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

In the Matter of the First Amended Accusation Against: **RSA HEALTH SERVICES INC., DBA FARMACIA ESTRELLA, ROBERT ANDONIAN AND SUZY ANDONIAN, OWNERS** 5020 South C Street Oxnard, CA 93033 **Pharmacy Permit License No. PHY 49140** and **ROBERT ANDONIAN** 5020 South C Street Oxnard, CA 93033 **Pharmacist License Number RPH 47233,** Respondents.	Case No. 5372 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about December 1, 2008, the Board of Pharmacy issued Pharmacy Permit Number PHY 49140 to RSA Health Services Inc. to do business as Farmacia Estrella, located at 5020 South C Street, Oxnard, CA 93033 (Respondent Farmacia). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2016, unless renewed. Robert Andonian has been an owner and the Chief Executive Officer, President, and Pharmacist-In-Charge (PIC) of Respondent Farmacia since December 1, 2008. Suzy Andonian is and has been an owner and the Director of Respondent Farmacia since December 1, 2008.

3. On or about August 3, 1994, the Board of Pharmacy issued Pharmacist License Number RPH 47233 to Robert Andonian (Respondent Andonian). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2017, unless renewed.

JURISDICTION

4. This Accusation is brought before the California State 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 4300 of the Code provides, in part, that every license issued by the Board is subject to discipline, including suspension or revocation.

6. Section 4302 of the Code states:

"The board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee."

7. Section 4113 of the Code states, in part:

"(b) 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."

8. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a

disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY AUTHORITY

9. Section 4301 of the Code states, in part:

"The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . Unprofessional conduct shall include, but is not limited to, any of the following:

. . .

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

. . .

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

. . .

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

10. 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."

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11. Section 4081 of the Code states, in part:

"(a) All records of manufacture and of sale, acquisition, receipt, shipment, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, third-party logistics provider, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

"(b) The owner, officer, and partner of a pharmacy, wholesaler, third-party logistics provider, or veterinary food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge, responsible manager, or designated representative-in-charge, for maintaining the records and inventory described in this section."

12. Section 4105 of the Code states, in part:

"(a) All records or other documentation of the acquisition and disposition of dangerous drugs and dangerous devices by any entity licensed by the board shall be retained on the licensed premises in a readily retrievable form.

. . .

"(c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.

. . .

"(f) When requested by an authorized officer of the law or by an authorized representative of the board, the owner, corporate officer, or manager of an entity licensed by the board shall provide the board with the requested records within three business days of the time the request was made…"

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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, subdivision (a), of the Code states, in pertinent part:

"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 manager, administrator, owner, member, officer, director, associate, or partner had knowledge of 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 manager, 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:

"(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."

STATE REGULATORY AUTHORITY

16. California Code of Regulations, title 16, section 1707.3 states:

"Prior to consultation as set forth in section 1707.2, a pharmacist shall review a patient's drug therapy and medication record before each prescription drug is delivered. The review shall include screening for severe potential drug therapy problems."

17. California Code of Regulations, title 16, section 1716 states, in part:

"Pharmacists shall not deviate from the requirements of a prescription except upon the prior consent of the prescriber or to select the drug product in accordance with Section 4073 of the Business and Professions Code."

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 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.

20. **DRUG CLASSIFICATIONS**

Brand Name(s)	Generic Name	Dangerous Drug Per Bus. & Prof. Code § 4022	Scheduled Drug per Health & Safety Code (HSC)	Indications For Use
Ambien	Zolpidem (non-barbiturate, non-benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(32)	Insomnia
Ativan	Lorazepam 2mg	Yes	Schedule IV HSC § 11057(d)(16)	Anxiety
Dolophine	Methadone	Yes	Schedule II HSC § 11055c(14)	Pain, Narcotic Addiction
Dilaudid	Hydromorphone	Yes	Schedule II HSC § 11055(b)(1)(J)	Pain
Duragesic	Fentanyl	Yes	Schedule II HSC § 11055(c)(8)	Pain
Klonopin	Clonazepam 2mg	Yes	Schedule IV HSC § 11057(d)(7)	Anxiety
	Morphine Sulphate IR (Immediate Release) or Morphine Sulphate ER (Extended Release)	Yes	Schedule II HSC § 11055(b)(1)(L)	Pain
Norco[1], Vicodin ES, Lorcet	Hydrocodone/ acetaminophen (APAP)	Yes	Schedule II HSC § 11055(b)(1)(I)	Pain

[1] Norco 10/325 mg contains 10 mg of hydrocodone and 325 mg of acetaminophen (brand name, Tylenol). The maximum recommended dosage for acetaminophen is four (4) grams or 4000mg every 24 hours.

Opana ER	Hydromorphone	Yes	Schedule II HSC § 11055(b)(1)(N)	Pain
OxyContin	Oxycodone	Yes	Schedule II HSC § 11055(b)(l)(M)	Pain
Soma[2]	Carisoprodol	Yes	Not scheduled in California. Schedule IV under federal law (21 CFR § 1308.14(c)(6))	Muscle relaxant
Subutex, Suboxone	Buprenorphine	Yes	Schedule V HSC § 11058(d)	Narcotic Addiction
Valium	Diazepam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(9)	Anxiety
Xanax	Alprazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(1)	Anxiety

FACTUAL SUMMARY

21. Beginning in January 2013, the Board conducted an investigation into Respondent Farmacia. On or about January 5, 2012, the Board was notified that Dr. Julio Gabriel Diaz also known as Otero Julio Gabriel Diaz, MD (Dr. Diaz) was arrested on federal painkiller trafficking charges. He was linked to a string of drug overdose deaths. Dr. Julio Diaz, a General Practice physician with secondary practice areas in Geriatrics and Pathology, operated Family Medical Clinic, located at 510 Milpas Street, Santa Barbara, CA 93103. Respondent Farmacia, located at 5020 South C Street, Oxnard, CA 93033, dispensed numerous prescriptions for controlled substances written by Dr. Diaz, despite the fact that the distance between Dr. Diaz's office and Respondent Farmacia's store was approximately 40 miles.

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[2] Drug abusers are known to combine Soma with hydrocodone to produce similar effects to those of Heroin.

22. Dr. Diaz was arrested pursuant to a criminal complaint filed in United States District Court that charges him with illegal distribution of controlled substances. The affidavit in support of the criminal complaint provides that Dr. Diaz wrote prescriptions for powerful painkillers, such as OxyContin, for "patients" who were drug addicts with no legitimate need for the drugs. Some of Dr. Diaz's "patients" diverted the pills they received to the black market and/or suffered fatal overdoses from the narcotics. On or about August 28, 2015, Dr. Diaz was convicted of 79 counts of unlawful distribution of a controlled substance in violation of 21 U.S.C. section 841. Twenty-six of the charges relate to oxycodone, ten of the charges relate to methadone, seven of the counts relate to hydromorphone, ten of the charges relate to fentanyl, eleven of the charges relate to hydrocodone, ten of the charges relate to alprazolam, and five of the charges related to the distribution of various controlled substances to a minor. The Court sentenced Dr. Diaz to 327 months in federal prison.

23. Effective November 2, 2012, the California Medical Board revoked Dr. Diaz's medical license in the case entitled *In the Matter of the Accusation against Otero Julio Gabriel Diaz, M.D.*, case no. 06-2010-209660. Dr. Diaz's license was revoked for committing gross negligence and incompetence and for excessive prescribing narcotic medications to a patient.

24. On or about January 9, 2013, two Board inspectors conducted an inspection of Respondent Farmacia, located at 5020 South C Street, Oxnard, CA 93033. When questioned about Dr. Diaz's prescriptions, Respondent Andonian, the Pharmacist-in-Charge, stated that Dr. Diaz was a pain treating physician who was arrested last year. He stated that when he bought the pharmacy, he had concerns on dispensing drugs prescribed by Dr. Diaz, however, he contacted the local pharmacies and they assured him Dr. Diaz was legitimate. As a result, he began to dispense drugs prescribed by Dr. Diaz.

25. The Board inspectors selected 19 random patients of Dr. Diaz who filled their prescriptions at Respondent Farmacia to profile and asked Respondent Andonian to complete questionnaires regarding these patients. Amongst the questions asked were the patients' diagnoses, the methods of payment, and the nature of the prescriber's practice. The Board inspectors also requested prescription records of the randomly selected patients. On or about

January 22, 2013, the Board inspector received the requested documents from Respondent Farmacia.

26. As part of the investigation, the Board inspectors also obtained CURES3 data for Respondent Farmacia for the period of December 1, 2008 to December 17, 2012, CURES Patient Activity Reports (PARs) for the 19 randomly selected patients for the period of January 1, 2009 to March 11, 2013, and CURES data for surrounding pharmacies.

27. The CURES data for Respondent Farmacia revealed that Respondent Farmacia dispensed a total of 21,704 controlled substance prescriptions from December 1, 2008, to December 17, 2012. During this period, Respondent Farmacia dispensed 3,986 controlled substance prescriptions written by Dr. Diaz, which represented 18.37% of the total controlled substance prescriptions dispensed by Respondent Farmacia. Dr. Diaz was the pharmacy's largest controlled substance prescriber for a total of 647,159 dosage units dispensed. Of the 21,704 controlled substance prescriptions dispensed, approximately 40% of the dispensed prescriptions were for cash patients.[4]

28. The CURES data also showed Dr. Diaz's questionable prescribing pattern. Dr. Diaz normally prescribed large quantities of opiates in combination with minor tranquilizers (anxiolytic or anti-anxiety). The usual combination included hydromorphone, hydrocodone/acetaminophen, oxycodone, methadone, fentanyl, OxyContin, morphine sulfate with alprazolam, clonazepam, lorazepam, and/or diazepam in large quantities. He prescribed on average 3 to 4 opiate prescriptions with 1 to 2 anxiolytic prescriptions to his patients. The table

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[3] CURES is an acronym for "California Utilization Review and Evaluation System." It contains over 100 million entries of controlled substance drugs that were dispensed in California. Pharmacists and prescribers can register with the Department of Justice to obtain access to the CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to report to the California Department of Justice every schedule II, II and IV drug prescription under Health and Safety Code section 11165, subdivision (d).

[4] In cases of drug diversion, most of the medications purchased from a pharmacy are purchased without the use of insurance to avoid tracking of activity. If the patients are fictitious persons, there is no insurance to bill. The bypassing of insurance is commonly referred to as "paying cash." Frequently, the medications are purchased with actual money but "paying cash" could also mean using a debit or credit card. The use of electronic payment is rare for the same reason drug diverters avoid using insurance.

below contains a list of selected drugs and the average quantities of those drugs prescribed by Dr. Diaz and dispensed by Respondent Farmacia for the period of January 1, 2011 to January 9, 2012.

Name of Drug	Number of Pills
hydrocodone/APAP 10/325mg	229
oxycodone 30mg	197
methadone 10mg	205
alprazolam 2mg	97
hydromorphone 8mg	170
OxyContin 80mg	118
Opana ER 40mg	105
morphine sulfate 100mg	98
morphine sulfate 30mg	164
diazepam 10mg	94
hydrocodone/APAP 10/500mg	258
clonazepam 2mg	75

29. For the randomly selected patients of Dr. Diaz, there were many irregularities found with prescriptions and dispensing methods, including: (1) a general practitioner that was prescribing an excessive amount of narcotics; (2) consistent early fills of controlled substance prescriptions; (3) patients paying cash for expensive narcotics, even when they had insurance; (4) failure to evaluate CURES Patient Activity Reports (PARs) for suspicious prescriptions; (5) evidence of doctor/pharmacy shopping by the patients; and (6) evidence of a pattern of prescribing controlled substances in large and redundant quantities and in questionable combinations, including combinations that constituted therapy duplication.

30. Furthermore, the patients' records showed that the total distance these patients travelled to obtain controlled substances was objectively and clearly excessive. 19 of the 19 patients resided outside the immediate trading area of Dr. Diaz. 4 of the 19 patients showed addresses outside the normal trading area of the pharmacy, which is considered to be 5 miles from the patient's residence or adjacent to the prescriber's office. The distance between Dr. Diaz's office and Respondent Farmacia was approximately 40 miles. The distance travelled for the randomly selected patients from home to Dr. Diaz office, then to the pharmacy and back home was 71.92 miles for the shortest distance to 220 miles for the longest distance roundtrip.[5] The

[5] Distances were determined by using MapQuest.

average distance was 82.47 miles. 6 of the 19 patient's home addresses were not recognized by MapQuest. Two patients had the same address.

31. Respondents failed to maintain records or files on the drug therapy for these patients.

32. A detailed review of the randomly selected patients' records revealed the following facts:

a. Patient CA

i. Respondents reported that Patient CA was diagnosed[6] with chronic lumbar, cervical pain, and severe intractable fibromyalgia. Dr. Diaz prescribed pain and anxiety medications for Patient CA that Respondent Farmacia dispensed, including oxycodone, OxyContin, hydrocodone/APAP (Norco), Methadone, Morphine Sulfate, Duragesic, alprazolam (Xanax), diazepam (Valium), and clonazepam (Klonopin), among others. Patient CA received most of her pain medication prescriptions from Dr. Diaz, despite the fact that Dr. Diaz was not a pain specialist. Patient CA was on Medi-Cal; however, when Medi-Cal did not pay for the medications, Patient CA paid over $500.00 for her OxyContin, $300.00 for oxycodone, and hundreds of dollars for various other drugs. According to the patient profile kept by Respondent Farmacia, Patient CA gave an address to the pharmacy that could not be found through MapQuest.

ii. Patient CA presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On October 19, 2010, Respondent Farmacia dispensed RX# 157515 (oxycodone 30mg) and 157517 (methadone 10mg), even though the prescription document itself did not have a date on it, as required. On September 21, 2011, Patient CA received two prescription hardcopies for oxycodone 30mg IR, written by Dr. Diaz. In addition, the date on the prescriptions was not written in the prescriber's handwriting on either of the prescription hardcopies. Nevertheless, Respondent Farmacia dispensed these prescriptions. On

[6] Patients' diagnoses were provided by PIC Andonian in the Board's pharmacy patient questionnaire, which was provided by the Board during its investigation to determine what PIC Andonian knew about the patients, the prescribers, their diagnoses and the patient's overall drug therapy.

