

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

In the Matter of the Second Amended
Accusation Against:

**TWIN PHARMACY, INC. dba
DABNEY PHARMACY,**
11115 S. Main Street
Los Angeles, CA 90061

Pharmacy Permit No. PHY 46745

AND

ROBERT ROTHMAN
16400 Saybrook Lane, No. 26
Huntington Beach, CA 92649

Pharmacist License No. RPH 30759

Respondents.

Case No. 4445

OAH No. 2014040886

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

**[AS TO RESPONDENT
TWIN PHARMACY, INC. dba
DABNEY PHARMACY ONLY]**

DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Board of Pharmacy, Department of Consumer Affairs, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on December 5, 2016.

It is so ORDERED on November 3, 2016.

BOARD OF PHARMACY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA



By

Amy Gutierrez, Pharm.D.
Board President

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS L. RINALDI
Supervising Deputy Attorney General
3 SUSAN MELTON WILSON
Deputy Attorney General
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Attorneys for Complainant
7

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10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

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**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

**[AS TO RESPONDENT
TWIN PHARMACY, INC. dba
DABNEY PHARMACY ONLY]**

22 IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-
23 entitled proceedings that the following matters are true:

24 **PARTIES**

25 1. Virginia Herold (Complainant) is the Executive Officer of the Board of Pharmacy.
26 She brought this action solely in her official capacity and is represented in this matter by Kamala
27 D. Harris, Attorney General of the State of California, by Susan Melton Wilson, Deputy Attorney
28 General.

1 adverse decision; and all other rights accorded by the California Administrative Procedure Act
2 and other applicable laws.

3 8. Respondent Pharmacy voluntarily, knowingly, and intelligently waives and gives up
4 each and every right set forth above.

5 **CULPABILITY**

6 9. For the purposes of settlement and the Board's purposes only, Respondent Pharmacy
7 admits the truth of each and every charge and allegation in Second Amended Accusation No.
8 4445. These admissions will not preclude Respondent Pharmacy from contesting any of the facts
9 and allegations in any legal, administrative, or other cause or proceeding to which the Board is
10 not a party.

11 10. Respondent Pharmacy agrees that its Pharmacy Permit is subject to discipline and
12 they agree to be bound by the Board's probationary terms as set forth in the Disciplinary Order
13 below.

14 **CONTINGENCY**

15 11. This stipulation shall be subject to approval by the Board of Pharmacy. Respondent
16 Pharmacy understands and agrees that counsel for Complainant and the staff of the Board of
17 Pharmacy may communicate directly with the Board regarding this stipulation and settlement,
18 without notice to or participation by Respondent Pharmacy or its counsel. By signing the
19 stipulation, Respondent Pharmacy understands and agrees that they may not withdraw its
20 agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it.
21 If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and
22 Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible
23 in any legal action between the parties, and the Board shall not be disqualified from further action
24 by having considered this matter.

25 12. The parties understand and agree that Portable Document Format (PDF) and facsimile
26 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
27 signatures thereto, shall have the same force and effect as the originals.

1 13. Parties agree that a clerical error appears in the numbering of causes in the Second
2 Amended Accusation, and further agree that the Second Amended Accusation shall be amended
3 by interlineation to correct and eliminate this error, so that the 16 causes for discipline are
4 numbered consecutively. No changes to the Second Amended Accusation, apart from re-
5 numbering the causes as described, is authorized by this stipulation.

6 14. This Stipulated Settlement and Disciplinary Order is intended by the parties to be an
7 integrated writing representing the complete, final, and exclusive embodiment of their agreement.
8 It supersedes any and all prior or contemporaneous agreements, understandings, discussions,
9 negotiations, and commitments (written or oral). This Stipulated Settlement and Disciplinary
10 Order may not be altered, amended, modified, supplemented, or otherwise changed except by a
11 writing executed by an authorized representative of each of the parties.

12 15. In consideration of the foregoing admissions and stipulations, the parties agree that
13 the Board may, without further notice or formal proceeding, issue and enter the following
14 Disciplinary Order:

15 **DISCIPLINARY ORDER**

16 IT IS HEREBY ORDERED that Pharmacy Permit No. PHY 46745 issued to Respondent
17 Pharmacy Twin Pharmacy, Inc. dba Dabney Pharmacy, Shlomo Rechnitz, President, is revoked.
18 However, the revocation is stayed and Respondent Pharmacy is placed on probation for five (5)
19 years on the following terms and conditions.

20 **1. Obey All Laws**

21 Respondent Pharmacy's owner shall obey all state and federal laws and regulations.

22 Respondent Pharmacy's owner or his designee, shall report any of the following
23 occurrences to the board, in writing, within seventy-two (72) hours of such occurrence:

- 24 an arrest or issuance of a criminal complaint for violation of any provision of the
25 Pharmacy Law, state and federal food and drug laws, or state and federal controlled
26 substances laws
27 a plea of guilty or nolo contendere in any state or federal criminal proceeding to any
28 criminal complaint, information or indictment

- 1 a conviction of any crime
- 2 discipline, citation, or other administrative action filed by any state or federal agency
- 3 which involves Respondent Pharmacy's permit or which is related to the practice of
- 4 pharmacy or the manufacturing, obtaining, handling or distributing, billing, or
- 5 charging for any drug, device or controlled substance.

6 Respondent Pharmacy's owner is responsible to insure compliance with this condition, and
7 failure to timely report any such occurrence shall be considered a violation of probation.

8 **2. Report to the Board**

9 Respondent Pharmacy's owner or his designee shall report to the board quarterly, on a
10 schedule as directed by the board or its designee. The report shall be made either in person or in
11 writing, as directed. Among other requirements, Respondent Pharmacy's owner shall state in
12 each report under penalty of perjury whether there has been compliance with all the terms and
13 conditions of probation. Failure to submit timely reports in a form as directed shall be considered
14 a violation of probation. Any period(s) of delinquency in submission of reports as directed may
15 be added to the total period of probation. Respondent Pharmacy's owner is responsible to insure
16 compliance with this condition. Moreover, if the final probation report is not made as directed,
17 probation shall be automatically extended until such time as the final report is made and accepted
18 by the board.

19 **3. Interview with the Board**

20 Upon receipt of reasonable prior notice, Respondent Pharmacy's owner or his designee
21 shall appear in person for interviews with the board or its designee, at such intervals and locations
22 as are determined by the board or its designee. Respondent Pharmacy's owner is responsible to
23 insure compliance with this condition, and failure to appear for any scheduled interview without
24 prior notification to board staff, or failure to appear for two (2) or more scheduled interviews with
25 the board or its designee during the period of probation, shall be considered a violation of
26 probation.

27 **4. Cooperate with Board Staff**

28 Respondent Pharmacy's owner shall cooperate with the board's inspection program and

1 with the board's monitoring and investigation of Respondent Pharmacy 's compliance with the
2 terms and conditions of their probation. Failure to cooperate shall be considered a violation of
3 probation.

4 **5. Reimbursement of Board Costs**

5 As a condition precedent to successful completion of probation, Respondent Pharmacy
6 owner shall pay to the board its costs of investigation and prosecution in the amount of
7 \$100,000.00 (one hundred thousand dollars).

8 Respondent Pharmacy's owner or his designee shall make said payments in accord with a
9 payment plan approved by the board or its designee; and there shall be no deviation from this
10 payment plan absent prior written approval by the board or its designee. Respondent Pharmacy's
11 owner is responsible to insure compliance with this condition , and failure to pay costs by the
12 deadline(s) as directed shall be considered a violation of probation.

13 The filing of bankruptcy by Respondent Pharmacy's owner shall not relieve Respondent
14 Pharmacy of its responsibility to reimburse the board its costs of investigation and prosecution.

15 **6. Probation Monitoring Costs**

16 Respondent Pharmacy owner or his designee shall pay any costs associated with probation
17 monitoring as determined by the board each and every year of probation. Such costs shall be
18 payable to the board on a schedule as directed by the board or its designee. Respondent
19 Pharmacy's owner is responsible to insure compliance with this condition , and failure to pay
20 such costs by the deadline(s) as directed shall be considered a violation of probation.

21 **7. Status of License**

22 Respondent Pharmacy's owner shall, at all times while on probation, maintain current
23 licensure with the board. If Respondent Pharmacy owner submits an application to the board, and
24 the application is approved, for a change of location, change of permit or change of ownership,
25 the board shall retain continuing jurisdiction over the license, and the Respondent Pharmacy shall
26 remain on probation as determined by the board. Failure to maintain current licensure shall be
27 considered a violation of probation.

28 If Respondent Pharmacy's owner's license expires or is cancelled by operation of law or

1 otherwise at any time during the period of probation, including any extensions thereof or
2 otherwise, upon renewal or reapplication Respondent Pharmacy's owner's license shall be subject
3 to all terms and conditions of this probation not previously satisfied.

4 **8. License Surrender While on Probation/Suspension**

5 Following the effective date of this decision, should Respondent Pharmacy's owner
6 discontinue business, Respondent Pharmacy's owner may tender the premises license to the board
7 for surrender. The board or its designee shall have the discretion whether to grant the request for
8 surrender or take any other action it deems appropriate and reasonable. Upon formal acceptance
9 of the surrender of the license, Respondent Pharmacy will no longer be subject to the terms and
10 conditions of probation.

11 Upon acceptance of the surrender, Respondent Pharmacy's owner shall relinquish the
12 premises wall and renewal license to the board within ten (10) days of notification by the board
13 that the surrender is accepted. Respondent Pharmacy's owner shall further submit a completed
14 Discontinuance of Business form according to board guidelines and shall notify the board of the
15 records inventory transfer.

16 Respondent Pharmacy's owner shall also, by the effective date of this decision, arrange for
17 the continuation of care for ongoing patients of the pharmacy by, at minimum, providing a written
18 notice to ongoing patients that specifies the anticipated closing date of the pharmacy and that
19 identifies one or more area pharmacies capable of taking up the patients' care, and by cooperating
20 as may be necessary in the transfer of records or prescriptions for ongoing patients. Within five
21 days of its provision to the pharmacy's ongoing patients, Respondent Pharmacy owner shall
22 provide a copy of the written notice to the board. For the purposes of this provision, "ongoing
23 patients" means those patients for whom the pharmacy has on file a prescription with one or more
24 refills outstanding, or for whom the pharmacy has filled a prescription within the preceding sixty
25 (60) days.

