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

In the Matter of the Accusation Against: **TWB VENTURE, INC., DBA VALUE RX PHARMACY, THUY VU NGUYEN, CEO** **22 Odyssey Suite 135** **Irvine, CA 92618** **Pharmacy Permit No. PHY 51246** **and** **THUY VU NGUYEN** **8811 Hewitt Place** **Garden Grove, CA 92844** **Pharmacist License No. 51877** Respondents.	Case No. 5685 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about April 16, 2013, the Board of Pharmacy issued Pharmacy Permit Number PHY 51246 to TWB Venture, Inc., dba Value Rx Pharmacy (Respondent Pharmacy). Thuy Vu Nguyen is the Chief Executive Officer and 100% shareholder of TWB Venture, Inc. The

Pharmacy Permit was in full force and effect at all times relevant to the charges brought herein and will expire on April 1, 2017, unless renewed. Thuy Vu Nguyen as been the Pharmacist-in-Charge (PIC) since April 16, 2013.

3. On or about August 30, 2000, the Board of Pharmacy issued Original Pharmacist License Permit Number PHY 51877 to Thuy Vu Nguyen (Respondent Nguyen). The Pharmacist License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2017, unless renewed.

JURISDICTION

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

5. Section 4011 of the Code provides that the Board shall administer and enforce both the Pharmacy Law [Bus. & Prof. Code, § 4000 et seq.] and the Uniform Controlled Substances Act [Health & Safety Code, § 11000 et seq.].

6. Section 4300 of the Code states in part:

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

7. Section 4300.1 of the Code states:

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

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STATUTORY AND REGULATORY PROVISIONS

8. Section 733 of the Code states in part:

(a) A licentiate shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

(b) Notwithstanding any other law, a licentiate shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

...

9. Section 4115 of the Code states in part:

(a) A pharmacy technician may perform packaging, manipulative, repetitive, or other nondiscretionary tasks only while assisting, and while under the direct supervision and control of, a pharmacist. The pharmacist shall be responsible for the duties performed under his or her supervision by a technician.

(b) This section does not authorize the performance of any tasks specified in subdivision (a) by a pharmacy technician without a pharmacist on duty.

(c) This section does not authorize a pharmacy technician to perform any act requiring the exercise of professional judgment by a pharmacist.

...

(f) (1) A pharmacy with only one pharmacist shall have no more than one pharmacy technician performing the tasks specified in subdivision (a). The ratio of

pharmacy technicians performing the tasks specified in subdivision (a) to any additional pharmacist shall not exceed 2:1, except that this ratio shall not apply to personnel performing clerical functions pursuant to Section 4116 or 4117. This ratio is applicable to all practice settings, except for an inpatient of a licensed health facility, a patient of a licensed home health agency, as specified in paragraph (2), an inmate of a correctional facility of the Department of Corrections and Rehabilitation, and for a person receiving treatment in a facility operated by the State Department of State Hospitals, the State Department of Developmental Services, or the Department of Veterans Affairs.

...

10. 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 or whose license has been procured by fraud or misrepresentation or issued by mistake. Unprofessional conduct shall include, but is not limited to, any of the following:

...

(c) Gross negligence.

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

(e) The clearly excessive furnishing of controlled substances in violation of subdivision (a) of Section 11153.5 of the Health and Safety Code. Factors to be considered in determining whether the furnishing of controlled substances is clearly excessive shall include, but not be limited to, the amount of controlled substances furnished, the previous ordering pattern of the customer (including size and frequency of orders), the type and size of the customer, and where and to whom the customer distributes its product.

...

(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.

...

11. Section 4113(c) of the Code states, "The pharmacist-in-charge shall be responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy."

12. Section 4306.5 states:

Unprofessional conduct for a pharmacist may include any of the following:

...

(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.

13. Section 4307 states:

(a) 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.

(b) "Manager, administrator, owner, member, officer, director, associate, or partner," as used in this section and Section 4308, may refer to a pharmacist or to any other person who serves in that capacity in or for a licensee.

(c) The provisions of subdivision (a) may be alleged in any pleading filed pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. However, no order may be issued in that case except as to a person who is named in the caption, as to whom the pleading alleges the applicability of this section, and where the person has been given notice of the proceeding as required by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of the Government Code. The authority to proceed as provided by this subdivision shall be in addition to the board's authority to proceed under Section 4339 or any other provision of law.

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

> (a) A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Except as authorized by this division, the following are not legal prescriptions: (1) an order purporting to be a prescription which is issued not in the usual course of professional treatment or in legitimate and authorized research; or (2) an order for an addict or habitual user of controlled substances, which is issued not in the course of professional treatment or as part of an authorized narcotic treatment program, for the purpose of providing the user with controlled substances, sufficient to keep him or her comfortable by maintaining customary use. ...

15. Title 16, California Code of Regulations ("CCR"), 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

16. Section 125.3 of the Code states, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

17. Alprazolam, sold under the brand name Xanax, is a Schedule IV controlled substance as pursuant to Health and Safety Code section 11057(d)(1) and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used for the management of anxiety disorder or the short-term relief of symptoms of anxiety.

18. Calcium acetate, sold under the brand name PhosLo and Eliphos, is a dangerous drug pursuant to Business and Professions Code section 4022. It is used in the treatment of hyperphosphatemia.

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19. Carisoprodol, sold under the brand name Soma, was added as a Schedule IV controlled substance pursuant to title 21 CFR 1308.14(c)(6). Carisoprodol is a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat muscle spasms.