November 16, 2011, Patient CA received two prescription hardcopies for oxycodone 30mg IR, written by Dr. Diaz, which Respondent Farmacia dispensed.

iii. In response to the Board inspector's records request, Respondents provided the Board with the CURES Patient Activity Reports (PARs) that it had printed out for Patient CA. The PARs printed out on March 26, 2010, May 12, 2011, and October 6, 2011, clearly showed that Patient CA was having Dr. Diaz's prescriptions for oxycodone 30mg and hydrocodone/APAP 10/325 mg dispensed at different pharmacies at or around the same time. Patient CA also used different addresses at different pharmacies. On the PAR printed out on October 6, 2011, Respondent Farmacia's staff wrote a note that they discussed with Patient CA and Dr. Diaz the fact that the patient was obtaining controlled substances prescriptions from more than one prescriber at the same time, and it was noted that the patient was having these prescriptions dispensed by more than one pharmacy.

iv. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient CA saw 12 prescribers and went to 16 pharmacies to obtain controlled substances.

b. Patient CB

i. Respondents reported that Patient CB was diagnosed with post traumatic chronic pain. Dr. Diaz prescribed pain and anxiety medications for Patient CB that Respondent Farmacia dispensed, including hydrocodone/APAP, Opana ER, oxycodone, OxyContin, alprazolam, and carisoprodol, among others. Patient CB received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Per his patient profile kept by Respondent Farmacia, Patient CB resided in Ventura, California. The distance between the patient's residence and Dr. Diaz's office was approximately 30 miles and the distance between the patient's residence to Respondent Farmacia's store was approximately 10 miles.

ii. Patient CB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On October 25, 2011, Respondent Farmacia dispensed two prescriptions for hydrocodone/APAP 10/325mg prescribed by Dr. Diaz: RX # 190759 for 240 pills (30 day supply) and 193618 for 240 pills (30 day supply). The recommended maximum

daily dose of acetaminophen is 4000mg; Patient CB would have the equivalent of 5200mg of acetaminophen per day. Respondent Farmacia also dispensed prescriptions of Opana ER for Patient CB above the recommended dose. The recommended dose for Opana ER was twice daily; Patient CB was directed to take it three times daily for RX# 198621, 196223, 191000, 188580, 186341, 183974, 175515, and 172780.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient CB. The PAR printed out on June 3, 2010, clearly shows that Patient CB was being treated with Suboxone, which is used for treatment of narcotic addiction. Respondents did not contact the prescriber to determine if the drug was used for pain or addiction. The PARs printed on October 6, 2011, and November 2, 2011, also show that the patient was treated with Suboxone while being prescribed other narcotics by Dr. Diaz.

iv. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient CB saw 4 prescribers and went to 6 pharmacies to obtain controlled substances. These reports show that Patient CB had no prior history of anxiety 16 months prior to going to Dr. Diaz, yet Dr. Diaz started therapy with alprazolam 2mg, the highest dose of alprazolam available.

c. Patient TB

i. Respondents reported that Patient TB was diagnosed with broken or crushed legs and a spinal injury due to a car accident and was in a wheelchair. Dr. Diaz prescribed pain and anxiety medications for Patient TB that Respondent Farmacia dispensed, including oxycodone, APAP/oxycodone, morphine sulfate, hydromorphone, Fentanyl, Norco, chlordiazepoxide (brand name is Librium, which is used for anxiety), among others. Patient TB received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Per his California driver's license, Patient TB resided in Palm Desert and travelled over 220 miles from Palm Desert to Santa Barbara to be treated by Dr. Diaz and to have his prescription filled in Oxnard. Patient TB had insurance but paid cash for oxycodone, OxyContin and hydrocodone/ acetaminophen on various occasions.

ii. Patient TB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Patient TB received two prescriptions for oxycodone IR prescribed by Dr. Diaz on each of the following dates, some with different directions: 11/2/2010, 1/25/2011, 4/21/2011, 5/24/2011, 6/23/2011, 7/21/2011, 8/18/2011, 9/21/2011, and 10/20/2011. As a result, Patient TB received prescriptions for the same medication with different directions at the same time.

iii. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient TB saw 14 prescribers and went to 11 pharmacies to obtain controlled substances. Patient TB did not have a significant pain or anxiety history prior to seeing Dr. Diaz. He received only hydrocodone products from various doctors 15 months prior to seeing Dr. Diaz, yet Dr. Diaz began therapy with oxycodone 30mg, hydrocodone/acetaminophen 10/325, OxyContin 80mg, methadone 10mg and alprazolam 2mg.

d. Patient RB

i. Respondents reported that Patient RB was diagnosed with degenerative Spine Scoliosis. Dr. Diaz prescribed pain and anxiety medications for Patient RB that Respondent Farmacia dispensed, including OxyContin, oxycodone, hydromorphone, Opana ER, methadone, alprazolam, Soma, and zolpidem, among others. Patient RB received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient RB resided in Oxnard. The distance between the patient's residence and Dr. Diaz's office was 36 miles.

ii. Patient RB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On September 15, 2011, Respondent Farmacia dispensed RX# 189739, 189738, 189737, and 189734, even though the date did not appear to have been written in Dr. Diaz's handwriting.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient RB. The PAR printed out on October 6, 2011, shows that on August 17, 2011, Patient RB went to two pharmacies to obtain pain

medications prescribed by Dr. Diaz, one in Oxnard and the other in Santa Barbara, over 30 miles away from each other to have medication dispensed on the same date.

iv. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient RB saw 6 prescribers and went to 7 pharmacies to obtain controlled substances. While going to Dr. Diaz, Patient RB received methadone and hydrocodone/acetaminophen 10/325mg prescriptions from Dr. Diaz and from another prescriber in Ventura, California. Patient RB had the prescriptions that were written by the other prescriber filled at a different pharmacy.

e. Patient SB

i. Respondents reported that Patient SB was diagnosed with multiple spinal fractures. Dr. Diaz prescribed pain and anxiety medications for Patient SB that Respondent Farmacia dispensed, including OxyContin, oxycodone, Opana ER, alprazolam, methadone, and Soma. The patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient SB had the same address as Patient RB in Oxnard. The distance between the patient's residence and Dr. Diaz's office was 36 miles.

ii. Patient SB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On December 2, 2010, Patient SB received RX# 161418 OxyContin above the recommended dosing interval of twice daily. Patient SB was directed to take it three times daily. On September 15, 2011, Respondent Farmacia dispensed RX# 189730 and 189731, even though the date on the prescription did not appear to have been written in Dr. Diaz's handwriting.

iii. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient SB had no pain or anxiety history 18 months prior to going to Dr. Diaz, yet Dr. Diaz began treatment with oxycodone 30mg, OxyContin 80mg (the highest dosage available), morphine sulfate 100mg, and alprazolam 2mg (the highest dosage available).

f. Patient JC

i. Respondents reported that Patient JC was diagnosed with chronic pain post trauma from an automobile/motorbike accident. Dr. Diaz prescribed pain and anxiety medications for Patient TB that Respondent Farmacia dispensed, including oxycodone, OxyContin, Norco,

and alprazolam, among others. Patient JC received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient JC had no pain history prior to September 30, 2009 and seeing Dr. Diaz, yet Dr. Diaz began her therapy with OxyContin 40mg, OxyContin 80mg, and hydrocodone/APAP 10/325mg.

ii. Patient JC resided in Port Hueneme, California. The distance from the patient's residence to Dr. Diaz's office was approximately 40 miles. Patient JC had insurance but paid between $800 and $1500 cash for OxyContin.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient JC saw 3 prescribers and went to 4 pharmacies to obtain controlled substances. Patient JC received multiple prescriptions from Dr. Diaz for hydrocodone/APAP 10/325 and alprazolam 2mg at or around the same time, which were dispensed at different pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
1/14/2010	hydrocodone/APAP 10/325 #240	20	Dr. Diaz	Respondent Farmacia	RX# 125584
1/28/2010	hydrocodone/APAP 10/325 #180	30	Dr. Diaz	Omac Pharmacy	RX# 6193181
3/15/2010	hydrocodone/APAP 10/325 #240	20	Dr. Diaz	Respondent Farmacia	RX# 125584
3/15/2010	hydrocodone/APAP 10/325 # 200	25	Dr. Diaz	Omac Pharmacy	RX# 6224819
1/14/2010	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 125582
1/28/2010	alprazolam 2mg #60	30	Dr. Diaz	Omac Pharmacy	RX# 6193182
2/15/2010	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 125582
2/25/2010	alprazolam 2mg #60	30	Dr. Diaz	Omac Pharmacy	RX# 6193182

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g. Patient DG

i. Respondents reported that Patient DG was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and injury to spine and neck, and was an Iraq War veteran. He resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, OxyContin, Norco, Opana ER, Fentanyl, Xanax, diazepam, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient DG had insurance, but paid between $350.00 and $2856.00 cash for his OxyContin. On December 28, 2010, Patient DG received prescriptions for OxyContin 80mg #120 which the patient wanted changed to OxyContin 40mg #240. Patient DG paid cash for the medication. The OxyContin 80mg prescription costs $1895.95 and the OxyContin 40 mg prescription costs $2856.00. It's unusual for a patient to request a medication that costs about $1,000 more than originally prescribed drug.

ii. Patient DG presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Respondent Farmacia dispensed alprazolam 2mg on March 26, 2010 for this patient twice on the same day with two different prescription numbers (RX# 140353 and RX # 125304). On May 4, 2010, Respondent Farmacia dispensed RX# 143720 for OxyContin above the recommended dosing interval of twice daily. Patient DG was directed to take it three times daily. On March 28, 2011 dispensed RX# 173557 for Opana ER 40mg above the recommended dosing interval of twice daily. Patient DG was directed to take it three times daily.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient DG saw 4 prescribers and went to 7 pharmacies to obtain controlled substances. CURES PAR data showed that Patient DG had no prior history of pain or anxiety 4 months prior to going to Dr. Diaz, yet Dr. Diaz began therapy with alprazolam 2mg and a large dose of hydrocodone/APAP 10/325mg.

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h. Patient JH

i. Respondents reported that Patient JH was diagnosed with bilateral foot pain, Charcott deformity and fractures, and extreme obesity. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, OxyContin, hydromorphone, Xanax, diazepam, and alprazolam. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Respondent resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient JH had insurance, but he paid cash for OxyContin, methadone and amphetamine. On November 16, 2010, Patient JH paid $1701.00 cash for OxyContin, RX# 159977.

ii. Patient JH presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On both September 28, 2011, and November 23, 2011, Patient JH received two prescriptions for Dilaudid 8mg written by Dr. Diaz with two different directions. According to CURES data and the patient profile kept by Respondent Farmacia, on October 3, 2011, Respondent Farmacia dispensed hydormorphone 8mg RX # 191305 two different times for 100 and 160 tablets, and RX# 191314 for 120 tablets, for a total of 380 tablets of hydromorphone 8mg, when the prescription was written for 280 tablets.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient JH saw 6 prescribers and went to 3 pharmacies to obtain controlled substances.

i. Patient KL

i. Respondents reported that Patient KL was diagnosed with chronic back pain, spinal injury and neck pain. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including methadone, oxycodone, hydromorphone, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient KL resided in Oxnard, approximately 40 miles from Dr. Diaz's office.

ii. Patient KL presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On October 12, 2010, Patient KL received two prescriptions for

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Soma with different directions. Respondent Farmacia verified with Dr. Diaz to dispense both prescriptions at the same time; however, when Dr. Diaz said "yes" to dispensing both, this was a red flag for the pharmacy.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient KL. The PAR printed out on February 26, 2010, showed that Patient KL was using multiple pharmacies to obtain controlled substances. There was a note made on the PAR which stated, discussed with patient on April 20, 2010, about using multiple pharmacies. However, the PAR printed on May 12, 2011, showed that Patient KL continued to go to multiple pharmacies to have his prescriptions for controlled substances filled and that Respondent Farmacia continued to dispense controlled substances for him.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient KL saw 10 prescribers and went to 11 pharmacies to obtain controlled substances. Patient KL went to Dr. Diaz and various other prescribers and pharmacies to obtain hydrocodone/APAP 10/325mg and alprazolam (various strengths) at or around the same time, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
1/11/2010	alprazolam 0.5mg #45	30	Dr. Vance Snyder	Biocare RX Specialty Pharmacy	RX# 4410545
1/14/2010	alprazolam 2mg #100	30	Dr. Diaz	Omac Pharmacy	RX# 6209747
2/26/2010	hydrocodone/APAP 10/325 #240	30	Dr. Diaz	Respondent Farmacia	RX# 137733
2/26/2010	alprazolam 2mg #100	25	Dr. Diaz	Respondent Farmacia	RX# 137735
3/9/2010	alprazolam 0.5mg #90	30	Dr. Vance Snyder	Biocare RX Specialty Pharmacy	RX# 4411452
3/9/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz.	Omac Pharmacy	RX# 6209744
10/4/2010	alprazolam 2mg # 100	25	Dr. Diaz	Omac Pharmacy	RX# 6242133
10/12/2010	alprazolam 2mg #100	25	Dr. Diaz	Respondent Farmacia	RX# 156991
10/12/2010	hydrocodone/APP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX # 156988
10/18/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Omac Pharmacy	RX# 6242132

v. The hydrocodone and alprazolam prescriptions had refills, which Patient KL had dispensed monthly at the respective pharmacies.

vi. Patient KL received an average of 16 tablets of hydrocodone/APAP per day, which resulted in Patient KL receiving 5200mg of acetaminophen per day. The combination above of alprazolam 2mg and hydrocodone/APAP 10/325mg prescribed by Dr. Diaz for Patient KL was dispensed monthly at Omac Pharmacy and Respondent Farmacia.

j. Patient ZL

i. Respondents reported that Patient ZL was diagnosed with multiple traumas and fractures with joint hardware from a car accident. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including methadone, oxycodone, hydrocodone and ibuprofen, Promethazine and Codeine, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist.

ii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient ZL saw 17 prescribers and went to 12 pharmacies to obtain controlled substances. Prior to going to Dr. Diaz, Patient ZL only received hydrocodone/APAP 10/325mg for pain, yet Dr. Diaz began therapy with oxycodone 30mg, hydrocodone/APAP 10/325mg and methadone all at the same time.

k. Patient RM

i. Respondents reported that Patient RM was diagnosed with postoperative pain right shoulder, back and spinal disease. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, hydromorphone, Norco, Xanax, and Soma. Patient RM saw Dr. Diaz for pain medications while going to other prescribers for primary care drugs, despite Dr. Diaz not being a pain specialist. Patient RM resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient RM had insurance but paid cash for his pain medications.

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ii. Patient RM's patient profile kept by Respondent Farmacia revealed that prior to going to Dr. Diaz, the quantity and numbers of pain medications received were less than from other prescribers. As soon as he saw Dr. Diaz, the quantity and number were increased.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient RM saw 17 prescribers and went to 11 pharmacies to obtain controlled substances.

l. Patient AP

i. Respondents reported that Patient AP was diagnosed with post herpetic neuralgia, post traumatic disc, herniated L4L5, and bilateral leg pain neuropathy. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, Norco, Xanax, Soma, methadone, and Suboxone. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient AP resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient AP paid cash for her pain medications. Respondents discovered that Patient AP had forged prescriptions, yet Respondent Farmacia continued to fill most of her prescriptions for controlled substances.

ii. Patient AP presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Patient AP received two prescription hardcopies for oxycodone 30mg on each of the following days: 8/27/2010, 9/27/2010, 11/22/2010, 12/20/2010, 8/4/2011, 9/1/2011, 9/29/2011, and 10/27/2011. In addition to the two prescriptions, some of the prescriptions written for the same drug and strength had different directions. On numerous occasions, Respondent Farmacia dispensed hydrocodone/APAP products prescribed by Dr. Diaz, which included well above the recommended dose of 4000mg/day of acetaminophen. For example, RX# 172358, 182237, 155549, 169296, 163618, 157709, and 159583, resulted in the patient taking 6000mg/day of acetaminophen; RX# 183920 resulted in the patient taking 8000 mg/day of acetaminophen; and RX# 144039 and 132125, resulted in the patient taking 5200mg/day of acetaminophen.