26 Respondent Pharmacy's owner may not apply for any new licensure from the board for
27 three (3) years from the effective date of the surrender. Respondent Pharmacy owner shall meet
28 all requirements applicable to the license sought as of the date the application for that license is

1 submitted to the board.

2 Respondent Pharmacy's owner further stipulates that he or she shall reimburse the board for
3 its costs of investigation and prosecution prior to the acceptance of the surrender.

4 **9. Notice to Employees**

5 Respondent Pharmacy's owner shall, upon or before the effective date of this decision,
6 ensure that all employees involved in permit operations are made aware of all the terms and
7 conditions of probation, either by posting a notice of the terms and conditions, circulating such
8 notice, or both. If the notice required by this provision is posted, it shall be posted in a prominent
9 place and shall remain posted throughout the probation period. Respondent Pharmacy's owner
10 shall ensure that any employees hired or used after the effective date of this decision are made
11 aware of the terms and conditions of probation by posting a notice, circulating a notice, or both.
12 Additionally, Respondent Pharmacy's owner shall submit written notification to the board,
13 within fifteen (15) days of the effective date of this decision, that this term has been satisfied.
14 Failure to submit such notification to the board shall be considered a violation of probation.

15 Various acts required to comply with this condition may be performed by Respondent's
16 Pharmacy's owner or his designee, however, Respondent Pharmacy's owner is responsible to
17 insure timely compliance with all condition requirements.

18 "Employees" as used in this provision includes all full-time, part-time, volunteer, temporary
19 and relief employees and independent contractors employed or hired at any time during
20 probation.

21 **10. Owners and Officers: Knowledge of the Law**

22 Respondent Pharmacy shall provide, within thirty (30) days after the effective date of this
23 decision, signed and dated statements from its owners, including any owner or holder of ten
24 percent (10%) or more of the interest in Respondent Pharmacy or Respondent Pharmacy's stock,
25 and any officer, stating under penalty of perjury that said individuals have read and are familiar
26 with state and federal laws and regulations governing the practice of pharmacy. The failure to
27 timely provide said statements under penalty of perjury shall be considered a violation of
28 probation.

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11. Posted Notice of Probation

Respondent Pharmacy's owner or his designee shall prominently post a probation notice provided by the board in a place conspicuous and readable to the public. The probation notice shall remain posted during the entire period of probation.

Respondent Pharmacy's owner shall not, directly or indirectly, engage in any conduct or make any statement which is intended to mislead or is likely to have the effect of misleading any patient, customer, member of the public, or other person(s) as to the nature of and reason for the probation of the licensed entity.

Failure to post such notice shall be considered a violation of probation.

12. Violation of Probation

If Respondent Pharmacy has not complied with any term or condition of probation, the board shall have continuing jurisdiction over Respondent Pharmacy's license, and probation shall be automatically extended until all terms and conditions have been satisfied or the board has taken other action as deemed appropriate to treat the failure to comply as a violation of probation, to terminate probation, and to impose the penalty that was stayed.

If Respondent Pharmacy's owner violates probation in any respect, the board, after giving Respondent Pharmacy's owner notice and an opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. Notice and opportunity to be heard are not required for those provisions stating that a violation thereof may lead to automatic termination of the stay and/or revocation of the license. If a petition to revoke probation or an accusation is filed against Respondent Pharmacy during probation, the board shall have continuing jurisdiction and the period of probation shall be automatically extended until the petition to revoke probation or accusation is heard and decided.

13. Completion of Probation

Upon written notice by the board or its designee indicating successful completion of probation, Respondent Pharmacy license will be fully restored.

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1 **14. Community Services Program**

2 Within sixty (60) days of the effective date of this decision, Respondent Pharmacy's owner
3 or his designee shall submit to the board or its designee, for prior approval, a community service
4 program for the benefit of the community where Dabney Pharmacy is located - in which
5 Respondent Pharmacy shall provide to a community or charitable group(s), facility or agency -
6 free health-care related services and/or programs providing education about diabetes, including
7 but not limited to prevention and/or management of diabetes. Said community service program(s)
8 shall have an approximate value of \$250,000.00 (two hundred and fifty thousand dollars), and
9 shall be completed prior to completion of probation.

10 Within thirty (30) days of board approval thereof, Respondent Pharmacy or his designee
11 shall submit documentation to the board demonstrating commencement of the community service
12 program. A record of this notification must be provided to the board upon request. Respondent
13 Pharmacy shall report on progress with the community service program in the quarterly reports.

14 Respondent Pharmacy's owner is responsible to insure compliance with this condition, and
15 failure to timely submit, commence, or comply with the program shall be considered a violation
16 of probation.

17 **15. Independent Consultant**

18 Respondent Pharmacy shall retain an independent consultant at its own expense, who shall
19 be responsible for reviewing pharmacy operations on a monthly basis for compliance by
20 Respondent Pharmacy with state and federal laws and regulations governing the practice of
21 pharmacy, and billing for dangerous drugs and devises (including billing for diabetic testing
22 supplies). The consultant shall be a pharmacist licensed by and not on probation with the Board,
23 and whose name shall be submitted to the Board or its designee, for prior approval, within thirty
24 (30) days of the effective date of the decision.

25 After the first year of probation, the frequency of review of pharmacy operations by the
26 independent consultant may be reduced by the board or its designee from monthly to quarterly, bi
27 annually or annually.

28 Failure to timely retain, seek approval of, or ensure timely reporting by the consultant shall

1 be considered a violation of probation.

2 **16. No Supervision by Respondent Rothman**

3 At no time during the period of probation shall Robert Rothman (Pharmacist License No.
4 RPH 30759), a named Respondent in Second Amended Accusation No. 4445, serve as
5 pharmacist in charge of Respondent Pharmacy, or otherwise have supervisory responsibility for
6 Respondent Pharmacy.

7 Failure to comply with this condition shall be considered a violation of probation.

8 **17. Pharmacy Related Activities Shall Take Place on Licensed Premises Only**

9 At all times during the period of probation, any and all pharmacy related activities,
10 including but not limited to packaging and labeling of dangerous drugs and devices, and billing
11 for such products, shall take place on the premises of the licensed pharmacy facility.

12 Failure to comply with this condition shall be considered a violation of probation.

13 **18. Notice of Investigation or Possible Change in Status with Specific Providers**

14 Respondent Pharmacy shall notify the board or its designee, verbally and in writing, if
15 Respondent Pharmacy discovers that any government agency has initiated an audit or
16 investigation related to its status as a service provider to patients insured by Cal Optima or
17 MediCal programs. Said report must be made within 15 (fifteen) days of discovery.

18 Failure to provide timely notification as described in this condition shall be considered a
19 violation of probation.

20
21 **ACCEPTANCE**

22 I am a duly authorized representative of Respondent Twin Pharmacy, Inc. dba Dabney
23 Pharmacy, license holder of Pharmacy Permit No. PHY 46745, referred to as "Respondent
24 Pharmacy" throughout this stipulation. I have carefully read the above Stipulated Settlement and
25 Disciplinary Order and have fully discussed it with attorney, Joe LaMagna. I understand the
26 stipulation and the effect it will have on Pharmacy Permit No. PHY 46745. On behalf of
27 Respondent Pharmacy I enter into this Stipulated Settlement and Disciplinary Order voluntarily,
28

1 knowingly, and intelligently, and agree that Twin Pharmacy, Inc. dba Dabney Pharmacy shall be
2 bound by the Decision and Order of the Board of Pharmacy.

3
4 DATED: 8/5/2016

Denise Wilson

TWIN PHARMACY, INC. dba DABNEY
PHARMACY

By: DENISE WILSON-RUANE
Authorized Representative of Respondent Pharmacy

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6
7
8 I have read and fully discussed with Respondent Twin Pharmacy, Inc. dba Dabney
9 Pharmacy; Shlomo Rechnitz, President, the terms and conditions and other matters contained in
10 the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

11 DATED: 8/5/16

Mark J. Lagna
JOE LAMAGNA

Attorney for Respondent Pharmacy


12
13
14
15 ENDORSEMENT

16 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
17 submitted for consideration by the Board of Pharmacy.

18
19 Dated: August ⁵, 2016

Respectfully submitted,

20 KAMALA D. HARRIS
Attorney General of California
21 THOMAS L. RINALDI
Supervising Deputy Attorney General

22
23 
24 SUSAN MELTON WILSON
Deputy Attorney General
25 *Attorneys for Complainant*

26
27
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1 knowingly, and intelligently, and agree that Twin Pharmacy, Inc. dba Dabney Pharmacy shall be
2 bound by the Decision and Order of the Board of Pharmacy.

3
4 DATED: 8/5/2016

Denise Wilson



TWIN PHARMACY, INC. dba DABNEY
PHARMACY

By: DENISE WILSON-RUANE

Authorized Representative of Respondent Pharmacy

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9 Pharmacy; Shlomo Rechnitz. President, the terms and conditions and other matters contained in
10 the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

11 DATED: _____

12 JOE LAMAGNA

Attorney for Respondent Pharmacy


13
14
15 ENDORSEMENT

16 The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully
17 submitted for consideration by the Board of Pharmacy.

18
19 Dated: ~~August~~ ^{September} 15, 2016

Respectfully submitted,

20 KAMALA D. HARRIS
Attorney General of California
21 THOMAS L. RINALDI
Supervising Deputy Attorney General

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23
24 
SUSAN MELTON WILSON
Deputy Attorney General
25 *Attorneys for Complainant*

26
27
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Exhibit A

Second Amended Accusation No. 4445

1 KAMALA D. HARRIS
Attorney General of California
2 THOMAS L. RINALDI
Supervising Deputy Attorney General
3 SUSAN MELTON WILSON
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Attorneys for Complainant
7

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13 **SHLOMO RECHNITZ, President, et al,**
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Case No. 4445

SECOND AMENDED
ACCUSATION

14 Pharmacy Permit No. PHY 46745

15 **AND**

16 **ROBERT ROTHMAN**
4682 Warner Avenue #C-115
17 Huntington Beach, CA 92649

18 Pharmacist License No. RPH 30759

19 Respondents.
20

21 Complainant alleges:

22 **PARTIES**

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

25 2. On or about December 20, 1976, the Board of Pharmacy issued Pharmacist License
26 Number RPH 30759 to Robert Rothman (Respondent Rothman). The Pharmacist License was in
27 full force and effect at all times relevant to the charges herein and will expire on May 31, 2016,
28 unless renewed.