20. Fentanyl patches, sold under the brand name Duragesic patches, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(c)(1) and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used in the treatment of pain.

21. Hydrocodone/acetaminophen, sold under the brand name Norco, is a Schedule III controlled substance pursuant to Health and Safety Code section 11056(e)(4) and is a Schedule II controlled substance pursuant to title 21, Code of Federal Regulations ("CFR"), section 1308 as of October 6, 2014. Norco is a dangerous drug pursuant to Business and Professions Code section 4022. It is used in the treatment of pain.

22. Hydromorphone, sold under the brand name Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(j) and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used in the treatment of pain.

23. Metoprolol, sold under the brand name Lopressor, is a dangerous drug pursuant to Business and Professions Code section 4022. It is used in the treatment of hypertension and congestive heart failure.

24. Oxycodone extended release, sold under the brand name Oxycontin, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(M) and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used in the treatment of pain.

25. Oxymorphone extended release, sold under the brand name Opana ER, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(N) and is a dangerous drug pursuant to Business and Professions Code section 4022. It is used in the treatment of pain.

FACTS

26. On or about October 28, 2014, the Board received an on-line complaint from A.T. complaining that Respondents failed to deliver S.S.'s prescriptions of calcium acetate (Rx No.

13653) and metoprolol (Rx No. 11080) after the medications were last delivered by Respondents on August 12, 2014. Both prescriptions were for a 30-day supply of the drugs.

27. On January 30, 2015, Board inspectors conducted an inspection of Respondent Pharmacy. While outside the pharmacy, Board inspectors observed multiple individuals in street clothes filling prescriptions inside the pharmacy. The Board inspectors entered the pharmacy and spoke with H.T., who was the only pharmacist present in the pharmacy at the time. There were three clerks and two pharmacy technicians present. Two pharmacy technicians were packaging drugs and filling prescriptions, which exceeded the ratio of pharmacy technicians allowed to package or perform other nondiscretionary tasks. H.T. stated she was aware of the pharmacy law regarding the required ratio of pharmacists to pharmacy technicians. H.T. was not the pharmacist on duty regarding S.S.'s prescriptions and stated she would refer the matter to Respondent Nguyen, who was not present at the time of the inspection.

28. Respondent Nguyen and documents obtained from the pharmacy confirmed that S.S.'s prescriptions had not been delivered to him in October, 2014. Respondent Nguyen stated pharmacy staff left a message at the patient's last known telephone number but did not get a return call so the prescription was not filled. A.T. denied receiving any messages. After this incident, A.T. terminated delivery service to S.S.

29. During the inspection on January 30, 2015, the Board inspectors also noted irregularities in Respondents' dispensing practice, including dispensing to patients who resided outside of Respondent's local trade area who filled controlled substance prescriptions at the pharmacy totaling as much as $750 per prescription; young patients who paid as much as $600 cash for highly abused drugs; and patients with military identification who paid high cash prices for controlled substances instead of using government issued insurance benefits.

30. On February 5, 2015, Board inspectors reviewed Respondent Pharmacy's dispensing record from June 12, 2014 through January 30, 2015 obtained from the Controlled Substance Utilization Review and Evaluation System ("CURES") and found the top three prescribers of controlled substances dispensed at Respondent Pharmacy were:

Prescriber	# of Rxs filled at Value Rx	% of Cash vs. Insurance payments	Rx generally written for	Prescriber's office location
Dr. D.P.	245	53% cash 47% insurance	Oxycodone 30 mg; Hydrocodone 325/10; Carisoprodol 350 mg; Alprazolam 2; Dextroamphetamine 10 mg, 20 mg, 30 mg	Irvine
Dr. J.Y.	205	56% cash 44% insurance	Suboxone (buprenorphine)	Irvine
Dr. A.B.	184	92% cash 8% insurance	Oxycodone 30 mg; Hydrocodone 325/10mg; Carisoprodol 350 mg; Alprazolam 2mg; Fentanyl 100 mcg	Lake Forest

31. The disproportionate ratio of cash versus insurance payments made by patients filling controlled substance prescriptions issued by Dr. A.B. was a factor of irregularity. All of the prescriptions issued by Dr. A.B. was for controlled substances, which was unusual for a family practice physician. Of the 184 prescriptions issued by Dr. A.B. and dispensed by Respondent, 35.87 percent of the prescriptions (or 66 of the 184) was for oxycodone HCL 30 mg, 30.98 percent (or 57) was for Fentanyl[1] Transdermal System 100 and 10.32 percent (or 19) was for alprazolam. A review of these prescriptions revealed further irregularities in that most of the patients began their treatment with the highest strength available for the medication instead of the lowest strength. Furthermore, Dr. A.B.'s prescriptions did not reflect individualized therapy because a majority of the patients received a similar combination of oxycodone and fentanyl. Dr. A.B.'s prescribing practices should have been a red flag to Respondents that Dr. A.B.'s prescriptions may not have been issued for a legitimate medical purpose and to inquire further into their legitimacy.

32. Further investigation by Respondents would have revealed that almost all, if not all, of the prescriptions were not written by Dr. A.B. In fact, most of the patients who presented with

[1] On March 18, 2015, the United Stated Drug Enforcement Administration issued a nationwide alert about the dangers of fentanyl and fentanyl compounds. Fentanyl is commonly laced in heroin, causing significant problems across the country, particularly as heroin abuse has increased. U.S. Drug Enforcement Administration, DEA News, March 18, 2015, http://www.dea.gov/divisions/hq/2015/hq031815.shtml.

prescriptions issued by Dr. A.B. were not Dr. A.B.'s patients at all. Dr. A.B. previously filed numerous police reports regarding forged prescriptions.