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iii. Patient AP received Suboxone, used for treatment of narcotic addiction, prescribed by Dr. Diaz and dispensed at Respondent Farmacia while other narcotics were being prescribed and dispensed.

iv. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient AP. The PAR printed out on May 26, 2010, showed that Patient AP was using multiple pharmacies to obtain controlled substances. There was a note made on the PAR which said "patient assured she will no longer get controls at other pharmacies". However, Patient AP continued to go to other pharmacies to have her prescriptions for controlled substances filled, which was clearly evident by the PARs printed after this date. On the PAR printed on August 3, 2010, Respondent Farmacia's staff noted that they talked to patient about requesting early refills of her controlled substance prescriptions. The PAR printed on October 6, 2011 showed Patient AP using multiple pharmacies for Dr. Diaz's controlled substance prescriptions and another note was made to discuss with the patient about getting the same drugs at two different pharmacies. The PARs printed on November 2, 2011 and December 8, 2011 showed Patient AP continued to use multiple pharmacies to fill Dr. Diaz's controlled substance prescriptions. On December 27, 2011, a note was made on the PAR printed out on December 8, 2011, that Respondent Farmacia's staff person spoke to Dr. Diaz regarding Patient AP's early refills on oxycodone. The PAR printed on May 17, 2012 showed patient AP continued using multiple pharmacies and prescribers to obtain controlled substances. These PARs also showed that Patient AP used different addresses at different pharmacies.

v. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient AP saw 4 prescribers and went to 10 pharmacies to obtain controlled substances. Patient AP received multiple prescriptions for hydrocodone/APAP and alprazolam 2mg at or around the same time from Dr. Diaz, but went to numerous pharmacies to have them dispensed, as shown in the table below:

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Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
1/15/2010	hydrocodone/APAP 10/500mg # 240	30	Dr. Diaz	Respondent Farmacia	RX# 133485
1/18/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Omac Pharmacy	RX# 6199498
1/25/2010	hydrocodone/APAP 10/500 #200	25	Dr. Diaz	Federal Drug	RX# 4515808
1/27/2010	hydrocodone/APAP 10/650 #30	7	Dr. Diaz	Respondent Farmacia	RX# 132125
1/28/2010	hydrocodone/APAP 10/500 #240	30	Dr. Diaz	CVS 9695	RX# 423534
6/9/2010	hydrocodone/APAP 10/500mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 136047
6/10/2010	hydrocodone/APAP 10/500 #240	30	Dr. Diaz	Omac Pharmacy	RX# 6222512
6/18/2010	hydrocodone/APAP 10/500 #240	60	Dr. Diaz	Leon's Pharmacy	RX# 1215674
6/24/2010	hydrocodone/APAP 10/650 #240	30	Dr. Diaz	Omac Pharmacy	RX# 6237504
6/28/2010	hydrocodone/APAP 10/500 #240	40	Dr. Diaz	CVS 9695	RX# 423534
3/2/2010	alprazolam 2mg #100	25	Dr. Diaz	Omac Pharmacy	RX# 6222510
3/25/2010	alprazolam 2mg # 100	25	Dr. Diaz	Respondent Farmacia	RX# 134063
3/26/2010	alprazolam 2mg # 100	25	Dr. Diaz	Federal Drug	RX# 4515809
3/29/2010	alprazolam 2mg #120	20	Dr. Diaz	Omac Pharmacy	RX# 6227393
5/2/2010	alprazolam 2mg #150	25	Dr. Diaz	Respondent Farmacia	RX# 163171
5/20/2010	alprazolam 2mg #120	30	Dr. Diaz	Omac Pharmacy	RX# 6272845
5/26/2010	alprazolam 2mg # 150	25	Dr. Diaz	Respondent Farmacia	RX# 163171

vi. As shown in the table above, from January 15, 2010 to January 28, 2010, Dr. Diaz prescribed 950 tablets of hydrocodone/APAP products for Patient AP in less than 15 days. As a result, Patient AP received at least 17,300 mg of acetaminophen per day, well over the recommended maximum daily dosage of acetaminophen of 4000mg. From March 2, 2010 to March 29, 2010, Dr. Diaz prescribed 420 tablets of alprazolam 2mg for Patient AP in 30 days. From May 2, 2010 to May 26, 2010, Dr. Diaz prescribed 420 tablets of alprazolam 2mg for AP in 30 days. From June 9, 2010 to June 28, 2010, Dr. Diaz prescribed 1200 tablets of

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hydrocodone/APAP products for Patient AP in 20 days. As a result, Patient AP received 18,200 mg of acetaminophen per day.

m. Patient JP

i. Respondents reported that Patient JP was diagnosed with chronic malignant back and joint pain and Hepatitis C. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including OxyContin, oxycodone, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient JP resided in Oxnard, approximately 40 miles from Dr. Diaz's office.

ii. Patient JP presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On December 23, 2011, Respondent Farmacia dispensed RX# 199521 for OxyContin, which was above the recommended dosing interval of twice daily. Patient JP was directed to take it three times daily. On August 22, 2011, Respondent Farmacia dispensed RX# 187698 (hydroxymorphone), RX# 187701 (Lyrica 75mg), and RX# 187700 (oxycodone 30mg), even though the dates on the three prescriptions appeared to have been altered.

iii. On November 2, 2011, Respondents printed out a CURES PAR for Patient JP for the first time, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since 2009.

n. Patient DR

i. Respondents reported that Patient DR was diagnosed with L4L5 herniated disc that is inoperable and severe leg pain and neck stabbing. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, Opana ER, Fentanyl, hydromorphone, Norco, Xanax, and Soma. Patient DR resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient DR had insurance, but paid cash for most of his pain medications. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist.

ii. Patient DR presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On April 20, 2011, Respondent Farmacia dispensed RX# 176114

which was unclear. The prescription was written for Oxycodone ER 30 IR. Respondent Farmacia did not verify and note the verification prior to dispensing. On April 22, 2011, Respondent Farmacia dispensed RX# 176116 for Opana ER to be taken three times daily, which is above the recommended dosing interval of twice daily.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient DR. Respondents printed a CURES PAR for Patient DR for the first time on November 2, 2011, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since April 21, 2011.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient DR saw 12 prescribers and went to 14 pharmacies to obtain controlled substances. Patient DR received multiple prescriptions for hydrocodone/APAP 10/325mg from Dr. Diaz all written at or around the same time, which were dispensed at multiple pharmacies. Patient DR received oxycodone 30mg prescriptions from Dr. Diaz and from various other prescribers at or around the same time and had the prescriptions dispensed at multiple pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
4/20/2011	Oxycodone 30mg #90	8	David Niknia PA	College Pharmacy	RX# 1200249
5/23/2011	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 176389
6/4/2011	hydrocodone/APAP 10/325mg # 240	30	Dr. Diaz	Walgreen's #7305	RX# 617823
6/4/2011	hydrocodone/APAP 10/325mg d #240	30	Dr. Diaz	LM Caldwell Pharmacist	RX# 785574
6/24/2011	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 176389
4/21/11	oxycodone 30mg # 180	15	Dr. Diaz	Respondent Farmacia	RX# 176114
6/2/2011	oxycodone 30mg #90	15	David Niknia PA	College Pharmacy	RX# 1200760
6/15/2011	oxycodone 30mg #180	18	Dr. Diaz	Respondent Farmacia	RX# 181766
6/21/2011	oxycodone 30mg #100	8	Dr. Gholemreza Borazjani	College Pharmacy	RX# 1200948

v. On June 4, 2011, Patient DR received two prescriptions for hydrocodone/acetaminophen 10/325mg written by Dr. Diaz, which resulted in 7800mg of acetaminophen per day, well over the recommended 4000mg/day dose. Patient DR received 720 tablets of hydrocodone/acetaminophen in one month.

o. Patient JS

i. Respondents reported that Patient JS was diagnosed with disc joint disease, anxiety and arthritis. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including Fentanyl, OxyContin, oxycodone, Duragesic, Opana ER, hydromorphone, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient JS resided in Oxnard, approximately 40 miles away from Dr. Diaz's office. Patient JS had Medi-Cal, but paid cash between $830 and $1320 for OxyContin, $109 for oxycodone, and $660 for Opana ER.

ii. Patient JS presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Respondent Farmacia filled two prescriptions for OxyContin for this patient above the recommended dosing interval of twice daily, on the following days: 9/28/2010, 10/9/2010, 11/11/2010, and 11/24/2010. On or about November 11, 2010 and November 24, 2010, Respondent Farmacia filled two prescriptions for OxyContin for this patient.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient JS saw 7 prescribers and went to 10 pharmacies to obtain controlled substances. Patient JS received prescriptions for oxycodone 30mg and alprazolam 2mg from Dr. Diaz and various other prescribers at or around the same time and had the prescriptions dispensed at multiple pharmacies, as shown on the table below:

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Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
10/1/2010	oxycodone 30mg #90	15	David Nakia, PA	Von Pharmacy 2164	RX# 2019354
11/6/2010	oxycodone 30mg #60	15	Dr. Diaz	Respondent Farmacia	RX# 155839
10/14/2010	oxycodone 30mg #90	15	PA Nakia	CVS 9286	RX# 193623
10/28/2010	oxycodone 30mg #90	15	David Nakia, PA	Von Pharmacy 2164	RX# 2019469
11/12/2010	oxycodone 30mg #180	14	Dr. Diaz	Respondent Farmacia	RX# 159712 and 159713
11/24/2010	oxycodone 30mg #180	45	Dr. Diaz	LM Caldwell Pharmacist	RX# 776418
11/27/2010	oxycodone 30mg #90	23	Dr. Kevin Gohar	College Pharmacy	RX# 940735
2/15/2011	oxycodone 30mg #90	8	Dr. Borazjani	College pharmacy	RX# 944551
2/16/2011	oxycodone 30mg #180	30	Dr. Diaz	LM Caldwell Pharmacist	RX# 780495
2/24/2011	oxycodone 30mg #150	30	Dr. Diaz	Respondent Farmacia	RX# 170528
9/2/2010	alprazolam 2mg #40	20	PA Niknia	Vons Pharmacy 2164	RX# 4136427
9/6/2010	alprazolam 2mg #40	20	PA Niknia	CVS Pharmacy 9327	RX# 781199
9/28/2010	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 155749
3/5/2011	alprazolam 2mg #40	20	Dr. Gohar	College Pharmacy	RX# 945517
3/11/2011	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 170531
3/16/2011	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 172744
3/31/2011	alprazolam 2mg #40	20	PA Niknia	College Pharmacy	RX# 1400029

p. Patient AS

i. Respondents reported that Patient AS was diagnosed with severe multiple degenerative joint disease. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist.

ii. Patient AS presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On July 18, 2011, Respondent Farmacia dispensed RX# 184788

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or oxycodone 30mg #150 with incorrect directions. The directions on the prescription was 1-2 every 4-6 hours as needed for pain, pharmacy dispensed 1-2 every 3-4 hours as needed for pain. Patient AS was prescribed Suboxone after Dr. Diaz stopped prescribing controlled substances.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient AS. The PARs printed out on May 26, 2010 and June 21, 2010, showed that Patient AS was using multiple pharmacies to fill Dr. Diaz's prescriptions for oxycodone and hydrocodone/APAP.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient AS saw 6 prescribers and went to 9 pharmacies for controlled substances. On October 18, 2011, Dr. Diaz wrote two prescriptions for oxycodone 30mg IR for Patient AS. Dr. Diaz wrote prescriptions for hydrocodone/APAP 10/325mg and oxycodone 30mg for Patient AS at or around the same time, which Patient AS had dispensed at multiple pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
10/13/2009	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 116076
10/20/2009	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Leon's Pharmacy	RX# 1201475
5/5/2010	hydrocodone/APAP 10/325mg #240	20	Dr. Diaz	he Medicine Shoppe	RX# 1417214
5/6/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Leon's Pharmacy	RX# 1210068
5/21/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 145272
5/28/2010	hydrocodone/APAP 10/325mg #240	20	Dr. Diaz	The Medicine Shoppe	RX# 1417214
6/1/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Leon's Pharmacy	RX# 1210068
6/10/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 145272
6/23/2010	hydrocodone/APAP 10/325mg #240	20	Dr. Diaz	The Medicine Shoppe	RX# 1417214
8/12/2009	oxycodone 30mg #150	18	Dr. Diaz	Respondent Farmacia	RX# 120425
8/20/2009	oxycodone 30mg #150	14	Dr. Diaz	Respondent Farmacia	RX# 120945
11/17/2009	oxycodone 30mg #150	12	Dr. Diaz	Respondent Farmacia	RX# 128644
11/18/2009	oxycodone 30mg # 150	30	Dr. Diaz	Leon's Pharmacy	RX# 1203418

5/4/2010	oxycodone 30mg #150	12	Dr. Diaz	Leon's Pharmacy	RX# 1213113
5/10/2010	oxycodone 30mg # 150	12	Dr. Diaz	Respondent Farmacia	RX# 144271

v. Patient AS received between 720 and 960 tablets of hydrocodone/ acetaminophen prescribed by Dr. Diaz per month, which resulted in 9100mg/day of acetaminophen.

q. Patient BS

i. Respondents reported that Patient BS was diagnosed with post traumatic lumbar pain, post surgery. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including Morphine sulfate, Norco, and diazepam. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient BS did not have any significant pain or anxiety history prior to going to Dr. Diaz, yet Dr. Diaz began the patient's therapy with morphine sulfate 100mg, hydrocodone/APAP 10mg and diazepam 10mg.

ii. Patient BS' driver's license showed his address in Malibu, approximately 60 miles from Dr. Diaz's office and 17 miles from Respondent Farmacia's store. It was unusual for a patient living in Malibu to travel to see a prescriber in Santa Barbara and then travel to Oxnard to have his prescription filled.

iii. Respondents printed out Patient BS' PAR for the first time on October 6, 2011, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since November 5, 2010. Respondents chose to wait one year to print out the patient's PAR.

iv. Pursuant to CURES reports for January 1, 2009 to March 11, 2013, Patient BS saw 7 prescribers and went to 7 pharmacies. Patient BS was placed on Suboxone, a treatment for narcotic addiction, after Dr. Diaz stopped prescribing for the patient.

r. Patient VV (1985)

i. Respondents reported that Patient VV (1985) was diagnosed with chronic lumbar disease due to a work injury. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, methadone, Norco, and

Xanax. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient VV (1985) resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient VV (1985) paid for his controlled substance prescriptions in cash.

ii. Patient VV (1985) presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. RX# 186735 for oxycodone 30mg was post-dated by Dr. Diaz to August 10, 2011. Respondent Farmacia received the prescription and verified it on July 29, 2011. On December 30, 2011, Respondent Farmacia dispensed RX# 200057 and RX# 200058, which Dr. Diaz authorized to refill early. On October 29, 2011, Dr. Diaz authorized refills on RX# 194078 for alprazolam 2mg and made a note on the prescription "must last 90 days", and then on November 4, 2011, he wrote another prescription for VV (1985) for alprazolam 2mg.

iii. Patient VV (1985) had no significant pain or anxiety history 12 months prior to seeing Dr. Diaz, yet Dr. Diaz began therapy with methadone 10mg, hydrocodone/APAP 10/325mg, oxycodone 30mg and alprazolam 2 mg.

iv. Respondents first printed this patient's CURES PAR on October 6, 2011, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since January 4, 2010. Respondents chose to wait over 1.5 years to print out the patient's PAR.

v. Pursuant to CURES, Patient VV (1985) saw 4 prescribers and went to 9 pharmacies for the period of January 1, 2009 to March 11, 2013. Patient VV received multiple prescriptions for hydrocodone/APAP 10/325mg from Dr. Diaz at or around the same time and had these prescriptions dispensed at multiple pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
4/1/2010	hydrocodone/APAP 10/325mg received# 200	25	Dr. Diaz	Omac Pharmacy	RX# 6217769
4/13/2010	hydrocodone/APAP 10/325mg received# 240	30	Dr. Diaz	Leon's Pharmacy	RX# 1205660
4/26/2010	hydrocodone/APAP 10/325mg received # 200	25	Dr. Diaz	Omac Pharmacy	RX# 6217769

5/5/2010	hydrocodone/APAP 10/325mg received# 200	25	Dr. Diaz	Respondent Farmacia	RX# 143856

vi. Patient VV (1985) received between 400-440 tablets of hydrocodone/APAP prescribed by Dr. Diaz in one month, which resulted in the patient having nearly 5200mg/day of acetaminophen.

s. Patient VV (DOB 1982)

i. Respondents reported that Patient VV (1982) was diagnosed with post traumatic pain and fibromyalgia. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including OxyContin, Norco, Xanax, Soma, oxycodone, diazepam. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient VV (1982) resided in Oxnard, approximately 40 miles from Dr. Diaz's office and approximately 6 miles from Respondent Farmacia's store. Patient VV (1982) paid cash for her drugs including between $1072 and $1325 for OxyContin.

ii. Patient VV (1982) presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On March 18, 2010, Respondent Farmacia dispensed RX# 139040 for OxyContin 80mg, which was above the recommended dosing interval of twice daily. Patient VV (1982) was directed to take it three times daily.

iii. Respondents first printed this patient's CURES PAR on February 9, 2010, even though Patient VV (1982) had his controlled substance prescriptions filled by Respondent Farmacia since January 16, 2009. Respondents chose to wait over one year to print out the patient's PAR.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient VV (1982) saw 4 prescribers and went to 4 pharmacies.