1 (4) Revoking his or her license.

2 (5) Taking any other action in relation to disciplining him or her as the board in its
3 discretion may deem proper.”

4 7. Business and Professions Code section **4301** states:

5 The board shall take action against any holder of a license who is guilty of unprofessional
6 conduct or whose license has been procured by fraud or misrepresentation or issued by mistake.
7 Unprofessional conduct shall include, but is not limited to, any of the following:

8 . . .

9 "(f) The commission of any act involving moral turpitude, dishonesty, fraud, deceit, or
10 corruption, whether the act is committed in the course of relations as a licensee or otherwise, and
11 whether the act is a felony or misdemeanor or not.

12 (g) Knowingly making or signing any certificate or other document that falsely represents
13 the existence or nonexistence of a state of facts.

14 . . .

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

17 . . .

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

22 . . .

23 8. Section **4306.5** states:

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

25 (a) Acts or omissions that involve, in whole or in part, the inappropriate exercise of his or
26 her education, training, or experience as a pharmacist, whether or not the act or omission arises in
27 the course of the practice of pharmacy or the ownership, management, administration, or
28 operation of a pharmacy or other entity licensed by the board.

1 (b) Acts or omissions that involve, in whole or in part, the failure to exercise or implement
2 his or her best professional judgment or corresponding responsibility with regard to the
3 dispensing or furnishing of controlled substances, dangerous drugs, or dangerous devices, or with
4 regard to the provision of services.

5 (c) Acts or omissions that involve, in whole or in part, the failure to consult appropriate
6 patient, prescription, and other records pertaining to the performance of any pharmacy function.

7 . . .

8 (d) Acts or omissions that involve, in whole or in part, the failure to fully maintain and
9 retain appropriate patient-specific information pertaining to the performance of any pharmacy
10 function.”

11 9. Section **4040** provides in pertinent part:

12 “(a) ‘Prescription’ means an oral, written, or electronic transmission order that is both of
13 the following:

14 (1) Given individually for the person or persons for whom ordered that includes all of the
15 following:

16 (A) The name or names and address of the patient or patients.

17 (B) The name and quantity of the drug or device prescribed and the directions for use.

18 (C) The date of issue.

19 (D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and
20 telephone number of the prescriber, his or her license classification, and his or her federal registry
21 number, if a controlled substance is prescribed.

22 (E) A legible, clear notice of the condition or purpose for which the drug is being
23 prescribed, if requested by the patient or patients.

24 (F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife,
25 nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to
26 Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug
27 order pursuant to either Section 4052.1 or 4052.2.

28 . . .

1 (b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug,
2 except for any Schedule II controlled substance, that contains at least the name and signature of
3 the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of
4 subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the
5 drug prescribed, directions for use, and the date of issue may be treated as a prescription by the
6 dispensing pharmacist as long as any additional information required by subdivision (a) is readily
7 retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164
8 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.”

9 10. Section **4063** states:

10 “No prescription for any dangerous drug or dangerous device may be refilled except upon
11 authorization of the prescriber. The authorization may be given orally or at the time of giving the
12 original prescription. No prescription for any dangerous drug that is a controlled substance may
13 be designated refillable as needed.”

14 11. Section **4059** subdivision (a) states:

15 “A person may not furnish any dangerous drug, except upon the prescription of a
16 physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section
17 3640.7.”

18 12. Section **4081** provides in pertinent part:

19 “(a) All records of manufacture and of sale, acquisition, or disposition of dangerous drugs
20 or dangerous devices shall be at all times during business hours open to inspection by authorized
21 officers of the law, and shall be preserved for at least three years from the date of making. A
22 current inventory shall be kept by every manufacturer, wholesaler, pharmacy ... or establishment
23 holding a currently valid and unrevoked certificate, license, permit, registration, or exemption
24 under Division 2 (commencing with Section 1200) of the Health and Safety Code or under Part 4
25 (commencing with Section 16000) of Division 9 of the Welfare and Institutions Code who
26 maintains a stock of dangerous drugs or dangerous devices.

27 / / /

28 / / /

1 (b) The owner, officer, and partner of a pharmacy ... shall be jointly responsible, with the
2 pharmacist-in-charge or designated representative-in-charge, for maintaining the records and
3 inventory described in this section.”

4 13. Section **4104** provides in pertinent part:

5 “(a) Every pharmacy shall have in place procedures for taking action to protect the public
6 when a licensed individual employed by or with the pharmacy is discovered or known to be
7 chemically, mentally, or physically impaired to the extent it affects his or her ability to practice
8 the profession or occupation authorized by his or her license, or is discovered or known to have
9 engaged in the theft, diversion, or self-use of dangerous drugs.

10 (b) Every pharmacy shall have written policies and procedures for addressing chemical,
11 mental, or physical impairment, as well as theft, diversion, or self-use of dangerous drugs, among
12 licensed individuals employed by or with the pharmacy.”

13 14. Section **4105** of the Code states:

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

17 “(b) The licensee may remove the original records or documentation from the licensed
18 premises on a temporary basis for license-related purposes. However, a duplicate set of those
19 records or other documentation shall be retained on the licensed premises.

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

22 “(d) Any records that are maintained electronically shall be maintained so that the
23 pharmacist-in-charge, the pharmacist on duty if the pharmacist-in-charge is not on duty, or, in the
24 case of a veterinary food-animal drug retailer or wholesaler, the designated representative on
25 duty, shall, at all times during which the licensed premises are open for business, be able to
26 produce a hard copy and electronic copy of all records of acquisition or disposition or other drug
27 or dispensing-related records maintained electronically.

28 / / /

1 "(e)(1) Notwithstanding subdivisions (a), (b), and (c), the board, may upon written request,
2 grant to a licensee a waiver of the requirements that the records described in subdivisions (a), (b),
3 and (c) be kept on the licensed premises.

4 (2) A waiver granted pursuant to this subdivision shall not affect the board's authority
5 under this section or any other provision of this chapter."

6 15. Section **4110** of the Code states at subdivision (a):

7 “(a) No person shall conduct a pharmacy in the State of California unless he or she has
8 obtained a license from the board. A license shall be required for each pharmacy owned or
9 operated by a specific person. A separate license shall be required for each of the premises of any
10 person operating a pharmacy in more than one location. The license shall be renewed annually.
11 The board may, by regulation, determine the circumstances under which a license may be
12 transferred.”

13 16. Section **4115** provides in pertinent part:

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

18 . . .

19 (f)(1) A pharmacy with only one pharmacist shall have no more than one pharmacy
20 technician performing the tasks specified in subdivision (a). The ratio of pharmacy technicians
21 performing the tasks specified in subdivision (a) to any additional pharmacists shall not exceed
22 2:1, except that this ratio shall not apply to personnel performing clerical functions pursuant to
23 Section 4116 or 4117.”

24 17. Section **4342** provides at subdivision (a):

25 The board may institute any action or actions as may be provided by law and that, in its
26 discretion, are necessary to prevent the sale of pharmaceutical preparations and drugs that do not
27 conform to the standard and tests as to quality and strength, provided in the latest edition of the

28 / / /

1 united States Pharmacopoeia or the Sherman, Drug and Cosmetic Law (Part 5 (commencing with
2 Section 109875) of Division 104 of the Health and Safety Code).

3 18. Health and Safety Code section **11153** provides at subsection (a):

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 19. Health and Safety Code section **11208** provides:

15 “In a prosecution under this division, proof that a defendant received or has had in his
16 possession at any time a greater amount of controlled substances than is accounted for by any
17 record required by law or that the amount of controlled substances possessed by the defendant is a
18 lesser amount than is accounted for by any record required by law is prima facie evidence of
19 guilt.”

20 20. Civil Code section **56.10** requires in pertinent part, that a provider of health care,
21 health care service plan, or contractor shall not disclose medical information regarding a patient
22 of the provider of health care or an enrollee or subscriber of a health care service plan without
23 first obtaining an authorization.

24 21. California Code of Regulations, Title 16, section **1718** states:

25 “Current Inventory” as used in Sections 4081 and 4332 of the Business and Professions
26 Code shall be considered to include complete accountability for all dangerous drugs handled by
27 every licensee enumerated in Sections 4081 and 4332.

28

1 The controlled substances inventories required by Title 21, CFR, Section 1304 shall be
2 available for inspection upon request for at least 3 years after the date of the inventory.”

3 22. California Code of Regulations, Title 16, section 1714 provides in pertinent part:

4 . . .

5 “(b) Each pharmacy licensed by the board shall maintain its facilities, space, fixtures, and
6 equipment so that drugs are safely and properly prepared, maintained, secured and distributed.
7 The pharmacy shall be of sufficient size and unobstructed area to accommodate the safe practice
8 of pharmacy.

9 . . .

10 (d) Each pharmacist while on duty shall be responsible for the security of the prescription
11 department, including provisions for effective control against theft or diversion of dangerous
12 drugs and devices, and records for such drugs and devices. Possession of a key to the pharmacy
13 where dangerous drugs and controlled substances are stored shall be restricted to a pharmacist.”

14 . . .

15 23. California Code of Regulations, Title 16, section 1717 provides in pertinent part:

16 “(b) In addition to the requirements of Business and Professions Code section 4040, the
17 following information shall be maintained for each prescription on file and shall be readily
18 retrievable:

19 (1) The date dispensed, and the name or initials of the dispensing pharmacist. All
20 prescriptions filled or refilled by an intern pharmacist must also be initialed by the supervising
21 pharmacist before they are dispensed.

22 (2) The brand name of the drug or device; or if a generic drug or device is dispensed, the
23 distributor's name which appears on the commercial package label; and

24 (3) If a prescription for a drug or device is refilled, a record of each refill, quantity
25 dispensed, if different, and the initials or name of the dispensing pharmacist.