33. According to Dr. A.B., there were 32 patients who had forged prescriptions under his name. They are D.A., K.B., M.B., R.B., T.B., A.B., C.B., B.C., M.C., T.C., D.C., K.F., R.G., M.G., A.G., L.G., C.G., R.H., S.I., B.K., J.M., C.M., V.M., K.N., M.N., R.O., B.P., K.R., L.S., Z.S., M.V., and M.W.

34. A summary of Respondents' dispensing history to these 32 patients whose prescriptions for controlled substances were alleged to have been forged follows:

Patient	Drug dispensed by Value Rx	Payment method	City of residence	Distance from Value Rx (1 way)	# of pharmacies used	Prescriber	Patient age
D.A.	Oxycodone 30 mg	Cash	San Clemente	22	2	Dr. A.B.	26
M.B.	Alprazolam 2 mg; fentanyl patch; oxymorphone ER 40 mg	Cash	Lake Forest	19	1	Dr. A.B. Dr. A.S.	30
R.B.	Alprazolam 2 mg; carisoprodol 350 mg; fentanyl patch; oxymorphone ER 40 mg	Cash	Foothill Ranch	7	5	Dr. A.B. Dr. G.V.D. Dr. M.B. Dr. M.B.	27
T.B.	Alprazolam 2mg; fentanyl patch; oxycodone 30 mg	Cash	Mission Viejo	8	4	Dr. A.B. Dr. G.V.D.	24
A.B.	Fentanyl patch; oxycodone 15 mg; oxycodone 30 mg	57% cash; 43% Insurance	Orange	12	10	Dr. A.B. Dr. B.L. Dr. B.P. Dr. M.C. Dr. M.G. Dr. N.S. Dr. B.R. Dr. G.V.D.	36
C.B.	Fentanyl patch; oxycodone 30 mg	54% cash; 46% insurance	Orange	12	8	Dr. A.B. Dr. L.L. Dr. M.B.	36
M.C.	Carisorprodol 350 mg; Fentanyl patch; Oxycodone 30 mg	Cash	Lake Forest	7	9	Dr. A.B. Dr. G.V.D. Dr. M.B.	34

Patient	Drug dispensed by Value Rx	Payment method	City of residence	Distance from Value Rx (1 way)	# of pharmacies used	Prescriber	Patient age
T.C.	Alprazolam 2mg; hydromorphone 4 mg; Hydromorphone 8 mg; Morphine sulfate ER 30 mg; oxycodone 15 mg; oxycodone 30 mg; oxymorphone ER 20 mg; oxymorphone ER 40 mg; Viagra	Cash	Lake Forest	7	16	Dr.A.B. Dr. D.Z. Dr. S.S. Dr. P.T. Dr. J. O. Dr. T.P. Dr. J.P. Dr .L.T. Dr. A.T. Dr. W.K. Dr. G.V.D. Dr. Y.G. Dr. A.L. Dr. J.H. Dr. J.C. Dr. J. A. Dr. M.B.S. Dr. M.H. Dr. J.L.	31
D.C.	Alprazolam 2mg; Fentanyl patch; oxycodone 30 mg	Cash	Dana Point	18	5	Dr. A.B. Dr. G.V.D.	50
K.F.	Carisoprodol 350 mg; Fentanyl patch; oxycodone 30 mg	Cash	Lake Forest	6	6	Dr. A.B. Dr. P.C. Dr. H.M.	31
R.G.	Alprazolam 2mg; Fentanyl patch; oxycodone 30 mg	Cash	Laguna Beach	14	11	Dr. A.B. Dr. G.V.D. Dr. Y.Z.	59
M.G.	Alprazolam 2mg; Fentanyl patch; oxycodone 30 mg	Cash	Camp Pendleton	42	7	Dr. A.B.	25
A.G.	Alprazolam 2mg; oxycodone 30 mg	Cash	Hollywood	49	2	Dr. A.B.	29
L.G.	Alprazolam 2mg; Amphetamine 30 mg; Hydrocodone/apap 10/325; oxycodone 30 mg	Cash	Laguna Niguel	13	1	Dr. A.B. Dr. G.V.D.	37
C.G.	Carisoprodol 350 mg; Fentanyl patch; oxycodone 30 mg	Cash	Saint Albans, VT	2916	2	Dr. A.B.	25
R.H.	Fentanyl patch; oxycodone 30 mg	Cash	San Clemente	26	2	Dr. A.B.	32
S.I.	Alprazolam 2mg; Hydrocodone/apap	Cash	Long Beach	25	5	Dr. A.B.	24
B.K.	oxycodone 30 mg	Cash	Westminster, CA	18	3	Dr. A.B.	22
J.M.	Fentanyl patch; oxycodone 30 mg	Cash	Mission Viejo	9	6	Dr. A.B.	27
C.M.	Carisoprodol 350 mg; Fentanyl patch; oxycodone 30 mg	Cash	Laguna Hills	8	3	Dr. A.B. Dr. A.A.	22