Survey of Neighboring Pharmacies

33. As part of the Board's investigation, pharmacy questionnaires were sent to the pharmacists-in-charge of pharmacies within a 5 mile radius of Respondent Farmacia. The survey of the surrounding pharmacies/pharmacists indicated that Respondent Farmacia had different

dispensing practices for controlled substances than all of the other neighboring pharmacies. The quantities prescribed by Dr. Diaz were far more than what the surrounding pharmacies/ pharmacists saw in their practice. The dispensing ratio of Dr. Diaz's prescriptions, given the number of controlled substance prescriptions dispensed by a pharmacy, was significantly higher for Respondent Farmacia than for the neighboring pharmacies. Most patients in the distance analysis sample drove in excess of 80 miles in order to use Respondent Farmacia and Dr. Diaz. Data from the CURES report regarding volume of drugs dispensed for the time period specified showed that Respondent Farmacia filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring pharmacies. According to the data, patients were not travelling the long distances to patronize the neighboring pharmacies; they came specifically to Respondent Farmacia to fill Dr. Diaz's prescriptions.

FIRST CAUSE FOR DISCIPLINE

(Failure to Review Drug Therapy and Patient Medication Record)

34. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivisions (d) and (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents repeatedly failed to review the patient's drug therapy and medication record prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3 and 1761, which resulted in filling prescriptions early and, thereby, over dispensing controlled substances and/or dangerous drugs. Early refills of powerful and highly addictive controlled substances place patients at risk. The table below shows the pattern of consistent early refills of Dr. Diaz's prescriptions for controlled substances dispensed by Respondent Farmacia between January 1, 2010, and December 31, 2011.

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Early Fills

Previous RX					Following RX				
Patients	Date Dispensed	RX#	QTY	Day Supply	Date Dispensed	RX#	QTY	Day Supply	Days Early (from previous RX)
CA	9/22/2011	190444	150	37	9/28/2011	191041	150	37	31
CB	11/29/2010	160911	120	30	12/23/2010	163555	120	30	6
CB	4/14/2011	169952	60	30	5/9/2011	169952	60	30	5
CB	11/21/2011	193618	240	30	12/14/2011	193618	240	30	7
CB	11/21/2011	196220	60	30	12/14/2011	196220	60	30	7
CB	11/21/2011	196223	180	30	12/14/2011	198627	180	30	7
TB	11/29/2010	158714	248	31	12/2/2010	161501	60	60	28
TB	2/24/2011	166959	248	31	3/1/2011	166959	248	31	24
TB	2/24/2011	170449	240	30	3/1/2011	170451	50	2	24
TB	3/24/2011	166959	248	31	4/7/2011	166959	200	25	17
TB	4/7/2011	166959	200	25	4/21/2011	176129	240	30	11
TB	4/21/2011	176129	240	30	4/29/2011	176129	60	7	22
RB	4/14/2011	162940	120	30	5/6/2011	177703	120	30	8
RB	5/6/2011	177703	120	30	5/24/2011	177938	120	30	12
RB	8/2/2011	185216	120	30	8/25/2011	187340	120	30	7

RB	9/22/2011	189733	120	30	10/14/2011	192553	60	30	8
DG	2/10/2010	136027	90	30	3/5/2010	138396	90	30	6
DG	2/10/2010	136028	120	30	3/5/2010	138397	100	25	6
DG	3/26/2010	125304	100	25	3/26/2010	140353	100	25	25
AP	1/4/2010	132380	200	11	1/4/2010	132442	280	11	11
AP	4/22/2010	136047	240	30	5/11/2010	136047	240	30	11
AP	8/30/2010	153242	300	37	8/30/2010	153244	300	25	25
AP	9/27/2010	155550	300	8	9/27/2010	155553	300	8	8
AP	11/22/2010	160491	300	8	11/22/2010	160493	300	8	8
AP	3/1/2011	171072	300	18	3/14/2011	172357	300	25	5
JP	6/27/2011	182868	180	30	7/22/2011	185206	180	30	5
JP	6/27/2011	182689	180	30	7/22/2011	185207	180	30	5
DR	9/30/2011	187590	240	30	10/24/2011	187590	240	30	6
JS	3/11/2011	170531	60	30	3/16/2011	172744	60	30	25
AS	2/3/2011	168157	150	12	2/10/2011	168802	150	30	5
VV	10/29/2011	194078	90	15	11/7/2011	194558	120	30	6
VV	12/5/2011	197429	240	30	12/30/2011	200057	240	30	5
VV	12/5/2011	197429	180	30	12/30/2011	200058	180	30	5

SECOND CAUSE FOR DISCIPLINE

(Dispensing of Erroneous or Uncertain Prescriptions)

35. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivision (o), 4302, and 4113, in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct, in that Respondent Farmacia dispensed prescriptions which contained a significant error, omission, irregularity, uncertainty, ambiguity or alteration. Specifically, between January 1, 2010, and January 9, 2013, Respondent Farmacia dispensed the following prescriptions which were erroneous or uncertain:

Patients	RX Numbers	Reasons erroneous or uncertain
CA	157518	Incorrect directions
CA	157515, 157517	No date on RX
CA	173310	Incorrect directions
CB	190759, 193618	acetaminophen dosage exceeded recommended maximum dosage of 4000mg per day
CB	198621, 196223, 191000, 188580, 186341, 183974, 175515,172780	Opana ER dosage exceed recommended dosing interval of twice daily
SB	161418	OxyContin dosage exceeded recommended dosing interval of twice daily
DG	140353, 125304	Dispensed alprazolam 2mg twice on the same day with 2 different prescription numbers
DG	143720	OxyContin dosage exceeded recommended dosing interval of twice daily
DG	173557	Opana ER dosage exceeded recommended dosing interval of twice daily
AP	172358, 182237, 163618, 157709, 159583, 183920, 144039, 132125, 155549, 169296	acetaminophen dosage exceeded the recommended maximum dosage of 4000mg per day.
JP	199521	OxyContin dosage exceeded recommended dosing interval of twice daily
JP	187698, 187701, 187700	Date appeared altered
DR	176116	Opana ER dosage exceeded recommended dosing interval of twice daily

AS	184788	Dispensed with incorrect directions
VV (10/21/1985)	186735	Post-dated prescription

Patients	**Reasons erroneous or uncertain**
CB	CB received Suboxone indicated for opiate addiction concurrently with other narcotics.
TB	On 1/25/2011, 4/21/2011, 5/24/2011, 6/23/2011, 7/21/2011, 8/18/2011, 9/21/2011, 10/20/2011, and 11/2/2010, Patient TB received two prescriptions for oxycodone IR from Dr. Diaz with 2 different set of directions.
AP	Patient AP had forged prescriptions. AP received Suboxone indicated for opiate addiction concurrently with other narcotics.
AS	On 10/18/2011, Patient AS received two prescriptions for oxycodone 30mg IR from Dr. Diaz.
VV (1985)	On 10/29/2011, Dr. Diaz authorized refills on RX# 194078 for alprazolam 2mg and made a note on the prescription "must last 90 days", then on 11/4/2014 he wrote another prescription for alprazolam 2mg for the patient.

THIRD CAUSE FOR DISCIPLINE

(Failure to Assume Corresponding Responsibility)

36. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivision (d), (j) and (o), 4302, and 4113, on the grounds of unprofessional conduct, in that they failed to assume their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose, in violation of Code section 4306.5, Health and Safety Code section 11153, and California Code of Regulations, title 16, section 1761, subdivision (b). Respondents failed to exercise their best professional judgment and evaluate the totality of the circumstances (information from the patient, physician and other sources) to determine a prescription's legitimate medical purpose, in connection with Dr. Diaz's controlled substance prescriptions. Respondents ignored numerous warning signs or red flags that should put a reasonable and prudent dispensing pharmacist on notice that a prescription may not have

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been issued for a legitimate medical purpose. The red flags included, but were not limited to the following:

- the prescriber wrote a disproportionate number of prescriptions for controlled substances, especially since he was a general practitioner with no specialty indicated;
- numerous patients had addresses outside of the prescriber's and the pharmacy's normal trade area;
- patients living at the same address presented prescriptions for the same drugs;
- pattern of patients willing to pay cash for extremely expensive prescriptions, even when they had insurance;
- relatively high percentage of cash patients specific to prescriber,
- same or similar prescribing patterns for individual patients from an alleged pain specialist,
- consistent requests for early refills of highly addictive controlled substances;
- prescriptions written for medications that address the same medical problem and appear unreasonably duplicative;
- the same drug combinations were repeatedly prescribed for multiple patients by the same prescriber;
- irregular and questionable prescriptions, including scripts with missing information that is required for a valid prescription and dates written by someone other than the prescriber;
- patients starting with highest dosage available for a highly addictive controlled substance for a medical condition;
- patients being prescribed Suboxone, which is used to alleviate opiate addiction, and opiates at the same time or opiate prescriptions after Suboxone has been prescribed;
- and CURES reports, including those acquired by Respondents, showing prescriber's patients obtaining prescriptions for controlled substances from multiple prescribers and having the prescriptions filled at different pharmacies.

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Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 20 through 34 above, as though set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

(Unauthorized Variation from Prescriptions)

37. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that they deviated from the requirements of prescriptions without the prior consent of the prescriber, in violation of California Code of Regulation, title 16, section 1716. Specifically, Respondent Farmacia dispensed the following prescriptions incorrectly:

a. RX# 157518 - Wrong Directions. On October 19, 2010, Respondent Farmacia dispensed Dr. Diaz's prescription for Duragesic 100mcg for Patient CA with incorrect directions. The directions on the prescription stated that the medication patch was to be applied to skin every 72 hours, but Respondent Farmacia erroneously dispensed the medication with directions stating that it was to be applied every 12 hours (RX# 157518).

b. RX# 182081 - Wrong Drug. On September 6, 2011, Respondent Farmacia erroneously dispensed Dr. Diaz's prescription (dated June 17, 2011) that was written for morphine sulfate IR for Patient CA with the wrong drug. The prescription was for morphine sulfate IR, but Respondent Farmacia erroneously dispensed morphine sulfate ER (RX# 182081).

c. RX# 173310 - Wrong Directions. On March 21, 2011, Respondent Farmacia dispensed Dr. Diaz's prescription for oxycodone for Patient CA with incorrect directions. The prescription's directions stated that 1-2 pills were to be taken every 4 to 6 hours, but Respondent Farmacia erroneously dispensed the medication with directions stating 1-2 pills every 4 hours (RX# 173310).

d. RX# 170618 - Wrong Drug. On February 25, 2011, Respondent Farmacia erroneously dispensed Dr. Diaz's prescription that was written for Adderall for Patient DG with the wrong drug. The prescription was written for Adderall 30mg 3 daily #90, but Respondent Farmacia erroneously dispensed Adderall XR #90 (RX# 170618).

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e. RX# 195035 - Wrong Directions. On November 19, 2011, Respondent Farmacia dispensed Dr. Diaz's prescription for oxycodone 30mg IR for patient ZL with incorrect directions. The prescription was written for 2 tablets were to be taken every 4-6 hours, but Respondent Farmacia erroneously dispensed the medication with directions stating 1-2 tablets were to be taken every 4-6 hours (RX# 195035).

f. RX# 184788 - Wrong Directions. On July 18, 2011, Respondent Farmacia dispensed Dr. Diaz's prescription for oxycodone 30mg #150 for patient AS with incorrect directions. The prescription was written for 1-2 tablets every 4-6 hours, Respondent Farmacia dispensed the medication with directions stating 1-2 every 3-4 hours (RX# 184788).

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Required Records)

38. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivisions (j) and (o), 4302, and 4113, in that they violated Code sections 4081, subdivision (a), and 4105, subdivision (a), by failing to maintain the required records of sale, acquisition and disposition of dangerous drugs. Specifically, Respondents failed to account for prescription hard copies for RX# 151058, 175097, 193030, 125303, 125304, 163835, 163836, 137733, 137735, and 136927, which Respondent Farmacia dispensed between January 1, 2010 and January 9, 2013.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Produce Records Within Three Business Days of a Board Request)

39. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code section 4301, subdivisions (j) and (o), and 4113, in that they violated Code section 4105, subdivision (a), for not retaining on the licensed premise records of disposition in a readily retrievable form, and subdivision (f), for failing to provide the board with the requested records within three business days. Specifically, on April 19, 2013, a board inspector requested the original prescription records for RX# 151058, 175097, 193030, 125303, 125304, 163835, 163836, 137733, 137735, and 136927, which Respondent Farmacia dispensed between January 1, 2010 and January 9, 2013 and which were not received within three business days.

SEVENTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

40. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, 4302, and 4113, in that Respondents committed unprofessional conduct, as more fully discussed in paragraphs 20 through 37, above.

OTHER MATTERS

41. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 49140 issued to RSA Health Services Inc. dba Farmacia Estrella, RSA Health Services Inc. 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 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if it is revoked.

42. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 49140 issued to RSA Health Services Inc. dba Farmacia Estrella while Robert Andonian has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Robert Andonian 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 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 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 California State Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit License Number PHY 49140, issued to RSA Health Services Inc. dba Farmacia Estrella;

2. Revoking or suspending Original Pharmacist License Number RPH 47233, issued to Robert Andonian;

3. Prohibiting RSA Health Services 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 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if Pharmacy Permit Number 49140 issued to RSA Health Services Inc. dba Farmacia Estrella is revoked;

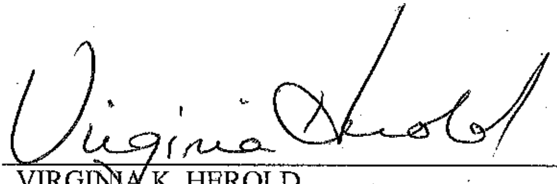
4. Prohibiting Robert Andonian from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if Pharmacy Permit Number PHY 49140 issued to RSA Health Services Inc. dba Farmacia Estrella is revoked;

5. Prohibiting Suzy Andonian from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if Pharmacy Permit Number 49140 issued to RSA Health Services Inc. dba Farmacia Estrella is revoked;

6. Ordering RSA Health Services Inc. dba Farmacia Estrella and Robert Andonian, jointly and severally, to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to business and Professions Code section 125.3;

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

DATED: 8/13/18



VIRGINIA K. HEROLD
Executive Officer
California State Board of Pharmacy
State of California
Complainant

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

In the Matter of the Accusation Against:	Case No. 5372
RSA HEALTH SERVICES INC., DBA FARMACIA ESTRELLA, ROBERT ANDONIAN AND SUZY ANDONIAN, OWNERS 5020 South C Street Oxnard, CA 93033 **Pharmacy Permit License No. PHY 49140** and **ROBERT ANDONIAN** 5020 South C Street Oxnard, CA 93033 **Pharmacist License Number RPH 47233,** Respondents.	**A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about December 1, 2008, the Board of Pharmacy issued Pharmacy Permit Number PHY 49140 to RSA Health Services Inc. to do business as Farmacia Estrella, located at 5020 South C Street, Oxnard, CA 93033 (Respondent Farmacia). The Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on December 1, 2016, unless renewed. Robert Andonian has been an owner and the Chief Executive Officer, President, and Pharmacist-In-Charge (PIC) of Respondent Farmacia since December 1, 2008. Suzy Andonian is and has been an owner and the Director of Respondent Farmacia since December 1, 2008.

3. On or about August 3, 1994, the Board of Pharmacy issued Pharmacist License Number RPH 47233 to Robert Andonian (Respondent Andonian). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2017, unless renewed.

JURISDICTION

4. This Accusation is brought before the California State 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 4300 of the Code provides, in part, that every license issued by the Board is subject to discipline, including suspension or revocation.

6. Section 4302 of the Code states:

"The board may deny, suspend, or revoke any license of a corporation where conditions exist in relation to any person holding 10 percent or more of the corporate stock of the corporation, or where conditions exist in relation to any officer or director of the corporation that would constitute grounds for disciplinary action against a licensee."

7. Section 4113 of the Code states, in part:

"(b) 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."

8. Section 118, subdivision (b), of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a

disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY AUTHORITY

9. Section 4301 of the Code states, in part:

"The board shall take action against any holder of a license who is guilty of unprofessional conduct . . . Unprofessional conduct shall include, but is not limited to, any of the following:

. . .

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

. . .

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

. . .

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

10. 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."

