensees found to have violated licensing acts to pay their case's reasonable investigation and enforcement costs.

FIRST CAUSE FOR DISCIPLINE

(AS TO MOJAVE PHARMACY AND TAN DO)

(Failure to Exercise or Implement Best Professional Judgment or Corresponding Responsibility with Regard to the Dispensing or Furnishing of Controlled Substances)

11. Respondents Tan Do and Mojacy Pharmacy are subject to discipline under Business and Professions Code section 4306.5 subdivision (c), as well as section 4301, subdivision (j), in conjunction with Health and Safety Code section 11153(a), for unprofessional conduct because

from January 2012 to October 31, 2013, Mr. Do and Mojave Pharmacy failed to exercise or implement their best professional judgment or failed to exercise or implement their corresponding responsibility to ensure that controlled substances were dispensed for a legitimate medical purpose. They failed to evaluate the totality of the circumstances to determine whether controlled substances prescriptions they filled and dispensed served legitimate medical purposes, including evaluating information from and about the patients receiving prescriptions for controlled substances, information from and about the physician prescribing those controlled substances, and information about how the medications prescribed related to patients' diagnoses and their overall course of treatment. They also ignored information available to them that could have helped them determine whether the controlled substance prescriptions they filled were for a legitimate medical purpose.

The circumstances are as follows:

12. On October 30, 2013, Pharmacy Board inspectors inspected Mojave Pharmacy, including interviewing Respondent Tan Do.

13. From October 2013 to May 2014, the inspectors also reviewed the pharmacy's drug inventories, its drug usage reports, selected patient prescription profiles, drug acquisition records, and reports from the Controlled Substance Utilization Review and Evaluation System, also known as CURES.

14. CURES is a system for monitoring patient controlled substance history information. (See Hlth. & Safety Code § 11165, Bus. & Prof. Code § 209.)(See also *In the Matter of the Accusation Against Pacifica Pharmacy; Thang Tran* (August 9, 2013) Board of Pharmacy Case No. 3802, Precedential Decision No. 2013-01, page 6, n.1, available at http://www.pharmacy.ca.gov/enforcement/precedential.shtml.)

15. Health and Safety Code section 11165 requires pharmacies to report within 7 days to the California Department of Justice every schedule II, III and IV drug prescription that is written or dispensed, and the information provided establishes the CURES database, which includes information about the drug dispensed, drug quantity and strength, patient name, address, prescriber name, and prescriber authorization number including DEA number and prescription

number. (See Hlth. & Safety Code § 11165.)(*In the Matter of the Accusation Against Pacifica Pharmacy; Thang Tran, supra*, at p.6.) The CURES database is intended to allow licensed healthcare prescribers and pharmacists the ability to access patient controlled substance history information. (See Hlth. & Safety Code § 11165, Bus. & Prof. Code § 209 [requiring DOJ and the Department of Consumer Affairs to streamline process to allow licensed health care practitioners and pharmacists to access CURES and run reports.])

16. CURES records showed that in a 21-month period, from January 1, 2012 to September 5, 2013, Respondents dispensed 15,694 prescriptions for controlled substances, of which 4,197 prescriptions were from Dr. Ali. Of the 4,197 controlled substances prescriptions from Dr. Ali, 583 were for 30 mg of oxycodone.

17. Oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and is a dangerous drug pursuant to Business and Professions Code section 4022.

18. Various forms of oxycodone are used to treat moderate to severe pain that is expected to last for an extended period of time. (See *In the Matter of the Accusation Against Pacifica Pharmacy; Thang Tran, supra*, page 7, notes 4-5, [specifically discussing Oxycontin, a brand name for oxycodone.]) Some individuals abuse oxycodone for the euphoric effect it produces – an effect that is said to be similar to that associated with heroin use. (See *id.*)

19. A 30 mg dose of oxycodone is atypically used for an initial prescription; it generally would be used for those with some oxycodone tolerance.

20. Based on information obtained from CURES records from January 1, 2012 to September 5, 2013, the inspectors undertook further investigation of selected patients for whom Respondents had provided oxycodone 30 mg prescriptions.

21. Dr. Ali, the physician who prescribed the medication, is primarily a general practitioner. He also has a secondary practice in family medicine and internal medicine. He does not have any specialty practice in pain management.

22. Dr. Ali had two offices. His primary office was in California City, but he had a second office in Mojave, adjacent to Respondent's pharmacy.