Patient	Drug dispensed by Value Rx	Payment method	City of residence	Distance from Value Rx (1 way)	# of pharmacies used	Prescriber	Patient age
V.M.	Alprazolam 2 mg; Fentanyl patch; oxycodone 30 mg; oxymorphone ER 40 mg	cash	Aliso Viejo	5	2	Dr. A.B. Dr. G.J.	31
K.N.	Carisoprodol 350 mg; Fentanyl patch; oxymorphone ER 40 mg	cash	Mission Viejo	10	12	Dr. A.B. Dr. G.V.D. Dr. J.O. Dr. D.R. Dr. A.B. Dr. W.C. Dr. M.F. Dr. T.R. Dr. A.P. Dr. S.B.; Dr. L.V.	24
M.N.	Alprazolam 2 mg; Carisoprodol 350 mg; Fentanyl patch; oxycodone 30 mg; oxymorphone ER 40 mg	Cash	Foothill, CA	7	9	Dr. A.B.	26
R.O.	Fentanyl patch; oxycodone 30 mg	Cash	Lake Forest	7	4	Dr. A.B. Dr. M.B.	35
B.P.	Fentanyl patch; oxycodone 30 mg	Cash	Rancho Santa Margarita	12	3	Dr. A.B. Dr. L.H. Dr. R.G. Dr. S.C. Dr. A.E.	24
K.R.	Amphetamine 30 mg; Fentanyl patch; oxycodone 30 mg	Cash	Corona	28	12	Dr. A.B. Dr. G.V.D. Dr. D.H.	64
L.S.	Alprazolam 2 mg; Fentanyl patch; oxycodone 30 mg	Cash	Santa Ana	10	5	Dr. A.B. Dr. G.V.D. Dr. L.B.	71
Z.S.	Fentanyl patch; oxycodone 30 mg	Cash	Irvine	4	6	Dr. A.B.	24
M.V.	Carisoprodol 350 mg; Fentanyl patch; oxycodone 30 mg	Cash	Laguna Hills	4	7	Dr. A.B.	24

35. On March 17, 2015, Board inspectors conducted an inspection at Respondent Pharmacy. During the inspection, Respondent Nguyen stated that the pharmacists at the pharmacy did not document communication with prescribers or their offices regarding prescriptions for controlled substances either on the prescription itself or in the pharmacy's

computer. None of the 69 prescriptions issued by Dr. A.B. and collected during this inspection had a notation by pharmacy staff regarding verification of the prescription.

36. The following examples are prescriptions with irregularities on the face of the prescriptions that should have alerted Respondents that the prescriptions may not have been issued for a legitimate medical purpose:

a. Rx No. 37660 – This prescription was written for R.B. by a dentist, Dr. M.B., for fentanyl transdermal patches 100 mcg. Fentanyl is a strong opioid used to manage severe pain requiring around-the-clock, long-term treatment. Respondents filled the prescription on February 4, 2015. Prescribing fentanyl patches is typically outside a dentist's scope of practice and necessitated further inquiry by Respondents into the legitimacy of the prescription. There was no documentation on the prescription indicating Dr. M.B. was contacted to verify the prescription. Dr. M.B. denied issuing this prescription to M.B. Of note, on the same day, February 4, 2015, Respondent noted that a prescription issued by the same dentist, Dr. M.B. for oxycodone 30 mg for M.C. was a "fake."

b. Rx Nos. 39559 and 39558 – The prescription was written for D.W. by Dr. M.G. for carisoprodol 350 mg and oxycodone 30 mg, respectively. The prescription document did not have a watermark printed on the reverse of the prescription blank stating "California Security Prescription." The patient's address was in Long Beach, California, which is outside the pharmacy's local trade area. In addition, the patient paid in cash for all medications, including $600 cash for oxycodone.

c. Rx Nos. 39218, 39222, 39869, 39870 – These prescriptions were written by Dr. G.V.D. for three individuals, R.B., T.C and M.V. and were filled by Respondents on February 17, 2015 and February 20, 2015. The signatures for Dr. G.V.D. in the three prescriptions varied. In addition, these individuals were identified by Dr. A.B. has having forged prescriptions under Dr. A.B.'s name.

37. According to Respondents, Respondents dispensed drugs to patients outside of Orange County if the patients were terminally ill, home-bound or non-ambulatory. At the request of the Board inspectors, Respondents provided a list consisting of 17 pages of patients who

resided outside of Orange County. Respondents identified two patients from the list who were residents of a nursing home where Dr. A.B. was the attending physician and who received non-controlled substance prescriptions issued by Dr. A.B. All others were dispensed highly abusive drugs such as oxycodone, alprazolam, fentanyl, oxymorphone, carisoprodol, morphine sulfate, hydromorphone and amphetamine.

38. In addition to irregularities on the face of prescriptions that should have alerted Respondents that prescriptions may not have been issued for a legitimate medical purpose, examples of other irregularities include:

a. Military personnel paying cash for controlled substances when, according to the website for military health insurance, active duty service members and their families are provided comprehensive health insurance including prescription drug coverage. Examples of such prescriptions are prescriptions issued to D.A., Z.S., B.K., M.G., C.G., R.H. and T.C.

b. Controlled substance prescriptions dispensed under Dr. A.B.'s name for the same drug therapy to patients with the same address. For example:

i) Respondent dispensed the same drug therapy to C.B. and A.B., which were oxycodone 30 mg tablets and fentanyl 100 mcg transdermal patches. Both patients received the highest strength of oxycodone for their first prescription dispensed by Respondent.

ii) Respondent dispensed the same drug therapy to R.B. and T.B., which were oxycodone 30 mg tablets, alprazolam 2 mg tablets, oxymorphone ER 40 mg tablets and fentanyl 100 mcg transdermal patches. R.B. also received carisoprodol 350 mg tablets, which in combination with the pain relievers and alprazolam, constitutes what is referred to as the "Holy Trinity."