26 (4) A new prescription must be created if there is a change in the drug, strength, prescriber
27 or directions for use, unless a complete record of all such changes is otherwise maintained.

28

1 (c) Promptly upon receipt of an orally transmitted prescription, the pharmacist shall reduce
2 it to writing, and initial it, and identify it as an orally transmitted prescription. If the prescription
3 is then dispensed by another pharmacist, the dispensing pharmacist shall also initial the
4 prescription to identify him or herself. All orally transmitted prescriptions shall be received and
5 transcribed by a pharmacist prior to compounding, filling, dispensing, or furnishing. Chart orders
6 as defined in section 4019 of the Business and Professions Code are not subject to the provisions
7 of this subsection.”

8 24. California Code of Regulations, Title 16, section 1761 states:

9 (a) No pharmacist shall compound or dispense any prescription which contains any
10 significant error, omission, irregularity, uncertainty, ambiguity or alteration. Upon receipt of any
11 such prescription, the pharmacist shall contact the prescriber to obtain the information needed to
12 validate the prescription.

13 (b) Even after conferring with the prescriber, a pharmacist shall not compound or dispense
14 a controlled substance prescription where the pharmacist knows or has objective reason to know
15 that said prescription was not issued for a legitimate medical purpose.

16 25. California Code of Regulations, Title 16, section 1764 states:

17 “No pharmacist shall exhibit, discuss, or reveal the contents of any prescription, the
18 therapeutic effect thereof, the nature, extent, or degree of illness suffered by any patient or any
19 medical information furnished by the prescriber with any person other than the patient or his or
20 her authorized representative, the prescriber or other licensed practitioner then caring for the
21 patient, another licensed pharmacist serving the patient, or a person duly authorized by law to
22 receive such information.”

23 26. California Code of Regulations, Title 16, section 1793.7 states in pertinent part:

24 . . .

25 “(b) Pharmacy technicians must work under the direct supervision of a pharmacist and in
26 such a relationship that the supervising pharmacist is fully aware of all activities involved in the
27 preparation and dispensing of medications, including the maintenance of appropriate records.

28 . . .

1 (e) A pharmacist shall be responsible for all activities of pharmacy technicians to ensure
2 that all such activities are performed completely, safely and without risk of harm to patients”

3 . . .

4 **COST RECOVERY**

5 27. Business and Professions Code section **125.3** provides, in pertinent part, that the
6 Board may request the administrative law judge to direct a licentiate found to have committed a
7 violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the
8 investigation and enforcement of the case, with failure of the licentiate to comply subjecting the
9 license to not being renewed or reinstated. If a case settles, recovery of investigation and
10 enforcement costs may be included in a stipulated settlement.

11 **DRUG DEFINITIONS**

12 28. **Hydrocodone with acetaminophen (“apap”)**, trade name Vicodin ES, is a Schedule
13 III controlled substance pursuant to Health and Safety Code Section 11056 and a dangerous drug
14 per Business and Professions Code Section 4022.

15 29. **Acetaminophen with codeine**, trade name **Tylenol #3**, is a Schedule III controlled
16 substance pursuant to Health and Safety Code Section 11056 and a dangerous drug per Business
17 and Professions Code Section 4022.

18 30. **Promethazine with codeine**, trade name **Phenergan with Codeine**, is a Schedule
19 V controlled substance pursuant to Health and Safety Code Section 11058 and a dangerous drug
20 per Business and Professions Code Section 4022.

21 **FACTS COMMON TO ALL CAUSES FOR DISCIPLINE**

22 31. The following allegations are common to all causes for discipline in this matter:

23 32. At all times relevant herein, Respondent Robert Rothman was Pharmacist-in-
24 Charge of Respondent Twin Pharmacy, Inc. dba Dabney Pharmacy (Respondent Pharmacy), a
25 retail pharmacy located at 11115 S. Main Street, in the city of Los Angeles.

26 **Background**

27 33. In or prior to April of 2011 a San Diego pharmacist informant led law enforcement
28 authorities to Milton Farmer, who was suspected of smuggling prescription drugs. A search of

1 Farmer's trashcan at his residence in Oceanside, CA revealed empty prescription bottles from
2 Respondent Pharmacy. Investigators subsequently concluded that Dr. Tyron Reece wrote
3 prescriptions for patients that he did not actually examine and that Anthony "Sam" Wright would
4 have these prescriptions filled at Respondent Pharmacy. Mr. Wright would then transport the
5 prescription medication from Los Angeles to San Diego and deliver them to couriers like Milton
6 Farmer. Mr. Farmer and other couriers would cross the border with the prescription medication
7 strapped to their body and sell the drugs to pharmacies in Mexico.

8 Board Investigation - 2011

9 34. On or about April 8, 2011, Board Inspectors reviewed the Controlled Substances
10 Utilization Review and Evaluation System (CURES)¹ data for Respondent Pharmacy. The
11 CURES data revealed that Respondents were 18 months late in filing CURES reporting.

12 35. On April 11, 2011, Board inspectors were present when a search warrant was served
13 at Respondent Pharmacy, pursuant to investigation of the Anthony "Sam" Wright/Milton Farmer
14 prescription drug smuggling operation by several cooperating law enforcement agencies,
15 including the California Department of Justice, the Federal Bureau of Investigation, and the Drug
16 Enforcement Administration.

17 36. On April 11, 2011, Board Inspectors interviewed Charles Dabney III, a pharmacy
18 technician who had worked at Respondent Pharmacy for seven (7) years.² Dabney stated that
19 "Sam" Wright had been a frequent customer at the pharmacy for 4-5 years, and that he brought in
20 prescriptions written by **Dr. Carlos Estiandan** or **Dr. Tyron Reece**. Dabney additionally stated
21 that during this time, at Sam's request, he routinely compiled special lists with patient

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23 ¹ The CURES program started in 1998 and required mandatory monthly pharmacy reporting of
24 dispensed Schedule II controlled substances and was since amended in January 2005 to include mandatory
25 weekly reporting of Schedule II-IV controlled substances. The data is sent to a data collection company,
26 who sends the pharmacy confirmation that the data was received and informs the pharmacy if the data was
27 rejected. The data is collected statewide and can be used by health care professionals to evaluate and
28 determine whether their patients are utilizing controlled substances correctly.

² In a sworn statement dated April 25, 2011, submitted later to Board Inspectors, Mr. Dabney's
position with the pharmacy was described as "Pharmacy Manager/Data Entry Typist/Compliance
Officer." Mr. Dabney was licensed by the Board as a pharmacy technician (TCH 9600) from September
20, 1993 to July 31, 2013.

1 prescription data, which he provided to Sam "every 2-3-weeks." Dabney stated that Respondent
2 Rothman knew of and/or saw him creating these lists for Sam.

3 **2011 Audit Shows Massive Quantity of "Missing" Drugs**

4 37. On or about April 11, 2011, Board Inspectors requested that Respondent Rothman
5 inventory the three most frequently dispensed controlled substances at Respondent Pharmacy:
6 Vicodin ES, Tylenol #3 and Phenergan with Codeine. This "stock on hand" data was the basis for
7 an audit of these three controlled substances, completed on or about June 15, 2011. Dates chosen
8 for the audit were August 4, 2009 through April 11, 2011 (approximately 20 months).

9 38. The audit revealed that massive quantities of each drug were "missing" from
10 pharmacy inventory, and could not be located or accounted for. Audit results are summarized as
11 follows:

	hydrocodone /apap (Vicodin ES)	acetaminophen with codeine (Tylenol #3)	promethazine with codeine (Phenergan with Codeine)
Starting Amount	2,800	1,100	10,560
Total Purchased	287,400	226,300	1,944,000
Total Dispensed	271,028	221,724	1,793,255
Amount in inventory (on hand) as of 4/11/11	613	1767	25,920
Total Unaccounted For/Missing	18,559 tablets	3,909 tablets	135,385 ml (about 282 pints)

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20 39. Failure to Produce Policy - On or around November 10, 2011, Board Inspectors
21 requested that Respondents produce a copy of its office policy relating to employee impairment
22 and theft in the workplace.

23 40. Verbal Orders - Respondent Rothman received a "large number of verbal orders"
24 When asked to produce written records of telephone orders, Respondent failed to produce
25 compliant documentation which requires name of patient, date of request, name, address,
26 telephone number, license number and DEA number of the prescriber, drug name, quantity and
27 directions for use.
28

1 41. Prescriptions for Patient SJ - Records of Respondent Pharmacy showed that
2 Patient SJ had medications dispensed pursuant to at least 15 prescriptions purportedly written by
3 Dr. Ayodele on dates between approximately November 27, 2000 and August 7, 2001. Pursuant
4 to Board investigation, Dr. Ayodele reported that SJ was first seen as a patient in his office in
5 May 2009 – and that he (Ayodele) had not authorized any prescriptions for SJ prior to May, 2009.

6 **Empty Prescription Bottles in an Oceanside Trashcan**

7 42. Board Inspectors reviewed patient profiles for 40 patients of Respondent
8 Pharmacy whose names were found on empty prescription bottles which had been discarded in
9 the trashcan at the Oceanside residence of known drug smuggler, Milton Farmer (See paragraph
10 24, above). Analysis of the 40 patient profiles revealed the following:

11 a. **Dr. Carlos Estiandan**³ and **Dr. Tyron Reece** wrote a combined **94.2%** of all
12 prescriptions attributed to the 40 patient prescriptions found in the trashcan and identified
13 as having received prescription drugs filled by Respondents Pharmacy and Rothman.

14 b. Respondents routinely refilled several duplicate prescriptions for the same patient
15 on the same day.

16 c. Respondents refilled three prescriptions for one patient when there was no
17 authorization from the prescriber.

18 d. Prescription records show treatment for the same medical conditions (cough,
19 anxiety and pain) with no prescription treatment for any other diagnosis (i.e. blood
20 pressure, diabetes, cholesterol, etc.).

21 e. Dr. Estiandan wrote prescriptions for 24 of the 40 patients (approximately 66.1%
22 of the prescriptions; 866 total prescriptions).