23. At the October 30, 2013 inspection, Respondent Tan Do stated to Pharmacy Board inspectors that he occasionally spoke to Dr. Ali about his patients' medications, but admitted that he did not keep notes or files about those conversations.

24. At that inspection, Mr. Do also stated that he had questioned Dr. Ali regarding excessive prescribing of pain medications.

25. Mr. Do falsely stated to the inspectors that Dr. Ali had a specialty in pain management. Dr. Ali did not. Mr. Do should have known that.

26. Mr. Do also stated at the inspection that he did not keep notes or files on any patients' drug therapies.

27. And Mr. Do stated at the inspection that he had not directly access CURES himself to check on patients' medication histories. He claimed that he had reviewed CURES records obtained from the prescribing physicians, but had no records of that in his files.

28. Respondents filled numerous prescriptions from Dr. Ali for 30 mg of oxycodone for 11 different patients over the almost-two-year-period from January 2012 to October 31, 2013.

29. Three of the 11 patients filled prescriptions for 30 mg of oxycodone at Respondents' pharmacy and at another nearby pharmacy in the same month. Had Respondents been checking CURES, they could have noticed this.

30. For 8 of the 11 patients, Respondents repeatedly dispensed promethazine with codeine in a high dosage. This medication is typically prescribed for the temporary cough relief. It would be unusual to have it prescribed for months on end for the conditions these patients were being treated for. It is potentially dangerous in combination with oxycodone and potentially dangerous in-and-of itself at the dosages and frequencies that Respondents dispensed it.

31. For 3 of the 11 patients, over the same period, Respondents also repeatedly dispensed Vicodin, a combination of hydrocodone and acetaminophen. At the time, Hydrocodone was a Schedule III controlled substance under California Health and Safety Code section 11055(b)(1)(I) and is a dangerous drug pursuant to Business and Professions Code section 4022. Vicodin is potentially dangerous in combination with oxycodone since they are both narcotics.

32. Respondents did not have a practice of verifying whether the patients' prescriptions were appropriate for each patient's diagnosis until questioned by the Pharmacy Board: Mr. Do did state he did this on occasion, but his records for the selected patients did not reflect that.

33. Respondents routinely dispensed 180 to 240 30 mg oxycodone pills per month to these 11 patients. For some patients, Dr. Ali would write two prescriptions a month for oxycodone – one for 150 pills, the other for 90 pills – and Respondents would dispense this amount. For other patients, Dr. Ali would write one prescription a month for 240 oxycodone pills and Respondents would dispense that amount.

34. Respondents dispensed oxycodone to each of the 11 patients for a year or more; for 7 of the 11 patients, Respondents did so from January 2012 through October 2013, the whole period the inspectors examined.

35. Of the 11 patients, 6 paid in a combination of cash and insurance, 2 paid in cash, and the other 3 paid through insurance. For cash purchases, Respondents generally charged $170 a month for 150 oxycodone 30 mg pills and $100 to $110 a month for 90 oxycodone 30 mg pills. So patients paying in cash would pay $270 to $280 a month for their oxycodone if they received 240 pills.

36. For 6 patients paying in a combination of insurance and cash, Respondents would charge the patients' insurers for one of the two monthly oxycodone prescriptions, but not the other. All 6 of these patients had other medications prescribed for them besides oxycodone. Respondents generally billed the insurers for dispensing these other medications, while allowing the patient to pay cash for some of the oxycodone.

37. Taken together, these circumstances should have led Respondents to exercise their corresponding responsibility to ensure that Dr. Ali's oxycodone prescriptions were being issued for a legitimate medical purpose and Respondents' responsibility to dispense and to fill prescriptions for oxycodone only for a legitimate medical purpose.

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SECOND CAUSE FOR DISCIPLINE

(AS TO MOJAVE PHARMACY AND TAN DO)

(Excessive Furnishing of Controlled Substances)

38. Respondents Tan Do and Mojave Pharmacy are also subject to discipline pursuant to section 4301, subdivision (d), for unprofessional conduct because they clearly excessively furnished oxycodone during the period of January 1, 2012 to October 31, 2013, as more fully set forth in paragraphs 10-34 above, which Complainant realleges in this cause for discipline.

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 Original Pharmacy Permit Number PHY 47150, issued to Mojave Pharmacy;

2. Revoking or suspending Original Pharmacist License Number RPH 47372 issued to Tan Do;

3. Ordering Mojave Pharmacy and Tan Do jointly and severally to pay the Board of Pharmacy its reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

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

DATED: 7/2/15

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

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