11. Section 4081 of the Code states, in part:

"(a) All records of manufacture and of sale, acquisition, receipt, shipment, or disposition of dangerous drugs or dangerous devices shall be at all times during business hours open to inspection by authorized officers of the law, and shall be preserved for at least three years from the date of making. A current inventory shall be kept by every manufacturer, wholesaler, third-party logistics provider, pharmacy, veterinary food-animal drug retailer, physician, dentist, podiatrist, veterinarian, laboratory, clinic, hospital, institution, or establishment holding a currently valid and unrevoked certificate, license, permit, registration, or exemption under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who maintains a stock of dangerous drugs or dangerous devices.

"(b) The owner, officer, and partner of a pharmacy, wholesaler, third-party logistics provider, or veterinary food-animal drug retailer shall be jointly responsible, with the pharmacist-in-charge, responsible manager, or designated representative-in-charge, for maintaining the records and inventory described in this section."

12. Section 4105 of the Code states, in part:

"(a) All records or other documentation of the acquisition and disposition of dangerous drugs and dangerous devices by any entity licensed by the board shall be retained on the licensed premises in a readily retrievable form.

. . .

"(c) The records required by this section shall be retained on the licensed premises for a period of three years from the date of making.

. . .

"(f) When requested by an authorized officer of the law or by an authorized representative of the board, the owner, corporate officer, or manager of an entity licensed by the board shall provide the board with the requested records within three business days of the time the request was made..."

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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, subdivision (a), of the Code states, in pertinent part:

"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 manager, administrator, owner, member, officer, director, associate, or partner had knowledge of 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 manager, 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.

1 (2) Where the license is denied or revoked, the prohibition shall continue until the
2 license is issued or reinstated."
3 15. Health and Safety Code section 11153 states:
4 "(a) A prescription for a controlled substance shall only be issued for a legitimate medical
5 purpose by an individual practitioner acting in the usual course of his or her professional practice.
6 The responsibility for the proper prescribing and dispensing of controlled substances is upon the
7 prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the
8 prescription. Except as authorized by this division, the following are not legal prescriptions: (1)
9 an order purporting to be a prescription which is issued not in the usual course of professional
10 treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of
11 controlled substances, which is issued not in the course of professional treatment or as part of an
12 authorized narcotic treatment program, for the purpose of providing the user with controlled
13 substances, sufficient to keep him or her comfortable by maintaining customary use."
14 **STATE REGULATORY AUTHORITY**
15 16. California Code of Regulations, title 16, section 1707.3 states:
16 "Prior to consultation as set forth in section 1707.2, a pharmacist shall review a patient's
17 drug therapy and medication record before each prescription drug is delivered. The review shall
18 include screening for severe potential drug therapy problems."
19 17. California Code of Regulations, title 16, section 1716 states, in part:
20 "Pharmacists shall not deviate from the requirements of a prescription except upon the
21 prior consent of the prescriber or to select the drug product in accordance with Section 4073 of
22 the Business and Professions Code."
23 18. California Code of Regulations, title 16, section 1761 states:
24 "(a) No pharmacist shall compound or dispense any prescription which contains any
25 significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any
26 such prescription, the pharmacist shall contact the prescriber to obtain the information needed to
27 validate the prescription.
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"(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 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.

20. **DRUG CLASSIFICATIONS**

Brand Name(s)	Generic Name	Dangerous Drug Per Bus. & Prof. Code § 4022	Scheduled Drug per Health & Safety Code (HSC)	Indications For Use
Ambien	Zolpidem (non-barbiturate, non-benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(32)	Insomnia
Ativan	Lorazepam 2mg	Yes	Schedule IV HSC § 11057(d)(16)	Anxiety
Dolophine	Methadone	Yes	Schedule II HSC § 11055c(14)	Pain, Narcotic Addiction
Dilaudid	Hydromorphone	Yes	Schedule II HSC § 11055(b)(1)(J)	Pain
Duragesic	Fentanyl	Yes	Schedule II HSC § 11055(c)(8)	Pain
Klonopin	Clonazepam 2mg	Yes	Schedule IV HSC § 11057(d)(7)	Anxiety
	Morphine Sulphate IR (Immediate Release) or Morphine Sulphate ER (Extended Release)	Yes	Schedule II HSC § 11055(b)(1)(L)	Pain

Norco[1], Vicodin ES, Lorcet	Hydrocodone/ acetaminophen (APAP)	Yes	Schedule II HSC § 11055(b)(1)(I)	Pain
Opana ER	Hydromorphone	Yes	Schedule II HSC § 11055(b)(1)(N)	Pain
OxyContin	Oxycodone	Yes	Schedule II HSC § 11055(b)(l)(M)	Pain
Soma[2]	Carisoprodol	Yes	Not scheduled in California. Schedule IV under federal law (21 CFR § 1308.14(c)(6))	Muscle relaxant
Subutex, Suboxone	Buprenorphine	Yes	Schedule V HSC § 11058(d)	Narcotic Addiction
Valium	Diazepam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(9)	Anxiety
Xanax	Alprazolam (non-barbiturate, benzodiazepine sedative hypnotic)	Yes	Schedule IV HSC § 11057(d)(1)	Anxiety

FACTUAL SUMMARY

21. Beginning in January 2013, the Board conducted an investigation into Respondent Farmacia. On or about January 5, 2012, the Board was notified that Dr. Julio Gabriel Diaz also known as Otero Julio Gabriel Diaz, MD (Dr. Diaz) was arrested on federal painkiller trafficking charges. He was linked to a string of drug overdose deaths. Dr. Julio Diaz, a General Practice physician with secondary practice areas in Geriatrics and Pathology, operated Family Medical Clinic, located at 510 Milpas Street, Santa Barbara, CA 93103. Respondent Farmacia, located at 5020 South C Street, Oxnard, CA 93033, dispensed numerous prescriptions for controlled

[1] Norco 10/325 mg contains 10 mg of hydrocodone and 325 mg of acetaminophen (brand name, Tylenol). The maximum recommended dosage for acetaminophen is four (4) grams or 4000mg every 24 hours.

[2] Drug abusers are known to combine Soma with hydrocodone to produce similar effects to those of Heroin.

substances written by Dr. Diaz, despite the fact that the distance between Dr. Diaz's office and Respondent Farmacia's store was approximately 40 miles.

22. Dr. Diaz was arrested pursuant to a criminal complaint filed in United States District Court that charges him with illegal distribution of controlled substances. The affidavit in support of the criminal complaint provides that Dr. Diaz wrote prescriptions for powerful painkillers, such as OxyContin, for "patients" who were drug addicts with no legitimate need for the drugs. Some of Dr. Diaz's "patients" diverted the pills they received to the black market and/or suffered fatal overdoses from the narcotics. On or about August 28, 2015, Dr. Diaz was convicted of 79 counts of unlawful distribution of a controlled substance in violation of 21 U.S.C. section 841. Twenty-six of the charges relate to oxycodone, ten of the charges relate to methadone, seven of the counts relate to hydromorphone, ten of the charges relate to fentanyl, eleven of the charges relate to hydrocodone, ten of the charges relate to alprazolam, and five of the charges related to the distribution of various controlled substances to a minor. The Court sentenced Dr. Diaz to 327 months in federal prison.

23. Effective November 2, 2012, the California Medical Board revoked Dr. Diaz's medical license in the case entitled *In the Matter of the Accusation against Otero Julio Gabriel Diaz, M.D.*, case no. 06-2010-209660. Dr. Diaz's license was revoked for committing gross negligence and incompetence and for excessive prescribing narcotic medications to a patient.

24. On or about January 9, 2013, two Board inspectors conducted an inspection of Respondent Farmacia, located at 5020 South C Street, Oxnard, CA 93033. When questioned about Dr. Diaz's prescriptions, Respondent Andonian, the Pharmacist-in-Charge, stated that Dr. Diaz was a pain treating physician who was arrested last year. He stated that when he bought the pharmacy, he had concerns on dispensing drugs prescribed by Dr. Diaz, however, he contacted the local pharmacies and they assured him Dr. Diaz was legitimate. As a result, he began to dispense drugs prescribed by Dr. Diaz.

25. The Board inspectors selected 19 random patients of Dr. Diaz who filled their prescriptions at Respondent Farmacia to profile and asked Respondent Andonian to complete questionnaires regarding these patients. Amongst the questions asked were the patients'

diagnoses, the methods of payment, and the nature of the prescriber's practice. The Board inspectors also requested prescription records of the randomly selected patients. On or about January 22, 2013, the Board inspector received the requested documents from Respondent Farmacia.

26. As part of the investigation, the Board inspectors also obtained CURES[3] data for Respondent Farmacia for the period of December 1, 2008 to December 17, 2012, CURES Patient Activity Reports (PARs) for the 19 randomly selected patients for the period of January 1, 2009 to March 11, 2013, and CURES data for surrounding pharmacies.

27. The CURES data for Respondent Farmacia revealed that Respondent Farmacia dispensed a total of 24,107 controlled substance prescriptions from December 1, 2008, to December 17, 2012. During this period, Respondent Farmacia dispensed 3,986 controlled substance prescriptions written by Dr. Diaz, which represented 18.37% of the total controlled substance prescriptions dispensed by Respondent Farmacia. Dr. Diaz was the pharmacy's largest controlled substance prescriber for a total of 647,159 dosage units dispensed. Of the 24,107 controlled substance prescriptions dispensed, approximately 40% of the dispensed prescriptions were for cash patients.[4]

28. The CURES data also showed Dr. Diaz's questionable prescribing pattern. Dr. Diaz normally prescribed large quantities of opiates in combination with minor tranquilizers (anxiolytic or anti-anxiety). The usual combination included hydromorphone, hydrocodone/acetaminophen, oxycodone, methadone, fentanyl, OxyContin, morphine sulfate

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[3] CURES is an acronym for "California Utilization Review and Evaluation System." It contains over 100 million entries of controlled substance drugs that were dispensed in California. Pharmacists and prescribers can register with the Department of Justice to obtain access to the CURES data through the California Prescription Drug Monitoring Program (PDMP). Patient Activity Reports (PARs) are provided and reflect all controlled substances dispensed to an individual. CURES herein refers to CURES in general and PARs. Pharmacies are required to report to the California Department of Justice every schedule II, II and IV drug prescription under Health and Safety Code section 11165, subdivision (d).

[4] In cases of drug diversion, most of the medications purchased from a pharmacy are purchased without the use of insurance to avoid tracking of activity. If the patients are fictitious persons, there is no insurance to bill. The bypassing of insurance is commonly referred to as "paying cash." Frequently, the medications are purchased with actual money but "paying cash" could also mean using a debit or credit card. The use of electronic payment is rare for the same reason drug diverters avoid using insurance.

with alprazolam, clonazepam, lorazepam, and/or diazepam in large quantities. He prescribed on average 3 to 4 opiate prescriptions with 1 to 2 anxiolytic prescriptions to his patients. The table below contains a list of selected drugs and the average quantities of those drugs prescribed by Dr. Diaz and dispensed by Respondent Farmacia for the period of January 1, 2011 to January 9, 2012.

Name of Drug	Number of Pills
hydrocodone/APAP 10/325mg	229
oxycodone 30mg	197
methadone 10mg	205
alprazolam 2mg	97
hydromorphone 8mg	170
OxyContin 80mg	118
Opana ER 40mg	105
morphine sulfate 100mg	98
morphine sulfate 30mg	164
diazepam 10mg	94
hydrocodone/APAP 10/500mg	258
clonazepam 2mg	75

29. For the randomly selected patients of Dr. Diaz, there were many irregularities found with prescriptions and dispensing methods, including: (1) a general practitioner that was prescribing an excessive amount of narcotics; (2) consistent early fills of controlled substance prescriptions; (3) patients paying cash for expensive narcotics, even when they had insurance; (4) failure to evaluate CURES Patient Activity Reports (PARs) for suspicious prescriptions; (5) evidence of doctor/pharmacy shopping by the patients; and (6) evidence of a pattern of prescribing controlled substances in large and redundant quantities and in questionable combinations, including combinations that constituted therapy duplication.

30. Furthermore, the patients' records showed that the total distance these patients travelled to obtain controlled substances was objectively and clearly excessive. 19 of the 19 patients resided outside the immediate trading area of Dr. Diaz. 4 of the 19 patients showed addresses outside the normal trading area of the pharmacy, which is considered to be 5 miles from the patient's residence or adjacent to the prescriber's office. The distance between Dr. Diaz's office and Respondent Farmacia was approximately 40 miles. The distance travelled for the randomly selected patients from home to Dr. Diaz office, then to the pharmacy and back home

was 71.92 miles for the shortest distance to 220 miles for the longest distance roundtrip.[5] The average distance was 82.47 miles. 6 of the 19 patient's home addresses were not recognized by MapQuest. Two patients had the same address.

31. Respondents failed to maintain records or files on the drug therapy for these patients.

32. A detailed review of the randomly selected patients' records revealed the following facts:

a. Patient CA

i. Respondents reported that Patient CA was diagnosed[6] with chronic lumbar, cervical pain, and severe intractable fibromyalgia. Dr. Diaz prescribed pain and anxiety medications for Patient CA that Respondent Farmacia dispensed, including oxycodone, OxyContin, hydrocodone/APAP (Norco), Methadone, Morphine Sulfate, Duragesic, alprazolam (Xanax), diazepam (Valium), and clonazepam (Klonopin), among others. Patient CA received most of her pain medication prescriptions from Dr. Diaz, despite the fact that Dr. Diaz was not a pain specialist. Patient CA was on Medi-Cal; however, when Medi-Cal did not pay for the medications, Patient CA paid over $500.00 for her OxyContin, $300.00 for oxycodone, and hundreds of dollars for various other drugs. According to the patient profile kept by Respondent Farmacia, Patient CA gave an address to the pharmacy that could not be found through MapQuest.

ii. Patient CA presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On October 19, 2010, Respondent Farmacia dispensed RX# 157515 (oxycodone 30mg) and 157517 (methadone 10mg), even though the prescription document itself did not have a date on it, as required. On September 21, 2011, Patient CA received two prescription hardcopies for oxycodone 30mg IR, written by Dr. Diaz. In addition,

[5] Distances were determined by using MapQuest.
[6] Patients' diagnoses were provided by PIC Andonian in the Board's pharmacy patient questionnaire, which was provided by the Board during its investigation to determine what PIC Andonian knew about the patients, the prescribers, their diagnoses and the patient's overall drug therapy.

1 the date on the prescriptions was not written in the prescriber's handwriting on either of the
2 prescription hardcopies. Nevertheless, Respondent Farmacia dispensed these prescriptions. On
3 November 16, 2011, Patient CA received two prescription hardcopies for oxycodone 30mg IR,
4 written by Dr. Diaz, which Respondent Farmacia dispensed.

5 iii. In response to the Board inspector's records request, Respondents provided
6 the Board with the CURES Patient Activity Reports (PARs) that it had printed out for Patient CA.
7 The PARs printed out on March 26, 2010, May 12, 2011, and October 6, 2011, clearly showed
8 that Patient CA was having Dr. Diaz's prescriptions for oxycodone 30mg and
9 hydrocodone/APAP 10/325 mg dispensed at different pharmacies at or around the same time.
10 Patient CA also used different addresses at different pharmacies. On the PAR printed out on
11 October 6, 2011, Respondent Farmacia's staff wrote a note that they discussed with Patient CA
12 and Dr. Diaz the fact that the patient was obtaining controlled substances prescriptions from more
13 than one prescriber at the same time, and it was noted that the patient was having these
14 prescriptions dispensed by more than one pharmacy. Despite the note, the PAR printed on
15 November 2, 2011, showed that Patient CA continued to use more than one pharmacy to obtain
16 oxycodone and that Respondent Farmacia kept dispensing her oxycodone prescriptions.

17 iv. Pursuant to CURES reports for the period of January 1, 2009, to March 11,
18 2013, Patient CA saw 12 prescribers and went to 16 pharmacies to obtain controlled substances.