23 (1) Of all prescriptions written by Dr. Carlos Estiandan (Dr. Estiandan), 283
24 prescriptions were for promethazine with codeine and 276 were for hydrocodone/apap.

25 ³ Dr. Carlos Estiandan, was arrested and found guilty on March 15, 2010 of 13 counts of
26 unlawfully writing controlled substance prescriptions without a legitimate medical purpose and outside the
27 usual scope of practice in *The People of the State of California v. Carlos Estiandan*, Los Angeles County
28 Superior Court Case No. BA34703 (2009). The Court may take judicial notice of this matter pursuant to
CA Evid. Code §452(h). On or around September 9, 2009, Dr. Estiandan surrendered his license to
practice medicine the state of California.

1 (2) Prescriptions written by Dr. Estiandan were filled on 221 different days, many of
2 which were filled by Respondents on the same day, in bulk.

3 (3) On or about February 10, 2009, the Medical Board of California, Department of
4 Consumer Affairs filed an Accusation against Dr. Estiandan alleging among other things,
5 repeated acts of negligence, violation of drug laws, prescribing without appropriate
6 examination of medical condition and prescribing to an addict.⁴ Dr. Estiandan was
7 subsequently arrested and eventually surrendered his license to practice medicine in
8 September, 2009. In Fall, 2009, Dr. Tyron Reece began writing prescriptions for Dr.
9 Estiandan's former "patients."

10 f. **Dr. Tyron Reece** wrote approximately 369 prescriptions for **38 of the 40** patients
11 during the period between October 2, 2009 – April 11, 2011.

12 (1) 100% of Dr. Reece's prescriptions were written for either promethazine
13 with codeine, hydrocodone/apap or ahydrocodone/prazolam (Xanax).⁵

14 43. **Corresponding Responsibility Analysis** - Dr. Estiandan and Dr. Reece wrote a
15 combined **94.2%** of all prescriptions attributed to the 40 patients whose prescriptions were found
16 in the trashcan and identified as having received prescription drugs dispensed by Respondents.
17 Prescriptions of Dr. Estiandan and Dr. Reece for the 40 patients were filled by Respondents
18 *despite key objective factors* indicating the prescriptions were not legitimate, including but not
19 limited to:

- 20 1. The patients all had similar diagnosis and saw the same two doctors;
- 21 2. The patients received the same drug combinations in the same quantities/amounts
22 irrespective of age;
- 23 3. The drugs prescribed are highly abused and have high street value;

24
25 ⁴ Administrative action was brought in The Matter of the Accusation Against Carlos Estiandan,
26 M.D., Before the Medical Board of California Department of Consumer Affairs State of California, File
27 No. 17-2004-162750, OAH No. 2009020501 (2009). The Court may take judicial notice of this matter
28 pursuant to CA Evid. Code §452(h). Dr. Estiandan surrendered his license to practice medicine in the
state of California on or around September 9, 2009.

⁵ Dr. Reece surrendered his DEA registration on July 8, 2011 in lieu of disciplinary action.

1 4. In many instances, the patient did not reside in close proximity to Respondent
2 Pharmacy or to either physician;

3 5. All patients were prescribed controlled substances for chronic conditions
4 (cough/anxiety/pain) - but were not submitting prescriptions for medications to treat other
5 common health issues (e.g. blood pressure, diabetes);

6 6. The patients purportedly all had the same medical condition (cough/anxiety/pain)
7 although neither physician specialized in treatment of these conditions (e.g.
8 pulmonologists (chronic bronchitis) or psychiatrist (anxiety));

9 7. The patients did not drop off their own prescriptions to be filled;

10 8. All prescriptions were paid for in cash, and not by insurance;

11 9. Dr. Estiandan was arrested and charged with crimes relating to unlawfully
12 prescribing medication;

13 10. After Dr. Estiandan was arrested – all of his patients were transferred to Dr. Reece,
14 although the physicians' respective offices are approximately 20 miles apart.

15 44. When interviewed in April and May of 2012 by Board Inspectors regarding the 40
16 patient profiles, Respondent Rothman admitted that he did not know anything about the patients
17 and failed to provide any specific information.

18 45. Respondent Rothman admitted that he defers to the doctor's judgment exclusively
19 in lieu of personally verifying patient prescriptions. Respondent Rothman also admitted that he
20 permits his pharmacy staff to make conclusive determinations regarding the legitimacy of patient
21 prescriptions.

22 46. Respondent Rothman admitted that he did not use CURES reports or his own
23 professional judgment when filling patient prescriptions.

24 47. Respondent Rothman admitted that he did not know about or act according to his
25 corresponding responsibility when filling patient prescriptions.

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1 **Analysis of CURES Patient Records (2007-2009)**

2 48. To investigate controlled substance dispensing practices of Respondents, Board
3 Inspectors obtained a CURES report for controlled substances dispensed by Respondent
4 Pharmacy between 2007 and 2009.

5 a. Refills Without Authorization – In reviewing a sample group of 13 patient profiles,
6 Inspectors found that Respondents had refilled at least *119 prescriptions* on dates between
7 approximately January 2007 and September, 2009, without authorization by a prescribing
8 physician.

9 **Corresponding Responsibility Analysis (2011)**

10 49. In closely analyzing the controlled substance drug treatment and therapy regimen
11 for a sample group of six (6) patients, using CURES data, Board Inspectors found that
12 Respondents routinely filled prescriptions despite key objective factors indicating the
13 prescriptions were not legitimate, or circumstances that should have caused Respondents to
14 question and investigate the prescription's legitimacy:

15 a. **PATIENT #41 ZA⁶**

16

17 DRUG	18 AMOUNT	19 DATE OF FILL
20 hydrocodone/apap ES	21 60	22 3/13/09
23 hydrocodone/apap ES	24 60	25 4/6/09
26 hydrocodone/apap ES	27 60	28 4/23/09
hydrocodone/apap ES	60	5/8/09
hydrocodone/apap ES	60	6/3/09
hydrocodone/apap ES	60	6/22/09
hydrocodone/apap ES	100	12/10/10
hydrocodone/apap ES	100	1/10/11

⁶ Patient initials are used to protect confidentiality throughout the Accusation.

hydrocodone/apap ES	100	2/10/11
hydrocodone/apap ES	100	3/14/11

Summary of Findings: Patient received a quantity of 60 hydrocodone/apap within quick succession during the time period between 4/6/09 and 5/8/09 for a total of 180 tablets in just over 30 days.

PATIENT #43 EA

DATE	DRUG	PRESCRIBING PHYSICIAN
4/2005	Tylenol #3	Habbestad ⁷
6/2005	promethazine/codeine	Reece
7/2005	Tylenol #3	Habbestad
7/2005	promethazine/codeine	Apusen
7/2005	Vicodin ES	Ayodele
8/2005	Vicodin ES	Apusen
8/2005	Vicodin ES	Ayodele
9/2005	Vicodin ES	Apusen
9/2005	promethazine/codeine	Rojas
10/2005	promethazine/codeine	Habbestad
10/2005	Vicodin ES	Ayodele
11/2005	promethazine/codeine	Rojas
11/2005	Vicodin ES	Rojas
12/2005	promethazine/codeine	Rojas

⁷ On or around October 10, 2008, Robert Habbestad received a Public Reprimand for failing to maintain adequate and accurate medical records and failing to record information relating to patient examinations in The Matter of the Accusation Against Robert Habbestad, M.D., OAH No. L2006120274.

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12/2005	Vicodin ES	Rojas
1/2006	Vicodin ES	Christian
3/2006	Vicodin ES	Apusen
3/2006	promethazine/codeine	Rojas
4/2006	Vicodin ES	Ware
6/2006	promethazine/codeine	Estiandan
8/2006	Vicodin ES	Rojas
8/2006	promethazine/codeine	Rojas
8/2006	Vicodin ES	Estiandan
10/2007	Vicodin ES	Chickey ⁸
10/2007	promethazine/codeine	Chickey
1/2008	Vicodin ES	Chickey
3/2008	Vicodin ES	Chickey
3/2008	promethazine/codeine	Chickey
5/2008	Vicodin ES	Ware
5/2008	promethazine/codeine	Chickey
6/2008	promethazine/codeine	Chickey
8/2008	promethazine/codeine	Reece
8/2008	Vicodin ES	Reece
9/2008	promethazine/codeine	Reece
9/2008	Vicodin ES	Habbestad
9/2008	Vicodin ES	Ayodele

⁸ Anna Lourdes Armada Chickey, M.D. DEA Registration is currently under investigation by DEA, Los Angeles Region.

1	10/2008	promethazine/codeine	Reece
2	10/2008	Vicodin ES	Reece
3	11/2008	Vicodin ES	Reece
4	1/2009	promethazine/codeine	Chickey
5	1/2009	Vicodin ES	Chickey
6	2/2009	promethazine/codeine	Chickey
7	7/2009	Vicodin ES	Chickey
8	7/2009	promethazine/codeine	Chickey
9	9/2009	Vicodin ES	Chickey
10	9/2009	promethazine/codeine	Chickey
11	9/2009	Vicodin ES	Chickey
12	9/2009	promethazine/codeine	Chickey
13	9/2009	promethazine/codeine	Chickey
14	11/2009	promethazine/codeine	Reece
15	11/2009	Vicodin ES	Chickey

17 **Summary of Findings:** Patient doctor shopped by using several different prescribers to
18 obtain the same medications. In 2005, the patient used 6 different doctors to obtain Vicodin ES
19 and promethazine/codeine. In 2006, the patient used 4 different doctors to obtain Vicodin ES and
20 promethazine/codeine. In 2008, the patient used 5 different doctors to obtain Vicodin ES and
21 promethazine/codeine. Respondents failed to document why the patient was seeing multiple
22 prescribers for the same drugs.