39. A review of prescription documents for drugs dispensed by Respondents, Respondent's Patient Medication Information and CURES reports for the period March 17, 2014 to March 14, 2015 revealed the following sample of irregularities, in addition to those set forth above, that should have alerted Respondents that the prescriptions may not have been issued for a legitimate medical purpose:

a. Patient A.B. – This patient was identified by Dr. A.B. as having a forged prescription issued in his name. This patient's first prescription, dispensed by Respondent on or about September 19, 2013, was for oxycodone 30 mg and was for the highest strength of oxycodone immediate release tablets. Payments for prescriptions were made in cash although this patient had insurance. Prescriptions for oxycodone in the 14 months that followed, and that were filled by Respondent, were issued by four different prescribers, which is indicative of doctor shopping. The directions on the prescription issued on July 18, 2014, for fentanyl patch stated, "1 patch q 48 hrs," that is, apply 1 patch to the skin every 48 hours. Respondent dispensed Rx 18017 with the directions to apply the patch every 72 hours. The prescription issued on July 18, 2014, has an irregularity that should have alerted Respondents that the prescriptions may not have been issued for a legitimate medical purpose because one fentanyl transdermal patch is indicated to be changed every 72 hours. Between September, 2014 and November, 2014, A.B. filled prescriptions for oxycodone 30 mg and fentanyl patch from Tower Pharmacy, CVS Pharmacy and Dial Pharmacy, alternating between cash and insurance payments.

b. Patient C.B. - This patient was identified by Dr. A.B. as having a forged prescription issued in his name. This patient's first prescription from Respondent for oxycodone 30 mg was dispensed on or about October 1, 2013 and was for the highest strength of oxycodone immediate release tablets. Payments for prescriptions were made in cash although this patient had insurance; this patient paid up to $600 in cash for oxycodone 30 mg. Subsequent prescriptions for oxycodone 30 mg were issued by two different prescribers.

c. Patient R.B. - This patient was identified by Dr. A.B. as having a forged prescription issued in his name. This patient's first prescription, dispensed by Respondent on or about July 19, 2014, was for oxycodone 30 mg tablets, alprazolam 2 mg tablets, oxymorphone ER 40 mg tablets and fentanyl 100 mcg transdermal patches. R.B. received the highest strength of fentanyl transdermal patch and alprazolam for his first prescriptions. R.B.'s prescription for fentanyl patch was written with directions to use 1 patch every 48 hours, which represented a factor of irregularity since the drug was indicated to be used every 72 hours and the prescription was written for the highest dose. This prescription was irregular on its face because of duplicative

therapy provided by oxymorphone ER at the highest strength and fentanyl transdermal patches, which is another extended release opioid product. There was no documentation Respondents verified this prescription with the prescriber. This patient paid with cash, including a cash payment of $720.00 on July 19, 2014. Review of CURES reports would have shown that T.B. obtained early refills of controlled substances by using multiple pharmacies.

d. Patient T.B. - This patient was identified by Dr. A.B. as having a forged prescription issued in his name. This patient's first prescription, dispensed by Respondent on or about April 14, 2014, was for oxycodone 30 mg and fentanyl transdermal patch 100 mcg. It was for the highest strength of fentanyl patch and oxycodone tablets. This patient paid with cash, including cash payments of $480.00 and $380.00 on April 14, 2014 for these drugs. Review of CURES reports would have shown that T.B. obtained early refills of controlled substances by using multiple pharmacies. Notes on a prescription purportedly issued by Dr. G.V.D. on January 26, 2015, indicated the prescription was a fake. This should have alerted Respondents that other prescriptions issued to this patient may not have been issued for a legitimate medical purpose.

e. Patient M.V. - This patient was identified by Dr. A.B. as having a forged prescription issued in his name. This patient's first prescription, dispensed by Respondent on on about December 12, 2013, was for oxycodone 30 mg and was for the highest strength of oxycodone tablets. This patient was 22 years old at the time and paid with cash. This patient continued to obtain controlled substances from Respondent and paid cash in increasing amounts. For example, on January 10, 2015, this patient paid $600.00 in cash for oxycodone 30 mg in the same quantity. On the same day, this patient paid $750.00 in cash for fentanyl. A review of CURES would have revealed that this patient had insurance, obtained early refills and engaged in doctor- and pharmacy-shopping activities. This patient also picked up prescriptions for Z.S. and J.M. as their prescription documents showed. All three patients were purportedly prescribed oxycodone 30 mg and fentanyl patches by Dr. A.B. Respondent's prescription document showed that cash was the form of payment used. The documentation for Rx 22999 and 23000 indicated that M.V. picked up Z.S.'s prescription and that M.V. was Z.S.'s roommate although Respondent's records show these patients had different addresses.

f. Patient M.B. – This patient was identified by Dr. A.B. as having a forged prescription issued in his name. This patient's first prescription, dispensed by Respondent on or about October 24, 2014, was for oxymorphone ER 40 mg, fentanyl patches 100 mcg, and alprazolam 2 mg tablets. All these drugs were for the highest strengths available. The oxymorphone and fentanyl prescriptions were prescribed to be used more often than their indicated uses. There was duplication in therapy with the prescribing of long-acting oxymorphone with long-acting fentanyl patches. This patient paid $1,300.00 cash for oxymorphone 30 mg and $750 cash for fentanyl transdermal patch 100 mcg.