19 b. Patient CB

20 i. Respondents reported that Patient CB was diagnosed with post traumatic
21 chronic pain. Dr. Diaz prescribed pain and anxiety medications for Patient CB that Respondent
22 Farmacia dispensed, including hydrocodone/APAP, Opana ER, oxycodone, OxyContin,
23 alprazolam, and carisoprodol, among others. Patient CB received most pain medication
24 prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Per his patient
25 profile kept by Respondent Farmacia, Patient CB resided in Ventura, California. The distance
26 between the patient's residence and Dr. Diaz's office was approximately 30 miles and the
27 distance between the patient's residence to Respondent Farmacia's store was approximately 10
28 miles.

ii. Patient CB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On October 25, 2011, Respondent Farmacia dispensed two prescriptions for hydrocodone/APAP 10/325mg prescribed by Dr. Diaz: RX # 190759 for 240 pills (30 day supply) and 193618 for 240 pills (30 day supply). The recommended maximum daily dose of acetaminophen is 4000mg; Patient CB would have the equivalent of 5200mg of acetaminophen per day. Respondent Farmacia also dispensed prescriptions of Opana ER for Patient CB above the recommended dose. The recommended dose for Opana ER was twice daily; Patient CB was directed to take it three times daily for RX# 198621, 196223, 191000, 188580, 186341, 183974, 175515, and 172780.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient CB. The PAR printed out on June 3, 2010, clearly shows that Patient CB was being treated with Suboxone, which is used for treatment of narcotic addiction. Respondents did not contact the prescriber to determine if the drug was used for pain or addiction. The PARs printed on October 6, 2011, and November 2, 2011, also show that the patient was treated with Suboxone while being prescribed other narcotics by Dr. Diaz.

iv. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient CB saw 4 prescribers and went to 6 pharmacies to obtain controlled substances. These reports show that Patient CB had no prior history of anxiety 16 months prior to going to Dr. Diaz, yet Dr. Diaz started therapy with alprazolam 2mg, the highest dose of alprazolam available.

c. Patient TB

i. Respondents reported that Patient TB was diagnosed with broken or crushed legs and a spinal injury due to a car accident and was in a wheelchair. Dr. Diaz prescribed pain and anxiety medications for Patient TB that Respondent Farmacia dispensed, including oxycodone, APAP/oxycodone, morphine sulfate, hydromorphone, Fentanyl, Norco, chlordiazepoxide (brand name is Librium, which is used for anxiety), among others. Patient TB received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain

specialist. Per his California driver's license, Patient TB resided in Palm Desert and travelled over 220 miles from Palm Desert to Santa Barbara to be treated by Dr. Diaz and to have his prescription filled in Oxnard. Patient TB had insurance but paid cash for oxycodone, OxyContin and hydrocodone/ acetaminophen on various occasions.

ii. Patient TB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Patient TB received two prescriptions for oxycodone IR prescribed by Dr. Diaz on each of the following dates, some with different directions: 11/2/2010, 1/25/2011, 4/21/2011, 5/24/2011, 6/23/2011, 7/21/2011, 8/18/2011, 9/21/2011, and 10/20/2011. As a result, Patient TB received prescriptions for the same medication with different directions at the same time.

iii. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient TB saw 14 prescribers and went to 11 pharmacies to obtain controlled substances. Patient TB did not have a significant pain or anxiety history prior to seeing Dr. Diaz. He received only hydrocodone products from various doctors 15 months prior to seeing Dr. Diaz, yet Dr. Diaz began therapy with oxycodone 30mg, hydrocodone/acetaminophen 10/325, OxyContin 80mg, methadone 10mg and alprazolam 2mg.

d. Patient RB

i. Respondents reported that Patient RB was diagnosed with degenerative Spine Scoliosis. Dr. Diaz prescribed pain and anxiety medications for Patient RB that Respondent Farmacia dispensed, including OxyContin, oxycodone, hydromorphone, Opana ER, methadone, alprazolam, Soma, and zolpidem, among others. Patient RB received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient RB resided in Oxnard. The distance between the patient's residence and Dr. Diaz's office was 36 miles.

ii. Patient RB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On September 15, 2011, Respondent Farmacia dispensed RX# 189739, 189738, 189737, and 189734, even though the date did not appear to have been written in Dr. Diaz's handwriting.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient RB. The PAR printed out on October 6, 2011, shows that on August 17, 2011, Patient RB went to two pharmacies to obtain pain medications prescribed by Dr. Diaz, one in Oxnard and the other in Santa Barbara, over 30 miles away from each other to have medication dispensed on the same date.

iv. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient RB saw 6 prescribers and went to 7 pharmacies to obtain controlled substances. While going to Dr. Diaz, Patient RB received methadone and hydrocodone/acetaminophen 10/325mg prescriptions from Dr. Diaz and from another prescriber in Ventura, California. Patient RB had the prescriptions that were written by the other prescriber filled at a different pharmacy.

e. Patient SB

i. Respondents reported that Patient SB was diagnosed with multiple spinal fractures. Dr. Diaz prescribed pain and anxiety medications for Patient SB that Respondent Farmacia dispensed, including OxyContin, oxycodone, Opana ER, alprazolam, methadone, and Soma. The patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient SB had the same address as Patient RB in Oxnard. The distance between the patient's residence and Dr. Diaz's office was 36 miles.

ii. Patient SB presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On December 2, 2010, Patient SB received RX# 161418 OxyContin above the recommended dosing interval of twice daily. Patient SB was directed to take it three times daily. On September 15, 2011, Respondent Farmacia dispensed RX# 189730 and 189731, even though the date on the prescription did not appear to have been written in Dr. Diaz's handwriting.

iii. Pursuant to CURES reports for the period of January 1, 2009, to March 11, 2013, Patient SB had no pain or anxiety history 18 months prior to going to Dr. Diaz, yet Dr. Diaz began treatment with oxycodone 30mg, OxyContin 80mg (the highest dosage available), morphine sulfate 100mg, and alprazolam 2mg (the highest dosage available).

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f. Patient JC

i. Respondents reported that Patient JC was diagnosed with chronic pain post trauma from an automobile/motorbike accident. Dr. Diaz prescribed pain and anxiety medications for Patient TB that Respondent Farmacia dispensed, including oxycodone, OxyContin, Norco, and alprazolam, among others. Patient JC received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient JC had no pain history prior to September 30, 2009 and seeing Dr. Diaz, yet Dr. Diaz began her therapy with OxyContin 40mg, OxyContin 80mg, and hydrocodone/APAP 10/325mg.

ii. Patient JC resided in Port Hueneme, California. The distance from the patient's residence to Dr. Diaz's office was approximately 40 miles. Patient JC had insurance but paid between $800 and $1500 cash for OxyContin.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient JC saw 3 prescribers and went to 4 pharmacies to obtain controlled substances. Patient JC received multiple prescriptions from Dr. Diaz for hydrocodone/APAP 10/325 and alprazolam 2mg at or around the same time, which were dispensed at different pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
1/14/2010	hydrocodone/APAP 10/325 #240	20	Dr. Diaz	Respondent Farmacia	RX# 125584
1/28/2010	hydrocodone/APAP 10/325 #180	30	Dr. Diaz	Omac Pharmacy	RX# 6193181
3/15/2010	hydrocodone/APAP 10/325 #240	20	Dr. Diaz	Respondent Farmacia	RX# 125584
3/15/2010	hydrocodone/APAP 10/325 # 200	25	Dr. Diaz	Omac Pharmacy	RX# 6224819
1/14/2010	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 125582
1/28/2010	alprazolam 2mg #60	30	Dr. Diaz	Omac Pharmacy	RX# 6193182
2/15/2010	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 125582
2/25/2010	alprazolam 2mg #60	30	Dr. Diaz	Omac Pharmacy	RX# 6193182

g. Patient DG

i. Respondents reported that Patient DG was diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and injury to spine and neck, and was an Iraq War veteran. He resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, OxyContin, Norco, Opana ER, Fentanyl, Xanax, diazepam, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient DG had insurance, but paid between $350.00 and $2856.00 cash for his OxyContin. On December 28, 2010, Patient DG received prescriptions for OxyContin 80mg #120 which the patient wanted changed to OxyContin 40mg #240. Patient DG paid cash for the medication. The OxyContin 80mg prescription costs $1895.95 and the OxyContin 40 mg prescription costs $2856.00. It's unusual for a patient to request a medication that costs about $1,000 more than originally prescribed drug.

ii. Patient DG presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Respondent Farmacia dispensed alprazolam 2mg on March 26, 2010 for this patient twice on the same day with two different prescription numbers (RX# 140353 and RX # 125304). On May 4, 2010, Respondent Farmacia dispensed RX# 143720 for OxyContin above the recommended dosing interval of twice daily. Patient DG was directed to take it three times daily. On March 28, 2011 dispensed RX# 173557 for Opana ER 40mg above the recommended dosing interval of twice daily. Patient DG was directed to take it three times daily.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient DG saw 4 prescribers and went to 7 pharmacies to obtain controlled substances. CURES PAR data showed that Patient DG had no prior history of pain or anxiety 4 months prior to going to Dr. Diaz, yet Dr. Diaz began therapy with alprazolam 2mg and a large dose of hydrocodone/APAP 10/325mg.

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h. Patient JH

i. Respondents reported that Patient JH was diagnosed with bilateral foot pain, Charcott deformity and fractures, and extreme obesity. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, OxyContin, hydromorphone, Xanax, diazepam, and alprazolam. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Respondent resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient JH had insurance, but he paid cash for OxyContin, methadone and amphetamine. On November 16, 2010, Patient JH paid $1701.00 cash for OxyContin, RX# 159970.

ii. Patient JH presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On both September 28, 2011, and November 23, 2011, Patient JH received two prescriptions for Dilaudid 8mg written by Dr. Diaz with two different directions. According to CURES data and the patient profile kept by Respondent Farmacia, on October 3, 2011, Respondent Farmacia dispensed hydormorphone 8mg RX # 191305 three different times for 100, 120, and 160 tablets, and RX# 191314 for 120 tablets, for a total of 400 tablets of hydromorphone 8mg, when the prescription was written for 280 tablets.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient JH saw 6 prescribers and went to 3 pharmacies to obtain controlled substances.

i. Patient KL

i. Respondents reported that Patient KL was diagnosed with chronic back pain, spinal injury and neck pain. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including methadone, oxycodone, hydromorphone, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient KL resided in Oxnard, approximately 40 miles from Dr. Diaz's office.

ii. Patient KL presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On October 12, 2010, Patient KL received two prescriptions for

Soma with different directions. Respondent Farmacia verified with Dr. Diaz to dispense both prescriptions at the same time; however, when Dr. Diaz said "yes" to dispensing both, this was a red flag for the pharmacy.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient KL. The PAR printed out on February 26, 2010, showed that Patient KL was using multiple pharmacies to obtain controlled substances. There was a note made on the PAR which stated, discussed with patient on April 20, 2010, about using multiple pharmacies. However, the PAR printed on May 12, 2011, showed that Patient KL continued to go to multiple pharmacies to have his prescriptions for controlled substances filled and that Respondent Farmacia continued to dispense controlled substances for him.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient KL saw 10 prescribers and went to 11 pharmacies to obtain controlled substances. Patient KL went to Dr. Diaz and various other prescribers and pharmacies to obtain hydrocodone/APAP 10/325mg and alprazolam (various strengths) at or around the same time, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
1/11/2010	alprazolam 0.5mg #45	30	Dr. Vance Snyder	Biocare RX Specialty Pharmacy	RX# 4410545
1/14/2010	alprazolam 2mg #100	30	Dr. Diaz	Omac Pharmacy	RX# 6209747
2/26/2010	hydrocodone/APAP 10/325 #240	30	Dr. Diaz	Respondent Farmacia	RX# 137733
2/26/2010	alprazolam 2mg #100	25	Dr. Diaz	Respondent Farmacia	RX# 137735
3/9/2010	alprazolam 0.5mg #90	30	Dr. Vance Snyder	Biocare RX Specialty Pharmacy	RX# 4411452
3/9/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz.	Omac Pharmacy	RX# 6209744
10/4/2010	alprazolam 2mg # 100	25	Dr. Diaz	Omac Pharmacy	RX# 6242133
10/12/2010	alprazolam 2mg #100	25	Dr. Diaz	Respondent Farmacia	RX# 156991
10/12/2010	hydrocodone/APP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX # 156988
10/18/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Omac Pharmacy	RX# 6242132

v. The hydrocodone and alprazolam prescriptions had refills, which Patient KL had dispensed monthly at the respective pharmacies.

vi. Patient KL received an average of 16 tablets of hydrocodone/APAP per day, which resulted in Patient KL receiving 5200mg of acetaminophen per day. The combination above of alprazolam 2mg and hydrocodone/APAP 10/325mg prescribed by Dr. Diaz for Patient KL was dispensed monthly at Omac Pharmacy and Respondent Farmacia.

l. Patient ZL

i. Respondents reported that Patient ZL was diagnosed with multiple traumas and fractures with joint hardware from a car accident. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including methadone, oxycodone, hydrocodone and ibuprofen, Promethazine and Codeine, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist.

ii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient ZL saw 17 prescribers and went to 12 pharmacies to obtain controlled substances. Prior to going to Dr. Diaz, Patient ZL only received hydrocodone/APAP 10/325mg for pain, yet Dr. Diaz began therapy with oxycodone 30mg, hydrocodone/APAP 10/325mg and methadone all at the same time.

j. Patient RM

i. Respondents reported that Patient RM was diagnosed with postoperative pain right shoulder, back and spinal disease. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, hydromorphone, Norco, Xanax, and Soma. Patient RM saw Dr. Diaz for pain medications while going to other prescribers for primary care drugs, despite Dr. Diaz not being a pain specialist. Patient RM resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient RM had insurance but paid cash for his pain medications.

ii. On November 2, 2011, Respondent Farmacia dispensed RX# 164322 for hydromorphone with incomplete directions.

iii. Patient RM's patient profile kept by Respondent Farmacia revealed that prior to going to Dr. Diaz, the quantity and numbers of pain medications received were less than from other prescribers. As soon as he saw Dr. Diaz, the quantity and number were increased.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient RM saw 17 prescribers and went to 11 pharmacies to obtain controlled substances.

k. Patient AP

i. Respondents reported that Patient AP was diagnosed with post herpetic neuralgia, post traumatic disc, herniated L4L5, and bilateral leg pain neuropathy. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, Norco, Xanax, Soma, methadone, and Suboxone. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient AP resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient AP paid cash for her pain medications. Respondents discovered that Patient AP had forged prescriptions, yet Respondent Farmacia continued to fill most of her prescriptions for controlled substances.

ii. Patient AP presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Patient AP received two prescription hardcopies for oxycodone 30mg on each of the following days: 8/27/2010, 9/27/2010, 11/22/2010, 12/20/2010, 8/4/2011, 9/1/2011, 9/29/2011, and 10/27/2011. In addition to the two prescriptions, some of the prescriptions written for the same drug and strength had different directions. On numerous occasions, Respondent Farmacia dispensed hydrocodone/APAP products prescribed by Dr. Diaz, which included well above the recommended dose of 4000mg/day of acetaminophen. For example, RX# 172358, 182237, 155549, 169296, 163618, 157709, and 159583, resulted in the patient taking 6000mg/day of acetaminophen; RX# 183920 resulted in the patient taking 8000 mg/day of acetaminophen; and RX# 144039 and 132125, resulted in the patient taking 5200mg/day of acetaminophen.