23 c. **PATIENT #44 JB**

24 A review of the patient's CURES records revealed the following:

25	DATE	DRUG	PRESCRIBING PHYSICIAN
26	1/2008	Tylenol #3	Habbestad

3/2008	Tylenol #3	Habbestad
5/2008	Tylenol #3	Habbestad
5/2008	Vicodin ES	Ayodele
7/2008	Tylenol #3	Habbestad
8/2008	Vicodin ES	Ayodele
9/2008	Tylenol #3	Ayodele
11/2008	Tylenol #3	Mays ⁹
12/2008	Tylenol #3	Habbestad

Summary of Findings : Patient received both Vicodin ES and Tylenol #3, both for pain. There is no documentation showing that the pharmacist consulted with the prescribing physicians to determine if both medications were appropriate or correctly prescribed for pain. In addition, the patient used multiple prescribers to receive the same medications in the same month.

d. **PATIENT #46 YD**

Summary of Findings: During the time period between December 2004 and 2012, approximately 123 of a total of 151 prescriptions written for the patient were for controlled substances. The patient received promethazine/codeine, Vicodin ES, Soma, Xanax, Tylenol #3, Valium, ampicillin, Keflex, ibuprofen, Pepcid and methocarbamol. In 2009 and 2010, the patient received controlled substances prescriptions from Drs. Estiandan, Al-Bussam, and Chickey – all of whom have had actions taken against their medical licenses or are currently under investigation. Respondents Pharmacy and Rothman failed to inquire about why the patient has had a cough and pain for 8 years and why so many different doctors were sought for these prescriptions.

e. **PATIENT #50 YG**

Summary of Findings: On or around April 13, 2009, Respondents Pharmacy and

⁹ On or around July 23, 2006, James Arthur Mays received a Public Reprimand for failing to maintain adequate and accurate medical records and in The Matter of the Public Letter of Reprimand Issued to James Arthur Mays, M.D., Case No. 06-2003-147182.

1 Rothman filled a prescription for 240ml of promethazine/codeine for this patient. On or around
2 April 20, 2009, Respondents Pharmacy and Rothman filled a second prescription for 240ml of
3 promethazine/codeine for his patient. The patient would not have been able to complete one
4 prescription within seven days. There is no documentation indicating that Respondents contacted
5 the prescribing physician or the patient regarding the patient's usage of the medication.

6 f. **PATIENT #53 TH**

7 A review of the patient's CURES records revealed the following:

8

9 DATE	DRUG	PRESCRIBING PHYSICIAN
10 1/8/07	promethazine/codeine	Fishman
11 1/17/07	promethazine/codeine	Ayodele
12 3/8/07	promethazine/codeine	Lin

13

14 **Summary of Findings:** Within two months, the patient received 3 prescriptions for
15 promethazine/codeine from 3 different prescribing physicians, the second arriving merely 9 days
16 after the first. The maximum recommended dose is 30ml/day. There is no documentation that
17 Respondents Pharmacy and Rothman contacted the prescribing physicians regarding deviation
18 from the recommended dosage or contacted the patient regarding use of the medication.

19 **Board Inspection – December 2013**

20 50. **Board Inspection** - On or about December 23, 2013, a Board Inspector visited
21 Respondent Pharmacy to investigate allegations made in an anonymous complaint. While at the
22 pharmacy, the Inspector noticed outdated prescription medicines and diabetic supplies on
23 pharmacy shelves, a violation of Business and Professions Code section 4342. Respondents were
24 given notice of the violation and ordered to remove and inventory outdated product – and provide
25 a disposal receipt to the Inspector, within thirty (30) days.

26 **Board Inspection – January 2014**

27 51. **Board Inspection**-On or about January 22, 2014, a Board Inspector returned to
28 Respondent Pharmacy to conduct a follow-up inspection. He observed that Respondent was the

1 only pharmacist present in the pharmacy – along with four pharmacy technicians. During that
2 inspection, the Inspector noted the following :

3 a. In random checks of pharmacy shelves, the Inspector found outdated medicines,
4 which he then quarantined.

5 b. He also observed dust and dirt on pharmacy shelves.

6 c. Although only one pharmacist was present, one technician (LL) was labeling
7 diabetic supplies while - simultaneously - a second technician (RY) was filling
8 prescriptions.

9 d. The Inspector observed that there was a locked storage area of the facility – and
10 was told that confidential patient prescription records were stored in that area. A key to
11 the locked area was stored in a drawer in the pharmacy.

12 52. At the conclusion of the inspection, Respondents were issued an Inspection Report
13 citing multiple violations of pharmacy law, and ordered to correct violations, including removal
14 of outdated drugs from pharmacy shelves. Pursuant to this order, Respondents removed hundreds
15 of different types of expired medications from their shelves - with expiration dates as far back as
16 June 30, 2011.

17 **Board Inspection – February 2016**

18 53. During a Board inspection on November 10, 2015, Inspectors identified two
19 separate areas of pharmacy operations at Respondent’s pharmacy premises. The front section of
20 the pharmacy was open to the public as a retail business for prescriptions, and a back section of
21 the pharmacy was dedicated to the processing, packaging and shipping of diabetic testing supplies
22 to long term care facilities.

23 54. A significant portion of Respondent Pharmacy’s business is derived from
24 providing “Assure” brand blood glucose testing machines and supplies needed to use the
25 machines (diabetic strips and lancets) to diabetic inpatients of state licensed skilled nursing
26 facilities, many of whom are insured by the state’s Medi-CAL program.

27 / / /

28 / / /

1 55. **Medi-CAL Reimbursement Guidelines** - At all times relevant herein, published
2 Medi-CAL program requirement guidelines for reimbursement of the cost of medical supplies for
3 inpatient residents of a nursing facility included the following:

4 a. “Program coverage”

5 ...

6 “Medical supplies provided to inpatients receiving Nursing Facility (services),
7 whether or not rendered in a hospital setting, are reimbursable only for the medical
8 supplies listed below and only when required by a specific patient **for that patient’s**
9 **exclusive use.**

10 • **Diabetic test strips and lancets**

11 ...”

12 b. “Medi-CAL Covered Services”

13 “Medi-CAL covers some medical supplies. When Medi-CAL covers an item and
14 the recipient is eligible for Medicare, providers bill Medicare before billing Medi-CAL.

15 **The products and product categories listed below must be billed to Medicare**
16 **before being billed to Medi-CAL:**

17 • **Diabetic testing supplies (lancets, test strips and reagent tablets)**

18 ...”

19 c. “Authorization”

20 An **approved Treatment Authorization request (TAR)** is required for claims
21 using certain supplies billing codes.

22 ...

23 d. “Code I”

24 Code I items marked with a single asterisk (*) require authorization in accordance
25 with CCR, Title 22, Section 51003¹⁰, unless used under the clinical conditions

26 ¹⁰ California Code of Regulations, title 22 §51003 describes the process for obtaining
27 authorization for treatment in the Medi-CAL program; §51476 sets out record-keeping
28 requirements for Medi-CAL service providers, with sub-section “c” requiring that records of
service providers “shall document the meeting of Code I restrictions for medical supplies.”

1 individually specified by the Code I message. Code I item are subject to the prescription
2 documentation requirements of Title 22, Section 51476(c).

3 e. “Quantity Limitations”

4 The quantity limitations for medical supply products are in the List of Medical
5 Supplies: Billing Codes, Units and Quantity Limits spreadsheet. **TARs are required for**
6 **claims billing for quantities in excess of the quantity limitations.**

7 f. “Diabetic Lancets and Test Strips”

8 (1) **Lancets and blood glucose test strips are Code I items**, restricted to
9 recipients being treated by a physician for a diabetes diagnosis documented in their
10 medical records. As a Code I requirement, **when billing for lancets and blood glucose**
11 **tests strips, the following must be documented on the physician’s order:**

- 12 • A description of item prescribed
- 13 • The specific frequency of testing (“as needed” or “PRN” are not
14 acceptable)
- 15 • For a recipient currently being treated with insulin injections, document the
16 recipient is an insulin user.

17 (2) **When billing for blood glucose test strips or lancets, claim quantities**
18 **are limited as follows:**

- 19 • For a diabetic recipient who is currently being treated with insulin
20 injections, no more than 150 blood glucose test strips and no more than 200 lancets are
21 allowed per claim, with no more than three (3) claims in a 90-day period
- 22 • For a diabetic recipient who is not currently being treated with insulin
23 injections, no more than 100 blood glucose test strips and no more than 100 lancets in a
24 90-day period
- 25 • For a gestational diabetic recipient being treated with or without insulin
26 injections, no more than 150 blood glucose test strips and no more than 200 lancets are
27 allowed per claim, with no more than three (3) claims in a 90-day period

1 (3) A **TAR documenting the following is required** if the recipient requires a
2 quantity of blood glucose test strips or lancets that **exceeds the quantity limits**:

- 3 • The recipient has nearly exhausted the supply of test strips and lancets
- 4 • A **specific narrative statement**, as documented in the recipient's medical
5 record, which supports the need for testing frequency that exceeds the billing
6 limitations
- 7 • The recipient was seen and evaluated by the treating physician for diabetes
8 control **within six months** prior to ordering quantities that exceed the quantity
9 limits.

10 (emphasis added)

11 57. Board Inspectors requested prescription orders for diabetic testing supplies for 24
12 inpatient residents of French Park Care Center (FPCC) a long term care facility located in Santa
13 Ana, CA, and related pharmacy purchase records for the supplies on dates 11/10/12 through
14 11/09/15.

15 58. The FPCC prescription records were subsequently received from Respondents. On
16 review, Inspectors noted that the test strips prescriptions included the **frequency of testing** based
17 on the physician order instructions - but that the lancet prescription records all showed "UUD"
18 (use as directed) as the "sig code"¹¹ and that the day supplies for the quantity dispensed didn't
19 appear to match. This was difficult to decipher because the day supply information was cut off on
20 the copies of the fill record tags provided for review.

21 59. Documents initially provided by Respondent's employees as evidence of purchase
22 records showed both Respondent and a different company - **Ramat Medical Supplies** listed on
23 records related to the test strips on lancets.

24 60. Owners of Respondent Pharmacy also own Ramat Medical Supplies, aka JI
25 Medical (Ramat) , a permitted Home Medical Devise Retailer¹², with offices in Los Angeles, CA.

26
27 ¹¹ The term "sig code" refers to abbreviations commonly used in pharmacy practice.
28 ¹² Home Medical Devise Retailer permits are issued by the California Department of
Public Health.

1 At the time of the subject inspection, Respondent Pharmacy officer Denise Wilson-Ruane was the
2 “chief operating officer” of Ramat, and Respondent Pharmacy’s book-keeper Alan Smith was
3 also “controller” for Ramat.