g. Patient T.C. – This patient used many different prescribers to obtain prescriptions for controlled substances, primarily opioids, dispensed by Respondent. The prescriptions were for duplicative therapy. The first nine prescriptions dispensed by Respondent were from nine different prescribers. This patient provided military identification but paid for the controlled substances with cash. Respondent's patient profile showed the following drugs dispensed by Respondent:

Date dispensed	Drug	Prescriber	Comments
8/6/2013	Oxycodone 30 mg #90 for a 30-day supply	Dr. J.A.	
8/19/2013	Oxycodone 30 mg #120 for a 30-day supply	Dr. M.S.	Early refill
8/26/2013	Oxycodone/acetaminophen 7.5/500 mg #60 for a 30-day supply	Dr. B.S.	Early refill
9/9/2013	Oxycodone 30 mg #50 for a 30-day supply	Dr. H.L.	Early refill
9/17/2014	Oxymorphone 20 mg #60 for a 30-day supply	Dr. G.V.D.	
9/17/2014	Oxycodone 30 mg #100 for a 30-day supply	Dr. G.V.D.	
9/23/2014	Hydromorphone 4 mg, #120 for a 30-day supply	Dr. A.B.	
9/23/2014	Oxycodone/acetaminophen 10/325 mg #60 for a 30-day supply	Dr. A.B.	
11/3/2014	Oxycodone 30 mg #90 for a 30-day supply	Dr. Y.G.	
11/5/2014	Morphine sulfate 30 mg, ER, #60 for a 30-day supply	Dr. W.K.	

Date dispensed	Drug	Prescriber	Comments
11/6/2014	Oxymorphone 20 mg ER #60 for a 30-day supply	Dr. G.V.D.	
11/7/2014	Oxycodone/acetaminophen 10/325 mg #75 for a 25-day supply	Dr. G.V.D.	
12/3/2014	Oxycodone 30 mg #60 for a 30-day supply	Dr. Y.G.	
12/12/2014	Morphine sulfate 30 mg, ER, #60 for a 30-day supply	Dr. W.K.	
12/17/2014	Oxymorphone 20 mg #60 for a 30-day supply	Dr. Y.G.	
12/17/2014	Oxycodone 30 mg #60 for a 30-day supply	Dr. Y.G.	

h. Patient S.I. – This patient's address is in Long Beach, which is approximately 25 miles driving distance away from Respondent Pharmacy and is therefore beyond Respondent's local trade area. There were no notes for this patient indicating an inquiry was made about the reason this patient traveled to Respondent Pharmacy to obtain controlled substance prescriptions. This patient was not identified as a home-bound or non-ambulatory patient. This patient received his first prescription from Respondent Pharmacy on or about September 24, 2013 for oxycodone 30 mg, immediate release tablets; the highest strength for this drug. This patient paid $120 in cash for this prescription on September 24, 2013. On June 28, 2014, this patient used insurance to obtain two controlled substance prescriptions (alprazolam 2 mg and methylphenidate 20 mg) for a $15.00 copay for each drug. On August 9, 2014 and September 12, 2014, this patient paid $600 in cash for oxycodone 30 mg.

40. CURES data has been available to licensed pharmacists without cost since at least 2010, although pharmacists must register with the Department of Justice to access CURES. Respondent Nguyen and Pharmacist H.T. advised the Board's inspector that the pharmacy checked CURES in their review of controlled substance prescriptions. The irregularities and red flags present in the prescriptions described above should have alerted Respondents to review CURES for additional patient information. Had Respondents done so, additional red flags would have alerted them to further investigate the legitimacy of the controlled substance prescriptions:

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a. Patient R.B.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
9/23/2014	Saddleback Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Should last patient until 10/23/2014
10/2/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #15 for a 30-day supply	Refilled too soon by 21 days

b. Patient T.B.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
9/29/2014	Seena Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Should last patient until 10/29/2014
10/10/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #15 for a 30-day supply	Refilled too soon by 19 days

c. Patient A.B.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
7/3/2014	Tower Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 8/3/2014
7/8/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 25 days
DATE	**PHARMACY**	**DRUG**	**COMMENTS**
7/28/2014	Seena Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Should last patient until 8/28/2014
8/7/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 21 days
8/7/2014	Tower Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 9/7/2014
8/8/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 29 days
11/23/2014	Dial Drug, Inc.	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Should last patient until 12/23/2014
12/3/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 20 days
12/28/2014	CVS Pharmacy #9242	Fentanyl patch, 100 mcg, #30 for a 30-day supply	Should last patient until 1/28/2015
1/8/2015	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 20 days

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d. Patient M.V.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
6/12/2014	CVS Pharmacy #9242	Fentanyl patch, 100 mcg, #10 for a 30-day supply	
6/21/2014	Foothill Ranch Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	
7/9/2014	CVS Pharmacy #9242	Fentanyl patch, 100 mcg, #10 for a 30-day supply	
7/19/2014	Foothill Ranch Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	The combined supplies on 6/12/2014, 6/21/2014, 7/9/2014 and 7/19/2014 should last patient until 10/12/2014.
8/16/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 56 days
8/19/2014	Seena Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Should last patient until 9/19/2014
9/11/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 8 days
9/20/2014	CVS Pharmacy #9485	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 10/20/2014
10/7/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 13 days
9/20/2014	Sav-On Pharmacy #6517	Fentanyl patch, 100 mcg, #5 for a 10-day supply	
9/28/2014	CVS Pharmacy #9485	Fentanyl patch, 100 mcg, #10 for a 30-day supply	The combined supplies on 9/20/2014 and 9/28/2014 should last patient until 10/30/2014.
10/8/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 22 days

e. Patient T.C.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
7/21/2014	Super Rx Pharmacy #186	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 8/21/2014
8/4/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 17 days; should last patient until 9/4/2014
8/25/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too early by 9 days