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iii. Patient AP received Suboxone, used for treatment of narcotic addiction, prescribed by Dr. Diaz and dispensed at Respondent Farmacia while other narcotics were being prescribed and dispensed.

iv. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient AP. The PAR printed out on May 26, 2010, showed that Patient AP was using multiple pharmacies to obtain controlled substances. There was a note made on the PAR which said "patient assured she will no longer get controls at other pharmacies". However, Patient AP continued to go to other pharmacies to have her prescriptions for controlled substances filled, which was clearly evident by the PARs printed after this date. On the PAR printed on August 3, 2010, Respondent Farmacia's staff noted that they talked to patient about requesting early refills of her controlled substance prescriptions. The PAR printed on October 6, 2011 showed Patient AP using multiple pharmacies for Dr. Diaz's controlled substance prescriptions and another note was made to discuss with the patient about getting the same drugs at two different pharmacies. The PARs printed on November 2, 2011 and December 8, 2011 showed Patient AP continued to use multiple pharmacies to fill Dr. Diaz's controlled substance prescriptions. On December 27, 2011, a note was made on the PAR printed out on December 8, 2011, that Respondent Farmacia's staff person spoke to Dr. Diaz regarding Patient AP's early refills on oxycodone. The PAR printed on May 17, 2012 showed patient AP continued using multiple pharmacies and prescribers to obtain controlled substances. These PARs also showed that Patient AP used different addresses at different pharmacies.

v. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient AP saw 4 prescribers and went to 10 pharmacies to obtain controlled substances. Patient AP received multiple prescriptions for hydrocodone/APAP and alprazolam 2mg at or around the same time from Dr. Diaz, but went to numerous pharmacies to have them dispensed, as shown in the table below:

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Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
1/15/2010	hydrocodone/APAP 10/500mg # 240	30	Dr. Diaz	Respondent Farmacia	RX# 133485
1/18/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Omac Pharmacy	RX# 6199498
1/25/2010	hydrocodone/APAP 10/500 #200	25	Dr. Diaz	Federal Drug	RX# 4515808
1/27/2010	hydrocodone/APAP 10/650 #30	7	Dr. Diaz	Respondent Farmacia	RX# 132125
1/28/2010	hydrocodone/APAP 10/500 #240	30	Dr. Diaz	CVS 9695	RX# 423534
6/9/2010	hydrocodone/APAP 10/500mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 136047
6/10/2010	hydrocodone/APAP 10/500 #240	30	Dr. Diaz	Omac Pharmacy	RX# 6222512
6/18/2010	hydrocodone/APAP 10/500 #240	60	Dr. Diaz	Leon's Pharmacy	RX# 1215674
6/24/2010	hydrocodone/APAP 10/650 #240	30	Dr. Diaz	Omac Pharmacy	RX# 6237504
6/28/2010	hydrocodone/APAP 10/500 #240	40	Dr. Diaz	CVS 9695	RX# 423534
3/2/2010	alprazolam 2mg #100	25	Dr. Diaz	Omac Pharmacy	RX# 6222510
3/25/2010	alprazolam 2mg # 100	25	Dr. Diaz	Respondent Farmacia	RX# 134063
3/26/2010	alprazolam 2mg # 100	25	Dr. Diaz	Federal Drug	RX# 4515809
3/29/2010	alprazolam 2mg #120	20	Dr. Diaz	Omac Pharmacy	RX# 6227393
5/2/2010	alprazolam 2mg #150	25	Dr. Diaz	Respondent Farmacia	RX# 163171
5/20/2010	alprazolam 2mg #120	30	Dr. Diaz	Omac Pharmacy	RX# 6272845
5/26/2010	alprazolam 2mg # 150	25	Dr. Diaz	Respondent Farmacia	RX# 163171

vi. As shown in the table above, from January 15, 2010 to January 28, 2010, Dr. Diaz prescribed 950 tablets of hydrocodone/APAP products for Patient AP in less than 15 days. As a result, Patient AP received at least 17,300 mg of acetaminophen per day, well over the recommended maximum daily dosage of acetaminophen of 4000mg. From March 2, 2010 to March 29, 2010, Dr. Diaz prescribed 420 tablets of alprazolam 2mg for Patient AP in 30 days. From May 2, 2010 to May 26, 2010, Dr. Diaz prescribed 420 tablets of alprazolam 2mg for AP in 30 days. From June 9, 2010 to June 28, 2010, Dr. Diaz prescribed 1200 tablets of

hydrocodone/APAP products for Patient AP in 20 days. As a result, Patient AP received 18,200 mg of acetaminophen per day.

l. Patient JP

i. Respondents reported that Patient JP was diagnosed with chronic malignant back and joint pain and Hepatitis C. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including OxyContin, oxycodone, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient JP resided in Oxnard, approximately 40 miles from Dr. Diaz's office.

ii. Patient JP presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On December 23, 2011, Respondent Farmacia dispensed RX# 199521 for OxyContin, which was above the recommended dosing interval of twice daily. Patient JP was directed to take it three times daily. On August 22, 2011, Respondent Farmacia dispensed RX# 187698 (hydroxymorphone), RX# 187701 (Lyrica 75mg), and RX# 187700 (oxycodone 30mg), even though the dates on the three prescriptions appeared to have been altered.

iii. On November 2, 2011, Respondents printed out a CURES PAR for Patient JP for the first time, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since 2009.

m. Patient DR

i. Respondents reported that Patient DR was diagnosed with L4L5 herniated disc that is inoperable and severe leg pain and neck stabbing. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, Opana ER, Fentanyl, hydromorphone, Norco, Xanax, and Soma. Patient DR resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient DR had insurance, but paid cash for most of his pain medications. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist.

ii. Patient DR presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On April 20, 2011, Respondent Farmacia dispensed RX# 176114

which was unclear. The prescription was written for Oxycodone ER 30 IR. Respondent Farmacia did not verify and note the verification prior to dispensing. On April 22, 2011, Respondent Farmacia dispensed RX# 176116 for Opana ER to be taken three times daily, which is above the recommended dosing interval of twice daily.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient DR. Respondents printed a CURES PAR for Patient DR for the first time on November 2, 2011, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since April 21, 2011.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient DR saw 12 prescribers and went to 14 pharmacies to obtain controlled substances. Patient DR received multiple prescriptions for hydrocodone/APAP 10/325mg from Dr. Diaz all written at or around the same time, which were dispensed at multiple pharmacies. Patient DR received oxycodone 30mg prescriptions from Dr. Diaz and from various other prescribers at or around the same time and had the prescriptions dispensed at multiple pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
4/20/2011	Oxycodone 30mg #90	8	David Niknia PA	College Pharmacy	RX# 1200249
5/23/2011	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 176389
6/4/2011	hydrocodone/APAP 10/325mg # 240	30	Dr. Diaz	Walgreen's #7305	RX# 617823
6/4/2011	hydrocodone/APAP 10/325mg d #240	30	Dr. Diaz	LM Caldwell Pharmacist	RX# 785574
6/24/2011	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 176389
4/21/11	oxycodone 30mg # 180	15	Dr. Diaz	Respondent Farmacia	RX# 176114
6/2/2011	oxycodone 30mg #90	15	David Niknia PA	College Pharmacy	RX# 1200760
6/15/2011	oxycodone 30mg #180	18	Dr. Diaz	Respondent Farmacia	RX# 181766
6/21/2011	oxycodone 30mg #100	8	Dr. Gholemreza Borazjani	College Pharmacy	RX# 1200948

v. On June 4, 2011, Patient DR received two prescriptions for hydrocodone/ acetaminophen 10/325mg written by Dr. Diaz, which resulted in 7800mg of acetaminophen per day, well over the recommended 4000mg/day dose. Patient DR received 720 tablets of hydrocodone/acetaminophen in one month.

n. Patient JS

i. Respondents reported that Patient JS was diagnosed with disc joint disease, anxiety and arthritis. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including Fentanyl, OxyContin, oxycodone, Duragesic, Opana ER, hydromorphone, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient JS resided in Oxnard, approximately 40 miles away from Dr. Diaz's office. Patient JS had Medi-Cal, but paid cash between $830 and $1320 for OxyContin, $109 for oxycodone, and $660 for Opana ER.

ii. Patient JS presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. Respondent Farmacia filled two prescriptions for OxyContin for this patient above the recommended dosing interval of twice daily, on the following days: 9/28/2010, 10/9/2010, 11/11/2010, and 11/24/2010. On both November 11, 2010 and November 24, 2010, Respondent Farmacia filled two prescriptions for OxyContin for this patient.

iii. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient JS saw 7 prescribers and went to 10 pharmacies to obtain controlled substances. Patient JS received prescriptions for oxycodone 30mg and alprazolam 2mg from Dr. Diaz and various other prescribers at or around the same time and had the prescriptions dispensed at multiple pharmacies, as shown on the table below:

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Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
10/1/2010	oxycodone 30mg #90	15	David Nakia, PA	Von Pharmacy 2164	RX# 2019354
11/6/2010	oxycodone 30mg #60	15	Dr. Diaz	Respondent Farmacia	RX# 155839
10/14/2010	oxycodone 30mg #90	15	PA Nakia	CVS 9286	RX# 193623
10/28/2010	oxycodone 30mg #90	15	David Nakia, PA	Von Pharmacy 2164	RX# 2019469
11/12/2010	oxycodone 30mg #180	14	Dr. Diaz	Respondent Farmacia	RX# 159712 and 159713
11/24/2010	oxycodone 30mg #180	45	Dr. Diaz	LM Caldwell Pharmacist	RX# 776418
11/27/2010	oxycodone 30mg #90	23	Dr. Kevin Gohar	College Pharmacy	RX# 940735
2/15/2011	oxycodone 30mg #90	8	Dr. Borazjani	College pharmacy	RX# 944551
2/16/2011	oxycodone 30mg #180	30	Dr. Diaz	LM Caldwell Pharmacist	RX# 780495
2/24/2011	oxycodone 30mg #150	30	Dr. Diaz	Respondent Farmacia	RX# 170528
9/2/2010	alprazolam 2mg #40	20	PA Niknia	Vons Pharmacy 2164	RX# 4136427
9/6/2010	alprazolam 2mg #40	20	PA Niknia	CVS Pharmacy 9327	RX# 781199
9/28/2010	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 155749
3/5/2011	alprazolam 2mg #40	20	Dr. Gohar	College Pharmacy	RX# 945517
3/11/2011	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 170531
3/16/2011	alprazolam 2mg #60	30	Dr. Diaz	Respondent Farmacia	RX# 172744
3/31/2011	alprazolam 2mg #40	20	PA Niknia	College Pharmacy	RX# 1400029

o. Patient AS

i. Respondents reported that Patient AS was diagnosed with severe multiple degenerative joint disease. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, Norco, Xanax, and Soma. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist.

ii. Patient AS presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On July 18, 2011, Respondent Farmacia dispensed RX# 184788

or oxycodone 30mg #150 with incorrect directions. The directions on the prescription was 1-2 every 4-6 hours as needed for pain, pharmacy dispensed 1-2 every 3-4 hours as needed for pain. Patient AS was prescribed Suboxone after Dr. Diaz stopped prescribing controlled substances.

iii. In response to the Board inspector's records request, Respondents provided the Board with the PARs that it had printed out for Patient AS. The PARs printed out on May 26, 2010 and June 21, 2010, showed that Patient AS was using multiple pharmacies to fill Dr. Diaz's prescriptions for oxycodone and hydrocodone/APAP.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient AS saw 6 prescribers and went to 9 pharmacies for controlled substances. On October 18, 2011, Dr. Diaz wrote two prescriptions for oxycodone 30mg IR for Patient AS. Dr. Diaz wrote prescriptions for hydrocodone/APAP 10/325mg and oxycodone 30mg for Patient AS at or around the same time, which Patient AS had dispensed at multiple pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
10/13/2009	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 116076
10/20/2009	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Leon's Pharmacy	RX# 1201475
5/5/2010	hydrocodone/APAP 10/325mg #240	20	Dr. Diaz	he Medicine Shoppe	RX# 1417214
5/6/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Leon's Pharmacy	RX# 1210068
5/21/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 145272
5/28/2010	hydrocodone/APAP 10/325mg #240	20	Dr. Diaz	The Medicine Shoppe	RX# 1417214
6/1/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Leon's Pharmacy	RX# 1210068
6/10/2010	hydrocodone/APAP 10/325mg #240	30	Dr. Diaz	Respondent Farmacia	RX# 145272
6/23/2010	hydrocodone/APAP 10/325mg #240	20	Dr. Diaz	The Medicine Shoppe	RX# 1417214
8/12/2009	oxycodone 30mg #150	18	Dr. Diaz	Respondent Farmacia	RX# 120425
8/20/2009	oxycodone 30mg #150	14	Dr. Diaz	Respondent Farmacia	RX# 120945
11/17/2009	oxycodone 30mg #150	12	Dr. Diaz	Respondent Farmacia	RX# 128644
11/18/2009	oxycodone 30mg # 150	30	Dr. Diaz	Leon's Pharmacy	RX# 1203418

5/4/2010	oxycodone 30mg #150	12	Dr. Diaz	Leon's Pharmacy	RX# 1213113
5/10/2010	oxycodone 30mg # 150	12	Dr. Diaz	Respondent Farmacia	RX# 144271

vi. Patient AS received between 720 and 960 tablets of hydrocodone/ acetaminophen prescribed by Dr. Diaz per month, which resulted in 9100mg/day of acetaminophen.

p. Patient BS

i. Respondents reported that Patient BS was diagnosed with post traumatic lumbar pain, post surgery. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including Morphine sulfate, Norco, and diazepam. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient BS did not have any significant pain or anxiety history prior to going to Dr. Diaz, yet Dr. Diaz began the patient's therapy with morphine sulfate 100mg, hydrocodone/APAP 10mg and diazepam 10mg.

ii. Patient BS' driver's license showed his address in Malibu, approximately 60 miles from Dr. Diaz's office and 17 miles from Respondent Farmacia's store. It was unusual for a patient living in Malibu to travel to see a prescriber in Santa Barbara and then travel to Oxnard to have his prescription filled.

iii. Respondents printed out Patient BS' PAR for the first time on October 6, 2011, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since November 5, 2010. Respondents chose to wait one year to print out the patient's PAR.

iv. Pursuant to CURES reports for January 1, 2009 to March 11, 2013, Patient BS saw 7 prescribers and went to 7 pharmacies. Patient BS was placed on Suboxone, a treatment for narcotic addiction, after Dr. Diaz stopped prescribing for the patient.

q. Patient VV (1985)

i. Respondents reported that Patient VV (1985) was diagnosed with chronic lumbar disease due to a work injury. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including oxycodone, methadone, Norco, and

Xanax. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient VV (1985) resided in Oxnard, approximately 40 miles from Dr. Diaz's office. Patient VV (1985) paid for his controlled substance prescriptions in cash.

ii. Patient VV (1985) presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. RX# 186735 for oxycodone 30mg was post-dated by Dr. Diaz to August 10, 2011. Respondent Farmacia received the prescription and verified it on July 29, 2011. On December 30, 2011, Respondent Farmacia dispensed RX# 200057 and RX# 200058, which Dr. Diaz authorized to refill early. On October 29, 2011, Dr. Diaz authorized refills on RX# 194078 for alprazolam 2mg and made a note on the prescription "must last 90 days", and then on November 4, 2011, he wrote another prescription for VV (1985) for alprazolam 2mg.

iii. Patient VV (1985) had no significant pain or anxiety history 12 months prior to seeing Dr. Diaz, yet Dr. Diaz began therapy with methadone 10mg, hydrocodone/APAP 10/325mg, oxycodone 30mg and alprazolam 2 mg.

iv. Respondents first printed this patient's CURES PAR on October 6, 2011, even though the patient had his controlled substance prescriptions filled by Respondent Farmacia since January 4, 2010. Respondents chose to wait over 1.5 years to print out the patient's PAR.

v. Pursuant to CURES, Patient VV (1985) saw 4 prescribers and went to 9 pharmacies for the period of January 1, 2009 to March 11, 2013. Patient VV received multiple prescriptions for hydrocodone/APAP 10/325mg from Dr. Diaz at or around the same time and had these prescriptions dispensed at multiple pharmacies, as shown in the table below:

Date	Drug	Day Supply	Prescriber	Pharmacy	Rx#
4/1/2010	hydrocodone/APAP 10/325mg received# 200	25	Dr. Diaz	Omac Pharmacy	RX# 6217769
4/13/2010	hydrocodone/APAP 10/325mg received# 240	30	Dr. Diaz	Leon's Pharmacy	RX# 1205660
4/26/2010	hydrocodone/APAP 10/325mg received # 200	25	Dr. Diaz	Omac Pharmacy	RX# 6217769

5/5/2010	hydrocodone/APAP 10/325mg received# 200	25	Dr. Diaz	Respondent Farmacia	RX# 143856

iii. Patient VV (1985) received between 400-440 tablets of hydrocodone/APAP prescribed by Dr. Diaz in one month, which resulted in the patient having nearly 5200mg/day of acetaminophen.

q. Patient VV (DOB 1982)

i. Respondents reported that Patient VV (1982) was diagnosed with post traumatic pain and fibromyalgia. Dr. Diaz prescribed pain and anxiety medications for this patient, which Respondent Farmacia dispensed, including OxyContin, Norco, Xanax, Soma, oxycodone, diazepam. This patient received most pain medication prescriptions from Dr. Diaz, despite the fact that he was not a pain specialist. Patient VV (1982) resided in Oxnard, approximately 40 miles from Dr. Diaz's office and approximately 6 miles from Respondent Farmacia's store. Patient VV (1982) paid cash for her drugs including between $1072 and $1325 for OxyContin.

ii. Patient VV (1982) presented questionable prescriptions to Respondent Farmacia, which the pharmacy dispensed. On March 18, 2010, Respondent Farmacia dispensed RX# 139040 for OxyContin 80mg, which was above the recommended dosing interval of twice daily. Patient VV (1982) was directed to take it three times daily.

iii. Respondents first printed this patient's CURES PAR on February 9, 2010, even though Patient VV (1982) had his controlled substance prescriptions filled by Respondent Farmacia since January 16, 2009. Respondents chose to wait over one year to print out the patient's PAR.

iv. Pursuant to CURES reports for the period of January 1, 2009 to March 11, 2013, Patient VV (1982) saw 4 prescribers and went to 4 pharmacies.