4 **Billing For Diabetic Medical Supplies**

5 61. Respondent employees explained Respondents’ “work flow” and routine practices
6 for processing diabetic supplies prescriptions to Board Inspectors as follows:

7 a. “Assure” brand blood glucose testing machines are provided to the patients
8 at no cost. However, the pharmacy bills for test strips and lancets used in the machines.

9 b. Respondent Pharmacy receives monthly physician chart orders from
10 various facilities they service for diabetic testing supplies. A pharmacy technician enters
11 the monthly orders, check insurance eligibility for the patient, requests authorizations for
12 those requiring it and then generates a prescription label once approved.

13 c. Typed labels and chart orders are then provided to a second pharmacy
14 technician, who fills/labels the orders, has the pharmacist check them, then packages them
15 for shipping to the ordering facility.

16 62. In inquiring about the “work flow” for processing diabetic supplies prescriptions at
17 Respondent Pharmacy, including billing and shipping of dispensed products - Board Inspectors
18 discovered that employees of Respondent Pharmacy routinely performed some of the work of
19 preparing prescription orders off site - including verifying patient eligibility and preparing
20 “packing slips.” These tasks were performed at **Ramat Medical Supplies**, an unlicensed facility.
21 During a Board Inspection of Ramat on or about February 19, 2016, two pharmacy technicians
22 employed by Respondent Pharmacy were observed preparing prescription orders without
23 requisite supervision of a pharmacist - using paper and electronic records pertaining to personal
24 health and billing information of patients, which was maintained and retained at Ramat.

25 **Audit of Medi-CAL Billings (2/1/15 To 11/10/15)**

26 63. Diabetic supplies dispensing records for 2015 were reviewed. From 2/1/2015
27 through 11/10/2015, Medi-CAL prescriptions accounted for over 40% of Respondent’s
28 prescription transactions:

Billings by Respondents from 2/1/2015-11/10/15 for diabetic testing supplies	Total Number of Prescriptions	Quantity of Testing Supplies Dispensed	Percentage of Total Number of Prescriptions
"Assure" lancets/low flow	25,792	2,702,200	49.79%
"Assure" lancets/low flow billed to CA Medi-CAL	10,607	1,172,750	20.48%
"Assure" platinum test strips	25,008	2,638,450	48.28%
"Assure" platinum test strips billed to CA Medi-CAL	10,538	1,165,550	20.34%
Total of all CA Medi-CAL testing supplies (lancets + strips) transaction billings	21,210	2,344,400	40.95%
Total of all testing supplies (lancets + strips) transaction billings	51,802	5,420,300	100.00%

64. Of the 10,607 "Assure Lance Lancets Low Flow" prescriptions submitted for payment to Medi-CAL during the audit period, nearly all of them (a total of 10,360 prescriptions) had the directions for use as : "UUD or UD. "

65. In auditing these prescriptions records, the Inspector saw a discrepancy between the directions for use indicated by the sig codes and the day supply for many prescriptions. Further evaluation showed the pharmacy was submitting incorrect day supplies for the prescriptions, resulting in excessive furnishing and billing for the diabetic testing supplies as detailed below.

Medi-CAL Billing Practices - Excessive Furnishing and Billing

66. Board inspectors reviewed prescriptions dispensed for quantities of 50, 100, and 150 with a corresponding day supply of 30 days.

a. A total of 3,519 prescriptions were processed with a dispensed quantity of 50 test strips (1,755 prescriptions) and 50 lancets (1,764 prescriptions), but billed to Medi-CAL as a 30 day supply. The 1,755 prescriptions for test strips were in actuality a 50 day supply, according to the sig codes provided in the dispensing history – billed incorrectly to Medi-CAL as a 30 day supply, according to the sig code supplied for the testing strips with a testing frequency of less than once daily. Some were refilled 30 days

1 later. Only 42 of the 1,764 lancet prescription records included directions other than "UD"
2 for the lancets¹³ and were still incorrectly billed with a 30 day supply.

3 b. A total of **3,995** prescriptions were processed with a dispensed quantity of
4 100 test strips (1,976 prescriptions) and lancets (2,019 prescriptions) and billed to Medi-
5 CAL as a 30 day supply. These prescriptions were actually a 50 day supply according to
6 the sig code supplied for the test strips with a testing frequency of **twice daily** and billed
7 as a 30 day supply. Only 48 prescriptions records included directions *other than* "UD" for
8 the lancets and they were still incorrectly processed with a 30 day supply.

9 c. A total of **9,013** prescriptions were processed with a dispensed quantity of
10 150 test strips (4,496 prescriptions) and lancets (4,518 prescriptions) and billed to Medi-
11 CAL as a 30 day supply. These prescriptions were actually a 37 day supply according to
12 the sig code supplied for the test strips with a testing frequency of **four times daily** and
13 billed as a 30 day supply Only 112 prescriptions records included directions *other than*
14 "UD" for the lancets and they were still incorrectly processed with a 30 day supply.

15 d. During the timeframe of 2/1/15 to 11/10/15, a total of 21,210 (40.9%) of
16 the 51,802 prescriptions were billed specifically to Medi-CAL. These prescriptions were
17 billed incorrectly to Medi-CAL as a 30 day supply and some were refilled 30 days later
18 resulting in excessive billing and furnishing of these diabetic test strips and corresponding
19 lancet prescriptions.

20 67. Close to half of the prescriptions submitted by Respondents were for Medi-CAL
21 patients, but Respondent also prepared and submitted incorrect billings to other insurers,
22 including the state funded "Cal Optima Cal Wrap" program.

23 **FPCC Patient Audit**

24 68. 24 patient profiles were obtained for diabetic inpatients of French Park Care
25 Center (FPCC), and Board Inspectors reviewed 48 prescriptions billed by Respondents for these
26

27 ¹³ A generalized 'use as directed' instruction does not comply with Medi-CAL
28 reimbursement requirements, which requires that a specific frequency of testing/use be identified.

1 twenty four patients. Of the 48 prescriptions, **22 prescriptions** were incorrectly billed as a 30
 2 day supply, as determined by frequency of use in the patient's chart, as summarized below:

3

4 **Prescriptions processed with incorrect day supplies determined by frequency of use in the patient's chart**

5	Prescription number	Drug Name/Form	Disp Qty.	SIG Codes	Day Supply Billed	Day Supply Actual	TP Name	
6	1.	4202263	Assure Test Strips	50	UD @ 6.30	30	50	Health Net
7	2.	4202264	Assure Lancets	50	UD Q 6.30 AM	30	50	Health Net
8	3.	4202438	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
9	4.	4202439	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
10	5.	4203957	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
11	6.	4203958	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
12	7.	4208411	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
13	8.	4208412	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
14	9.	4211309	Assure Test Strips	50	UD QAM ISS	30	50	Cal Optima CalWrap
15	10.	4211311	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
16	11.	4211318	Assure Test Strips	100	UD BID ISS	30	50	Cal Optima CalWrap
17	12.	4211319	Assure Lancets	100	UUD	30	50	Cal Optima CalWrap
18	13.	4211320	Assure Test Strips	100	UD BID ISS	30	50	Cal Optima CalWrap
19	14.	4211321	Assure Lancets	100	UUD	30	50	Cal Optima CalWrap
20	15.	4211324	Assure Test Strips	100	UD BID look at chart	30	50	LA PHP Medi-CAL
21	16.	4211325	Assure Lancets	100	UUD	30	50	LA PHP Medi-CAL
22	17.	4212988	Assure Test Strips	50	UD QAM	30	50	CA Medi-CAL
23	18.	4212989	Assure Lancets	50	UUD	30	50	CA Medi-CAL
24	19.	4212994	Assure Test Strips	50	UD Once a day	30	50	Cal Optima CalWrap
25	20.	4212995	Assure Lancets	50	UUD	30	50	Cal Optima CalWrap
26	21.	4217225	Assure Test Strips	100	UD BID AC ISS	30	50	Cal Optima CalWrap
27	22.	4217226	Assure Lancets	100	UUD	30	50	Cal Optimal CalWrap

1 **FIRST CAUSE FOR DISCIPLINE**

2 (Failure to Assume Corresponding Responsibility to Assure Legitimacy of Prescriptions)

3 69. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
4 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in
5 conjunction with Health and Safety Code section 11153, subdivision (a) and Title 16 California
6 Code of Regulations section 1761, in that, approximately between January 2007 and April 11,
7 2011, they failed to comply with their corresponding responsibility to ensure that controlled
8 substances were dispensed for a legitimate medical purpose as follows:

9 a. Respondents furnished (and/or continued to furnish) prescriptions for controlled
10 substances written by Dr. Carlos Estiandan and/or Dr. Tyron Reece to 40 patients despite
11 key objective factors indicating prescriptions were not issued for a legitimate medical
12 purpose.

13 b. Respondents furnished (and/or continued to furnish) prescriptions for controlled
14 substances to patients #41 ZA, #43 EA, #44 JB, # 46 YD, #50 YG and #53 TH, despite key
15 objective factors indicating prescriptions were not issued for a legitimate medical purpose.

16 **SECOND CAUSE FOR DISCIPLINE**

17 (Failure of Pharmacist to Exercise or Implement Best Professional Judgment or Corresponding
18 Responsibility when Dispensing Controlled Substances)

19 70. Respondent Rothman *only* is subject to disciplinary action under section 4300 for
20 unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with
21 section 4306.5(a) and (b), in that he failed to exercise or implement his best professional
22 judgment and/or corresponding responsibility when dispensing controlled substances.