DATE	PHARMACY	DRUG	COMMENTS
9/30/2014	Sav-On Pharmacy #6507	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 10/30/2014
10/13/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 17 days
11/23/2017	Sav-On Pharmacy #6507	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 12/23/2014
12/3/2014	Value Rx Pharmacy	Oxycodone 30 mg #60 for a 30-day supply	Refilled too soon by 20 days

f. Patient C.G.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
9/22/2014	Foothill Ranch Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	
	Foothill Ranch Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	
10/18/2014	Foothill Ranch Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	
10/18/2014	Foothill Ranch Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	
11/15/2014	Foothill Ranch Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	The combined supplies of oxycodone 30 mg on 9/22/2014, 10/18/2014 and 11/15/2014 should last patient until 12/22/2014.
	Foothill Ranch Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	The combined supplies of fentanyl patch 100 mcg on 9/22/2014, 10/18/2014 and 11/15/2014 should last patient until 12/22/2014.
12/13/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 9 days
	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 9 days

g. Patient S.I.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
7/30/2014	Foothill Ranch Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 8/30/2014
8/9/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too early by 19 days

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h. Patient Z.S.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
8/1/2014	Foothill Ranch Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Should last until 9/1/2014
8/18/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too early by 13 days

i. Patient K.F.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
8/5/2014	Seena Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Should last until 9/5/2014
8/13/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too early by 23 days
9/8/2014	Seena Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Should last patient until 10/8/2014
9/18/2014	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 20 days

j. Patient R.L.G.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
10/20/2014	Dial Drug, Inc.	Oxycodone 30 mg #120 for a 30-day supply	Should last until 11/20/2014
11/3/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too early by 17 days

k. Patient L.G.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
1/5/2015	Value Rx Pharmacy.	Oxycodone 30 mg #120 for a 60-day supply	Should last until 3/5/2015
1/23/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too early by 42 days. Even if there was a change in instructions for 120 tablets to last 30 days, the refill would still be early by 12 days.

l. Patient M.N.'s CURES information:

DATE	PHARMACY	DRUG	COMMENTS
6/20/2014	Tower Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	

DATE	PHARMACY	DRUG	COMMENTS
6/27/2014	Foothill Ranch Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	The combined supplies of oxycodone 30 mg on 6/20/2014 and 6/27/2014 should last patient until 8/20/2014.
7/3/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 47 days
9/16/2014	CVS Pharmacy #8882	Oxycodone 30 mg #120 for a 30-day supply	Should last patient until 10/16/2014
	CVS Pharmacy #8882	Fentanyl patch, 100 mcg, #15 for a 30-day supply	Should last patient until 10/16/2014
10/6/2014	Value Rx Pharmacy	Oxycodone 30 mg #120 for a 30-day supply	Refilled too soon by 10 days
	Value Rx Pharmacy	Fentanyl patch, 100 mcg, #10 for a 30-day supply	Refilled too soon by 10 days
10/14/2014	Saddleback Pharmacy	Oxymorphone 40 mg #90 for a 30-day supply	Should last patient until 11/14/2014
11/7/2014	Value Rx Pharmacy	Oxymorphone 40 mg #90 for a 30-day supply	Refilled too soon by 7 days

FIRST CAUSE FOR DISCIPLINE

AS TO VALUE RX PHARMACY AND THUY V. NGUYEN ONLY

(Obstructing Patient from Obtaining A Prescription Drug That was Legally Prescribed)

41. Respondents Value Rx Pharmacy and Thuy V. Nguyen are subject to discipline pursuant to Code section 733, subdivision (a) in that on or about October, 2014, Respondents failed to notify, or deliver to, S.S. his prescriptions for calcium acetate (Rx No. 13653) and metroporlol (Rx No. 11080) in a timely manner, as more fully set forth in paragraphs 26-28 above, and incorporated by this reference as though set forth in full herein.

SECOND CAUSE FOR DISCIPLINE

AS TO ALL RESPONDENTS

(Required Supervision of Pharmacy Technicians)

42. Respondents Value Rx Pharmacy and Thuy V. Nguyen are subject to discipline pursuant to Code section 4115, subdivision (a) in that on or about January 30, 2015, while H.T. was the only pharmacist on duty, Pharmacy Technicians C.N. and Z.A. were performing duties such as packaging and filling prescriptions without the required 1:1 pharmacist/pharmacy

technician ratio, as more fully set forth in paragraphs 26-28 above, and incorporated by this reference as though set forth in full herein.

THIRD CAUSE FOR DISCIPLINE

AS TO ALL RESPONDENTS

(Failure to Comply with Corresponding Responsibility for Legitimate Controlled Substance Prescriptions)

43. Respondents Value Rx Pharmacy and Thuy V. Nguyen are subject to discipline pursuant to Code section 4301, subdivision (j), in conjunction with Health and Safety Code section 11153, subdivision (a), for unprofessional conduct in that Respondents failed to comply with their corresponding responsibility to ensure that controlled substances are dispensed for a legitimate medical purpose when between June 12, 2014 and January 30, 2015, Respondents failed to evaluate the totality of the circumstances (information from the patient, physician and other sources) to determine the prescription's legitimate medical purpose in light of information showing that prescriptions for controlled substances were filled early, there was duplication of therapy dispensed on the same day or soon thereafter, multiple patients received the same or similar drug therapy with opioid medications, numerous patients paid with cash for controlled substances, numerous patients initially presented prescriptions for the highest strengths available for controlled substances, military personnel paid with cash, evidence of doctor shopping and pharmacy shopping, younger patients on high dose of controlled substances, irregular dosing of fentanyl transdermal patches and oxymorphone ER tablets, irregularities in prescribing pattern of Dr. A.B., among other things, as more fully set forth in paragraphs 29-40 above, and incorporated by this reference as though set forth in full herein.