Survey of Neighboring Pharmacies

33. As part of the Board's investigation, pharmacy questionnaires were sent to the pharmacists-in-charge of pharmacies within a 5 mile radius of Respondent Farmacia. The survey of the surrounding pharmacies/pharmacists indicated that Respondent Farmacia had different

dispensing practices for controlled substances than all of the other neighboring pharmacies. The quantities prescribed by Dr. Diaz were far more than what the surrounding pharmacies/ pharmacists saw in their practice. The dispensing ratio of Dr. Diaz's prescriptions, given the number of controlled substance prescriptions dispensed by a pharmacy, was significantly higher for Respondent Farmacia than for the neighboring pharmacies. Most patients in the distance analysis sample drove in excess of 80 miles in order to use Respondent Farmacia and Dr. Diaz. Data from the CURES report regarding volume of drugs dispensed for the time period specified showed that Respondent Farmacia filled tens of thousands more controlled substances prescribed by Dr. Diaz when compared to neighboring pharmacies. According to the data, patients were not travelling the long distances to patronize the neighboring pharmacies; they came specifically to Respondent Farmacia to fill Dr. Diaz's prescriptions.

FIRST CAUSE FOR DISCIPLINE

(Failure to Review Drug Therapy and Patient Medication Record)

34. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivisions (d) and (o), 4302, and 4113, on the grounds of unprofessional conduct, in that Respondents repeatedly failed to review the patient's drug therapy and medication record prior to dispensing prescriptions, in violation of Code section 4306.5, subdivision (c), and California Code of Regulations, title 16, sections 1707.3 and 1761, which resulted in filling prescriptions early and, thereby, over dispensing controlled substances and/or dangerous drugs. Early refills of powerful and highly addictive controlled substances place patients at risk. The table below shows the pattern of consistent early refills of Dr. Diaz's prescriptions for controlled substances dispensed by Respondent Farmacia between January 1, 2010, and December 31, 2011.

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Early Fills

Previous RX					Following RX				
Patients	Date Dispensed	RX#	QTY	Day Supply	Date Dispensed	RX#	QTY	Day Supply	Days Early (from previous RX)
CA	9/22/2011	190444	150	37	9/28/2011	191041	150	37	31
CB	11/29/2010	160911	120	30	12/23/2010	163555	120	30	6
CB	4/14/2011	169952	60	30	5/9/2011	169952	60	30	5
CB	11/21/2011	193618	240	30	12/14/2011	193618	240	30	7
CB	11/21/2011	196220	60	30	12/14/2011	196220	60	30	7
CB	11/21/2011	196223	180	30	12/14/2011	198627	180	30	7
TB	11/29/2010	158714	248	31	12/2/2010	161501	60	60	28
TB	2/24/2011	166959	248	31	3/1/2011	166959	248	31	24
TB	2/24/2011	170449	240	30	3/1/2011	170451	50	2	24
TB	3/24/2011	166959	248	31	4/7/2011	166959	200	25	17
TB	4/7/2011	166959	200	25	4/2112011	176129	240	30	11
TB	4/21/2011	166959	240	30	4/29/2011	176129	60	7	22
RB	4/14/2011	162940	120	30	5/6/2011	177703	120	30	8
RB	5/6/2011	177703	120	30	5/24/2011	177938	120	30	12
RB	8/2/2011	185216	120	30	8/25/2011	187340	120	30	7

RB	9/22/2011	189733	120	30	10/14/2011	192553	60	30	8
DG	2/10/2010	136027	90	30	3/5/2010	138396	90	30	6
DG	2110/2010	136028	120	30	3/5/2010	138397	100	25	6
DG	3/26/2010	125304	100	25	3/26/2010	140353	100	25	25
AP	1/4/2010	132380	200	11	1/4/2010	132442	280	11	11
AP	4/22/2010	136047	240	30	5/11/2010	136047	240	30	11
AP	8/30/2010	153242	300	37	8/30/2010	153244	300	25	25
AP	9/27/2010	155550	300	8	9/27/2010	155553	300	8	8
AP	11/22/2010	160491	300	8	11/22/2010	160493	300	8	8
AP	3/1/2011	171072	300	18	3/14/2011	172357	300	25	5
JP	6/27/2011	182868	180	30	7/22/2011	185206	180	30	5
JP	6/27/2011	182689	180	30	7/22/2011	185207	180	30	5
DR	9/30/2011	187590	240	30	10/24/2011	187590	240	30	6
JS	3/11/2011	170531	60	30	3/16/2011	172744	60	30	25
AS	2/3/2011	168157	150	12	2/10/2011	168802	150	30	5
VV	10/29/2011	194078	90	15	11/7/2011	194558	120	30	6
VV	12/5/2011	197429	240	30	12/30/2011	200057	240	30	5
VV	12/5/2011	197429	180	30	12/30/2011	200058	180	30	5

SECOND CAUSE FOR DISCIPLINE

(Dispensing of Erroneous or Uncertain Prescriptions)

35. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivision (o), 4302, and 4113, in conjunction with California Code of Regulations, title 16, section 1761, on the grounds of unprofessional conduct, in that Respondent Farmacia dispensed prescriptions which contained a significant error, omission, irregularity, uncertainty, ambiguity or alteration. Specifically, between January 1, 2010, and January 9, 2013, Respondent Farmacia dispensed the following prescriptions which were erroneous or uncertain:

Patients	RX Numbers	Reasons erroneous or uncertain
CA	157518	Incorrect directions
CA	157515, 157517	No date on RX
CA	173310	Incorrect directions
CB	190759, 193618	acetaminophen dosage exceeded recommended maximum dosage of 4000mg per day
CB	198621, 196223, 191000, 188580, 186341, 183974, 175515,172780	Opana ER dosage exceed recommended dosing interval of twice daily
SB	161418	OxyContin dosage exceeded recommended dosing interval of twice daily
DG	140353, 125304	Dispensed alprazolam 2mg twice on the same day with 2 different prescription numbers
DG	143720	OxyContin dosage exceeded recommended dosing interval of twice daily
DG	173557	Opana ER dosage exceeded recommended dosing interval of twice daily
AP	172358, 182237, 163618, 157709, 159583, 183920, 144039, 132125, 155549, 169296	acetaminophen dosage exceeded the recommended maximum dosage of 4000mg per day.
JP	199521	OxyContin dosage exceeded recommended dosing interval of twice daily
JP	187698, 187701, 187700	Date appeared altered
DR	176116	Opana ER dosage exceeded recommended dosing interval of twice daily

AS	184788	Dispensed with incorrect directions
VV (10/21/1985)	186735	Post-dated prescription

Patients	**Reasons erroneous or uncertain**
CB	CB received Suboxone indicated for opiate addiction concurrently with other narcotics.
TB	On 1/25/2011, 4/21/2011, 5/24/2011, 6/23/2011, 7/21/2011, 8/18/2011, 9/21/2011, 10/20/2011, and 11/2/2010, Patient TB received two prescriptions for oxycodone IR from Dr. Diaz with 2 different set of directions.
AP	Patient AP had forged prescriptions. AP received Suboxone indicated for opiate addiction concurrently with other narcotics.
AS	On 10/18/2011, Patient AS received two prescriptions for oxycodone 30mg IR from Dr. Diaz.
VV (1985)	On 10/29/2011, Dr. Diaz authorized refills on RX# 194078 for alprazolam 2mg and made a note on the prescription "must last 90 days", then on 11/4/2014 he wrote another prescription for alprazolam 2mg for the patient.

THIRD CAUSE FOR DISCIPLINE

(Failure to Assume Corresponding Responsibility)

36. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivision (d), (j) and (o), 4302, and 4113, on the grounds of unprofessional conduct, in that they failed to assume their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose, in violation of Code section 4306.5, Health and Safety Code section 11153, and California Code of Regulations, title 16, section 1761, subdivision (b). Respondents failed to exercise their best professional judgment and evaluate the totality of the circumstances (information from the patient, physician and other sources) to determine a prescription's legitimate medical purpose, in connection with Dr. Diaz's controlled substance prescriptions. Respondents ignored numerous warning signs or red flags that should put a reasonable and prudent dispensing pharmacist on notice that a prescription may not have

been issued for a legitimate medical purpose. The red flags included, but were not limited to the following:

- the prescriber wrote a disproportionate number of prescriptions for controlled substances, especially since he was a general practitioner with no specialty indicated;
- numerous patients had addresses outside of the prescriber's and the pharmacy's normal trade area;
- patients living at the same address presented prescriptions for the same drugs;
- pattern of patients willing to pay cash for extremely expensive prescriptions, even when they had insurance;
- relatively high percentage of cash patients specific to prescriber,
- same or similar prescribing patterns for individual patients from an alleged pain specialist,
- consistent requests for early refills of highly addictive controlled substances;
- prescriptions written for medications that address the same medical problem and appear unreasonably duplicative;
- the same drug combinations were repeatedly prescribed for multiple patients by the same prescriber;
- irregular and questionable prescriptions, including scripts with missing information that is required for a valid prescription and dates written by someone other than the prescriber;
- patients starting with highest dosage available for a highly addictive controlled substance for a medical condition;
- patients being prescribed Suboxone, which is used to alleviate opiate addiction, and opiates at the same time or opiate prescriptions after Suboxone has been prescribed;
- and CURES reports, including those acquired by Respondents, showing prescriber's patients obtaining prescriptions for controlled substances from multiple prescribers and having the prescriptions filled at different pharmacies.

Complainant refers to, and by this reference incorporates, the allegations set forth above in paragraphs 20 through 34 above, as though set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

(Unauthorized Variation from Prescriptions)

37. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant to Code sections 4301, subdivision (o), 4302, and 4113, on the grounds of unprofessional conduct, in that they deviated from the requirements of prescriptions without the prior consent of the prescriber, in violation of California Code of Regulation, title 16, section 1716. Specifically, Respondent Farmacia dispensed the following prescriptions incorrectly:

a. RX# 157518 - Wrong Directions. On October 19, 2010, Respondent Farmacia dispensed Dr. Diaz's prescription for Duragesic 100mcg for Patient CA with incorrect directions. The directions on the prescription stated that the medication patch was to be applied to skin every 72 hours, but Respondent Farmacia erroneously dispensed the medication with directions stating that it was to be applied every 12 hours (RX# 157518).

b. RX# 182081 - Wrong Drug. On September 6, 2011, Respondent Farmacia erroneously dispensed Dr. Diaz's prescription (dated June 17, 2011) that was written for morphine sulfate IR for Patient CA with the wrong drug. The prescription was for morphine sulfate IR, but Respondent Farmacia erroneously dispensed morphine sulfate ER (RX# 182081).

c. RX# 173310 - Wrong Directions. On March 21, 2011, Respondent Farmacia dispensed Dr. Diaz's prescription for oxycodone for Patient CA with incorrect directions. The prescription's directions stated that 1-2 pills were to be taken every 4 to 6 hours, but Respondent Farmacia erroneously dispensed the medication with directions stating 1-2 pills every 4 hours (RX# 173310).

d. RX# 170618 - Wrong Drug. On February 25, 2011, Respondent Farmacia erroneously dispensed Dr. Diaz's prescription that was written for Adderall for Patient DG with the wrong drug. The prescription was written for Adderall 30mg 3 daily #90, but Respondent Farmacia erroneously dispensed Adderall XR #90 (RX# 170618).

1 e. RX# 195035 - Wrong Directions. On November 19, 2011, Respondent Farmacia
2 dispensed Dr. Diaz's prescription for oxycodone 30mg IR for patient ZL with incorrect
3 directions. The prescription was written for 2 tablets were to be taken every 4-6 hours, but
4 Respondent Farmacia erroneously dispensed the medication with directions stating 1-2 tablets
5 were to be taken every 4-6 hours (RX# 195035).

6 e. RX# 184788 - Wrong Directions. On July 18, 2011, Respondent Farmacia dispensed
7 Dr. Diaz's prescription for oxycodone 30mg #150 for patient AS with incorrect directions. The
8 prescription was written for 1-2 tablets every 4-6 hours, Respondent Farmacia dispensed the
9 medication with directions stating 1-2 every 3-4 hours (RX# 184788).

10 **FIFTH CAUSE FOR DISCIPLINE**

11 **(Failure to Maintain Required Records)**

12 38. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant
13 to Code sections 4301, subdivisions (j) and (o), 4302, and 4113, in that they violated Code
14 sections 4081, subdivision (a), and 4105, subdivision (a), by failing to maintain the required
15 records of sale, acquisition and disposition of dangerous drugs. Specifically, Respondents failed
16 to account for prescription hard copies for RX# 151058, 175097, 193030, 125303, 125304,
17 163835, 163836, 137733, 137735, 136926, and 136927, which Respondent Farmacia dispensed
18 between January 1, 2010 and January 9, 2013.

19 **SIXTH CAUSE FOR DISCIPLINE**

20 **(Unprofessional Conduct)**

21 39. Respondent Farmacia and Respondent Andonian are subject to discipline pursuant
22 to Code sections 4301, 4302, and 4113, in that Respondents committed unprofessional conduct,
23 as more fully discussed in paragraphs 20 through 37, above.

24 **OTHER MATTERS**

25 40. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit
26 Number PHY 49140 issued to RSA Health Services Inc. dba Farmacia Estrella, RSA Health
27 Services Inc. shall be prohibited from serving as a manager, administrator, owner, member,
28 officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number

PHY 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if it is revoked.

41. Pursuant to Code section 4307, if discipline is imposed on Pharmacy Permit Number PHY 49140 issued to RSA Health Services Inc. dba Farmacia Estrella while Robert Andonian has been an officer and owner and had knowledge of or knowingly participated in any conduct for which the licensee was disciplined, Robert Andonian 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 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 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 California State Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit License Number PHY 49140, issued to RSA Health Services Inc. dba Farmacia Estrella;

2. Revoking or suspending Original Pharmacist License Number RPH 47233, issued to Robert Andonian;

3. Prohibiting RSA Health Services 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 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if Pharmacy Permit Number 49140 issued to RSA Health Services Inc. dba Farmacia Estrella is revoked;

4. Prohibiting Robert Andonian from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit Number PHY 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if Pharmacy Permit Number PHY 49140 issued to RSA Health Services Inc. dba Farmacia Estrella is revoked;

5. Prohibiting Suzy Andonian from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee for five years if Pharmacy Permit

Number PHY 49140 is placed on probation or until Pharmacy Permit Number PHY 49140 is reinstated if Pharmacy Permit Number 49140 issued to RSA Health Services Inc. dba Farmacia Estrella is revoked;

6. Ordering RSA Health Services Inc. dba Farmacia Estrella and Robert Andonian, jointly and severally, to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to business and Professions Code section 125.3;

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

DATED: 2/4/17

VIRGINIA K. HEROLD
Executive Officer
California State Board of Pharmacy
State of California
Complainant

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