23 **THIRD CAUSE FOR DISCIPLINE**

24 (Failure to Maintain Operational Standards and Security)

25 71. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
26 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in
27 conjunction with Title 16, California Code of Regulations section 1714 subdivision (b) and/or (d)
28 and Health and Safety Code section 11208, in that pursuant to Board audit, between

1 approximately August 4, 2009 and April 11, 2011, Respondents failed to maintain pharmacy
2 security or provide effective controls against theft or diversion, resulting in substantial inventory
3 losses, and no ability to account for the whereabouts or disposition of missing drug stock as
4 follows:

- 5 a. hydrocodone/apap - 18,559 tablets missing/unaccounted for
- 6 b. acetaminophen with codeine - 3,909 tablets missing/unaccounted for
- 7 c. promethazine with codeine - 135,385 ml (282 pints) missing/unaccounted for

7 **FOURTH CAUSE FOR DISCIPLINE**

8 (Failure to Maintain Records of Acquisition and Disposition)

9 72. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
10 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in
11 conjunction with section 4081, subdivisions (a) and (b) and Health and Safety Code section
12 11208, in that, per Board audit for dates between August 4, 2009 and April 11, 2011,
13 Respondents had substantial inventory losses, with no records to account for the whereabouts or
14 disposition of the missing drug stock as follows:

- 15 a. hydrocodone/apap - 18,559 tablets missing/unaccounted for
- 16 b. acetaminophen with codeine - 3,909 tablets missing/unaccounted for
- 17 c. promethazine with codeine - 135,385 ml (282 pints) missing/unaccounted for

17 **FIFTH CAUSE FOR DISCIPLINE**

18 (Failure to Timely Submit CURES Data)

19 73. Respondents Twin Pharmacy and Rothman are subject to subject to disciplinary
20 action under section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j)
21 and (o), in conjunction with Health and Safety Code section 11165, in that during the 18 month
22 period between October 2009 and April 2011, Respondents failed to comply with state law
23 requirements for submission of CURES data on a weekly basis.

24 **SIXTH CAUSE FOR DISCIPLINE**

25 (Failure to Comply with Prescription Refill Requirements)

26 74. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
27 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in
28

1 conjunction with section 4063, in that in 119 instances between approximately January 2007 and
2 September 2009, Respondents refilled prescriptions without requisite authorization of the
3 prescriber.

4 SEVENTH CAUSE FOR DISCIPLINE

5 (Failure to Establish Policies and Procedures Regarding Employee Misconduct)

6 75. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
7 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in
8 conjunction with section 4104, in that on or about November, 2011, Board Inspectors determined
9 that Respondents had failed to comply with state law requirements to establish written policies
10 and procedures addressing chemical, mental or physical impairment or diversion by licensed
11 individuals employed by the pharmacy.

12 EIGHTH CAUSE FOR DISCIPLINE

13 (Failure to Comply with Requirements for Documenting Oral Prescriptions)

14 76. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
15 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in
16 conjunction with section 4040, and California Code of Regulations, title 16, section 1717 (which
17 requires that an orally transmitted prescription must be reduced to a writing initialed by a
18 pharmacist, and that all prescriptions must document specified information) in that in or about
19 April, 2011, Board Inspectors discovered that Respondents routinely filled oral prescriptions
20 without compliant documentation.

21 NINTH CAUSE FOR DISCIPLINE

22 (Furnishing Dangerous Drugs without a Prescription)

23 77. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
24 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in
25 conjunction with 4059, in that Respondents furnished controlled substances dangerous drugs to
26 patient SJ pursuant to prescriptions purportedly issued by a Dr. A. In fact, SJ was not a patient of
27 Dr. A prior to May 2009 – so that any prescriptions in his name prior to that date were
28 unauthorized.

1 TENTH CAUSE FOR DISCIPLINE

2 (Drugs Lacking Quality of Strength – January 2014)

3 78. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
4 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in
5 conjunction with 4342, subdivision (a) in that during and following a Board Inspection on or
6 about January 22, 2014, hundreds of different types of medication on the shelves of Respondent
7 Pharmacy were identified as past the expiration date (thus failing to conform to the standard and
8 tests as to quality and strength).

9 ELEVENTH CAUSE FOR DISCIPLINE

10 (Failure to Adequately Supervise Technicians – January 2014)

11 79. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
12 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in
13 conjunction with 4115, subdivisions (a) and (f), in that Respondents failed to provide adequate
14 supervision to Pharmacy Technicians in the following instances:

15 a. **Board Inspection – January 2014**

16 During a Board Inspection on or about January 22, 2014, two pharmacy technicians
17 were observed filling prescriptions, although only one pharmacist (Respondent Rothman) was
18 present and working in Respondent Pharmacy.

19 b. **Board Inspection – February 2016**

20 During a Board Inspection on or about February 19, 2016, two pharmacy technicians
21 employed by Respondent Pharmacy were observed to be engaged in the practice of pharmacy at
22 an unlicensed location where they reviewed and retained personal health information and billing
23 information of patients without the supervision of a pharmacist.

24 TWELFTH CAUSE FOR DISCIPLINE

25 (Misuse of Pharmacist Education - 2015)

26 80. Respondent Rothman *only* is subject to disciplinary action under section 4300 for
27 unprofessional conduct as defined in section 4301, subdivisions (j) and (o) in conjunction with
28 section 4306.5(a) ,in that on dates approximately February 1, 2015 to November 10, 2015, he

1 failed to exercise his education, training and experience as pharmacist , resulting in his
2 verification of thousands of prescriptions for diabetic testing supplies, which were then
3 transmitted to Medi-CAL for payment, and were later discovered to have an incorrect or
4 excessive amount of supplies per patient, and/or incorrect or too early refill dates - resulting in
5 incorrect and excessive billings to Medi-CAL.

6 **THIRTEENTH CAUSE FOR DISCIPLINE**

7 (Acts Involving Dishonesty, Fraud, or Deceit – 2015)

8 81. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
9 section 4301, subdivision (f), in that on dates approximately February 1, 2015 to November 10,
10 2015, Respondents committed acts involving dishonesty, fraud, or deceit with the intent to
11 substantially benefit themselves. Specifically, during a November 2015 inspection of Respondent
12 Pharmacy, a Board Inspector identified 22 prescriptions for diabetic testing supplies transmitted
13 to Medi-CAL with an incorrect 30 day supply when the pharmacy was actually dispensing a 50
14 day supply, resulting in excessive billing and excessive furnishing of these testing supplies.
15 Furthermore, a review of the pharmacy's dispensing history from February 1, 2015 to November
16 10, 2015 showed thousands of prescriptions were billed to Medi-CAL and other insurers with
17 incorrect day supplies for test strips and lancets.

18 **FOURTEENTH CAUSE FOR DISCIPLINE**

19 (Knowing Misrepresentation in Document - 2015)

20 82. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
21 section 4301, subdivision (g), in that on dates approximately February 1, 2015 to November 10,
22 2015, Respondents knowingly made or signed a certificate or other document that falsely
23 represents the existence or non-existence of a state of facts. Specifically, during a November 2015
24 inspection of Respondent Pharmacy, a Board Inspector identified 22 prescriptions for diabetic
25 testing supplies transmitted to Medi-CAL and other insurers with an incorrect 30 day supply
26 when the pharmacy was actually dispensing a 50 day supply, resulting in excessive billing and
27 excessive furnishing of these testing supplies. Furthermore, a review of the pharmacy's
28

1 dispensing history from February 1, 2015 to November 10, 2015 showed thousands of
2 prescriptions were billed with incorrect day supplies for test strips and lancets.

3 **FIFTEENTH CAUSE FOR DISCIPLINE**

4 (Unlicensed Pharmacy Activity- February 2016)

5 83. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
6 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in
7 conjunction with section 4110, subdivision (a) and (b) in that, on or about February 19, 2016,
8 during a Board inspection of Ramat Medical Supplies, an unlicensed location, two pharmacy
9 technicians employed by Respondent Pharmacy were found engaged in the practice of pharmacy
10 at that location and without requisite supervision of a pharmacist.

11 **SIXTEENTH CAUSE FOR DISCIPLINE**

12 (Retention of Pharmacy Records at Unlicensed Facility – February 2016)

13 84. Respondents Twin Pharmacy and Rothman are subject to disciplinary action under
14 section 4300 for unprofessional conduct as defined in section 4301, subdivisions (j) and (o), in
15 conjunction with section 4105, subdivision (a) in that, on or about February 19, 2016, during a
16 Board inspection of Ramat Medical Supplies, an unlicensed location, two pharmacy technicians
17 employed by Respondent Pharmacy were found engaged in the practice of pharmacy at that
18 location ,where they reviewed and retained paper and electronic records pertaining to personal
19 health and billing information of patients without requisite supervision of a pharmacist.

20 **DISCIPLINARY CONSIDERATIONS**

21 85. To determine the degree of discipline, if any, to be imposed on Respondents in this
22 matter, Complainant alleges as follows:

23 **Prior Discipline - Respondent Rothman**

24 a. On or about January 31, 1987, in a prior disciplinary action entitled *In the*
25 *Matter of the Accusation Against Robert Rothman* before the Board of Pharmacy, Case
26 Number 1217 Respondent's license was revoked and revocation was stayed and
27 Respondent Rothman was placed on three (3) years probation with terms and conditions. In
28

1 addition, Respondent's Pharmacist License Number RPH 30759 was suspended for ninety
2 (90) days.

3 b. Charges in that matter stemmed from Respondent's conviction on or about
4 November 28, 1983, on his guilty plea, of violating Business and Professions Code section
5 4227 [furnishing or dispensing drugs without a prescription] and Penal Code sections
6 664/496 [attempted receipt of stolen property] in the matter *The People of the State of*
7 *California v. Robert Bruce Rothman et al.*, Orange County Superior Court, Case No. C-
8 1554 (1983).

9 **PRAYER**

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

- 12 1. Revoking or suspending Pharmacy Permit Number PHY 46745, issued to Respondent
13 Twin Pharmacy, Inc. dba Dabney Pharmacy; Shlomo Rechnitz, and Denise Wilson-Ruane;
 - 14 2. Revoking or suspending Pharmacist License Number RPH 30759, issued to
15 Respondent Robert Rothman;
 - 16 3. Ordering Respondents Dabney Pharmacy and Robert Rothman to pay the Board of
17 Pharmacy the reasonable costs of the investigation and enforcement of this case, pursuant to
18 Business and Professions Code section 125.3;
 - 19 4. Taking such other and further action as deemed necessary and proper.
- 20
21

22 DATED: May 16, 2016

23 _____
24 VIRGINIA HEROLD
25 Executive Officer
26 Board of Pharmacy
27 Department of Consumer Affairs
28 State of California
Complainant

27 LA2012507854
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