FOURTH CAUSE FOR DISCIPLINE

AS TO ALL RESPONDENTS

(Excessive Furnishing of Controlled Substances)

44. Respondents Value Rx Pharmacy and Thuy V. Nguyen are subject to discipline pursuant to Code section 4301, subdivision (d), for unprofessional conduct in that Respondents excessively furnished controlled substances during the period June 12, 2014 to January 30 2015,

as more fully set forth in paragraphs 29-40 above, and incorporated by this reference as though set forth in full herein.

FIFTH CAUSE FOR DISCIPLINE

AS TO THUY V. NGUYEN ONLY

(Unprofessional Conduct - Failure to Exercise Professional Judgment)

45. Respondent Thuy V. Nguyen is subject to discipline pursuant to Code section 4306, subdivisions (c) and (d), for unprofessional conduct in that from June 12, 2014 to January 30, 2015, Respondent failed to exercise or implement his best professional judgment or corresponding responsibility with regard to the dispensing or furnishing of controlled substances and dangerous drugs, and/or failed to consult appropriate patient, prescription, and other records, prior to dispensing, or allowing the dispensing of, controlled substances, as more fully set forth in paragraphs 29-40 above, and incorporated by this reference as though set forth in full herein.

SIXTH CAUSE FOR DISCIPLINE

AS TO THUY V. NGUYEN ONLY

(Unprofessional Conduct – Dispensing Prescriptions with Significant Irregularities)

46. Respondent Thuy V. Nguyen is subject to discipline pursuant to title 16, CCR, section 1761, subdivisions (a) and (b), for unprofessional conduct in that from June 12, 2014 to January 30, 2015, Respondent dispensed, or allowed to be dispensed, prescriptions which contained significant errors or irregularities, even after conferring with the prescriber, when Respondent knew or should have known said prescriptions were not issued for a legitimate medical purpose, as more fully set forth in paragraphs 29-40 above, and incorporated by this reference as though set forth in full herein.

SEVENTH CAUSE FOR DISCIPLINE

AS TO THUY V. NGUYEN ONLY

(Unprofessional Conduct – Gross Negligence)

47. Respondent Thuy V. Nguyen is subject to discipline pursuant to Code section 4301, subdivision (c) for gross negligence in that from June 12, 2014 to January 30, 2015, Respondent knew or should have known that the prescriptions for controlled substances issued by Dr. A.B.

were likely to be diverted or used for other than a legitimate medical purpose. Respondent also failed to take appropriate steps upon being presented with numerous prescriptions for the same controlled substances to ensure they were issued for a legitimate medical purpose, as more fully set forth in paragraphs 29-40 above, and incorporated by this reference as though set forth in full herein.

EIGHTH CAUSE FOR DISCIPLINE

AS TO THUY V. NGUYEN ONLY

(Unprofessional Conduct)

48. Respondent Thuy V. Nguyen is subject to discipline pursuant to Code section 4301 for unprofessional conduct, as more fully set forth in paragraphs 26-40 above, and incorporated by this reference as though set forth in full herein. Respondent Nguyen exhibited unprofessional conduct in failing to notify, or deliver to, S.S. his prescriptions for calcium acetate (Rx No. 13653) and metoprolol (Rx No. 11080) in a timely manner. From June 12, 2014 to January 30, 2015, Respondent knew or should have known that the prescriptions for controlled substances issued by Dr. A.B. were likely to be diverted or used for other than a legitimate medical purpose. Respondent also failed to take appropriate steps upon being presented with numerous prescriptions for the same controlled substances to ensure they were issued for a legitimate medical purpose, as more fully set forth in paragraphs 26-40 above, and incorporated by this reference as though set forth in full herein.

OTHER MATTERS

49. Pursuant to Section 4307, if Pharmacy Permit Number PHY 51246 issued to TWB Venture, Inc., dba Value Rx Pharmacy is suspended, revoked or placed on probation, and Respondent Nguyen, while acting as the manager, administrator, owner, member, officer, director, associate, or partner, had knowledge of or knowingly participated in any conduct for which Pharmacy Permit Number PHY 51246 was revoked, suspended, or placed on probation, Respondent Nguyen shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee of the Board.

50. Pursuant to Section 4307, if Pharmacist License Number RPH 51877 issued to Thuy Vu Nguyen is suspended or revoked, Respondent Nguyen shall be prohibited from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Pharmacy issue a decision:

1. Revoking or suspending Pharmacy Permit Number PHY 51246, issued to TWB Venture, Inc., dba Value Rx Pharmacy, Thuy Vu Nguyen, CEO;

2. Revoking or suspending Pharmacist License Number RPH 51877 issued to Thuy Vu Nguyen;

3. Prohibiting Thuy Vu Nguyen from serving as a manager, administrator, owner, member, officer, director, associate, or partner of a licensee of the Board;

4. Ordering TWB Venture, Inc., dba Value Rx Pharmacy and Thuy V. Nguyen, jointly and severally, to pay the Board of Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

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

DATED: 8/11/16

Virginia Herold

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

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